CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1189	**Date: February 15, 2013**
	Change Request 8196

SUBJECT: Bundled Payments for Care Improvement Model 4 - HI and SMI Payment Attribution and Outlier Payments

I. SUMMARY OF CHANGES: This change request is being initiated to ensure that payments made under Model 4 of the Bundled Payments for Care Improvement (BPCI) initiative are able to flow through all systems including HIGLAS for correct attribution to the Part A and Part B Medicare Trust Funds. It also excludes outlier payments from the Model 4 program, allowing outlier payments to be paid as usual throughout the life of BPCI.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1189	Date: February 15, 2013	Change Request: 8196

SUBJECT: Bundled Payments for Care Improvement Model 4 - HI and SMI Payment Attribution and Outlier Payments

EFFECTIVE DATE: July 1, 2013
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I. GENERAL INFORMATION

A. Background:

The Affordable Care Act (ACA) provides a number of new tools and resources to help improve health care and lower 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 and Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative (BPCI). On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In Model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B professional services furnished during the hospitalization, and hospital and Part B professional services for related readmissions. Applicants for this model will propose a target price for the episode that includes a single rate of discount off of expected payment (including both hospital and Part B professional services) for all beneficiaries with the agreed-upon Medicare Severity Diagnosis Related Group (MS-DRG). This model will require changes to payment starting in July 2013.

This implementation Change Request (CR) continues the work of CRs 7784, 7887, and 8070. It focuses on correcting a problem identified with the flow of payment information between FISS and HIGLAS. It also implements necessary changes to ensure outlