

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Related Change Request (CR) #: CR 8792

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Affordable Care Act Bundled Payments for Care Improvement (BPCI) Initiative: Provider education regarding new demonstration codes for Skilled Nursing Facility (SNF) claims and payment of SNF claims for BPCI Model 2 beneficiaries who have not met the 3-day hospital stay requirement

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8792, which directs MACs to engage in provider education regarding use of a demonstration code when utilizing a waiver of the 3-day hospital stay requirement for SNF claims. Specifically, CR 8792 supports the continuing implementation of Model 2 of the Bundled Payments for Care Improvement initiative (BPCI) by informing SNFs of the policies surrounding use of the 3-day stay waiver. Make sure that your billing staffs are aware of these changes.

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Background

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower health care costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare & Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the BPCI. Section 1115A of the Social Security Act provides authority for CMS to test the BPCI models. Model 1 Awardees began the period of performance on or after April 1, 2013; Models 2, 3, and 4 Awardees began the period of performance on or after October 1, 2013.

The BPCI models link payments for multiple services that beneficiaries receive during an episode of care.

- Under Model 1, the episode includes the acute inpatient hospital stay for all Medicare fee-for-service (FFS) beneficiaries admitted for all Medicare Severity Diagnosis Related Groups (MS-DRGs).
- Under Models 2 - 4, CMMI has developed 48 clinical episodes of care that BPCI Awardees may select to test. Each episode of care is composed of a family of anchor MS-DRGs, and each Model has a different set of services included in the episode. Select clinically-unrelated readmissions are excluded from these episodes on an MS-DRG basis, and select clinically-unrelated Part B services are excluded from these episodes on a principle ICD-9 diagnosis code basis.

The following summarizes each of the models.

- In Model 1, the episode of care is defined as the acute inpatient hospital stay and includes all inpatient hospital services. Medicare pays the Awardee a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). For each performance year, the aggregate Part A and Part B expenditures on Model 1 beneficiaries in the 30-day period following discharge from the Model 1 hospitalization are calculated and compared to expected post-episode expenditures. If the aggregate Part A and Part B expenditures exceed the expected post-episode spending threshold by a calculated risk threshold, the Model 1 Awardee must repay Medicare for this Excess Spending Amount. All Model 1 Awardees are acute care hospitals paid under the IPPS.
- In Model 2, the episode of care is defined as the acute inpatient hospital stay and post-acute care and includes physician and nonphysician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and

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Part B covered services such as clinical laboratory services; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and Part B drugs. An admission to a Model 2 episode-initiating IPPS hospital, or to any IPPS hospital where the operating or attending physician is a member of a Model 2 episode-initiating physician group practice, that results in a discharge assigned to a selected MS-DRG initiates a BPCI Model 2 episode. The episode ends, at the Awardee's selection, either 30, 60, or 90 days after discharge. Payments to providers and suppliers are made at the usual fee-for-services rates through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payments for services included in the episode are reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee; any expenditures above the target price must be repaid to Medicare by the Awardee. Awardees are also liable for any Excess Spending Amount. Model 2 Awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries in IPPS hospitals.

- In Model 3, the episode of care is defined as post-acute care including physician and nonphysician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services; DMEPOS; and Part B drugs. The episode is initiated upon admission to or initiation of post-acute services within 30 days of discharge from an IPPS hospital for a selected MS-DRG, with the Awardee's episode-initiating post-acute care provider (home health agency, skilled nursing facility, long term care hospital, or inpatient rehabilitation facility) or upon initiation of post-acute care at any post-acute care provider where the operating or attending physician for the hospitalization was a member of a Model 3 episode-initiating physician group practice. The episode ends, at the Awardee's selection, either 30, 60, or 90 days after the episode is initiated. Payments to providers and suppliers are made at the usual fee-for-services rates, through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payment for the episode is reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee; any expenditures above the target price must be repaid to Medicare by the Awardee. Awardees are also liable for any Excess Spending Amount. Model 3 Awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries receiving post-acute services.

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- In Model 4, the episode of care is defined as the acute inpatient hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services furnished during related readmissions. A single, prospectively determined bundled payment is made to the episode-initiating hospital to encompass all services furnished to all beneficiaries with the selected MS-DRG during the inpatient stay by the hospital, physicians, and non-physician practitioners. Awardees are liable for any Readmissions Amount, the dollar amount of the aggregate Medicare payments made for a clinically related readmission of a Model 4 beneficiary at a hospital other than the episode-initiating hospital; any Opt-out Physicians Amount, the dollar amount of any fee-for-service payments made to physicians declining payment under Model 4 for services covered in an episode; and any Excess Spending Amount. Awardees can be Medicare providers or suppliers, or conveners of participating health care providers.

Medicare providers that provide the initial care to beneficiaries in an Episode are referred to as Episode Initiators. Episode Initiators are generally Acute Care Hospitals paid under the IPPS (under Models 1, 2, and 4) or SNFs, long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and home health agencies (HHAs) (under Model 3). Note that physician group practices (PGPs) are also eligible Episode Initiators under Models 2 and 3.

Awardees assuming financial risk under the BPCI models have signed a participation agreement with CMS, agreeing to BPCI model payment policies and obligating the Awardees to repay the Medicare Trust Funds any outstanding amounts owed, as determined at the end of each quarter. Single Awardees are those individual Medicare providers or suppliers that assume financial risk under the model and that are the sole Episode Initiator. Awardee Conveners are parent companies, health systems, or other organizations that assume financial risk under the model on behalf of other Episode Initiators, but may or may not be Episode Initiators themselves. Awardee Conveners may or may not be Medicare providers/suppliers themselves. Additionally, Facilitator Conveners are entities that serve administrative and technical assistance functions on behalf of Designated Awardees (which occupy roles identical to those of Single Awardees) and Designated Awardee Conveners (which occupy roles identical to those of Awardee Conveners).

Participants in BPCI Model 2 may qualify for a waiver of the Medicare payment policy requiring a 3-day hospital stay prior to coverage of SNF services for a given beneficiary. Under current SNF payment policy, as a prerequisite for Part A coverage of “extended care” services in a SNF, section 1861(i) of the Social Security Act (the Act) requires a beneficiary to have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). For SNF claims included in an episode under Model 2, CMS may waive the 3-day hospital stay requirement. This waiver is granted on a Model 2 Awardee-specific basis, in response to an Awardee’s request to use the waiver and CMS’ determination that the Awardee meets all the associated requirements for waiver use.

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For Model 2 participants who qualify for use of the waiver and are granted use by CMS, the post-hospital extended care services furnished by SNFs during a Model 2 episode of care are covered under Medicare Part A in the case of Model 2 beneficiaries who are discharged from an inpatient hospital stay of less than 3 days, as long as all other coverage requirements for such services are satisfied. In order to qualify for use of the waiver, the majority of the Awardee's identified SNF partners as reported to CMS must have in effect a quality rating of 3 or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website, for at least 7 out of the preceding 12 months. CMS monitors the Awardee's use of this waiver to ensure that discharges to a SNF are medically appropriate and that the majority of the Model 2 beneficiaries that are discharged to a SNF after an inpatient hospital stay of less than 3 days are cared for at SNFs rated 3-stars or better.

When submitting claims to Medicare that require a waiver of the 3-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a "62" in the Treatment Authorization Code Field. This allows MACs to appropriately pay SNFs treating beneficiaries during Model 2 episodes.

In order to determine if use of the demonstration code "62" is appropriate, the following circumstances must be met:

- The hospitalization must not meet the prerequisite hospital stay requirement of at least 3 consecutive days for Part A coverage of "extended care" services in a SNF. If the hospital stay would lead to covered post-acute SNF treatment in the absence of the waiver, no demonstration code should be reported by the SNF;
- Model 2 Awardee (hospital, physician group practice, or Awardee Convener) responsible for the episode-initiating hospital or physician member of the episode-initiating physician group practice has been approved by CMS to use the 3-day stay waiver for the period of time of the beneficiary's hospitalization;
- The beneficiary's discharge MS-DRG is included in a Model 2 episode selected by the episode-initiating hospital or episode-initiating physician group practice;
- The beneficiary must have been discharged from a Model 2 episode-initiating hospital or an IPPS hospital where the beneficiary was treated by a physician member of a Model 2 episode-initiating physician group practice; and
- The beneficiary must have been discharged from an IPPS hospital within 30 days of the initiation of SNF services.

Any SNF with questions about determination of the above steps should consult with the episode-initiating hospital or physician group practice to identify the Model 2 Awardee that

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has documentation from CMS applicable to the use of the waiver for episodes during a certain performance quarter.

The policies described above are enforced through the MACs, who receive quarterly updates from CMS to ensure that use of Treatment Authorization Code 62 is appropriate. If a SNF claim does not meet the above requirements, then there shall be no waiver of the 3-day stay requirement for that SNF claim.

Additional Information

The official instruction, CR 8792, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106DEMO.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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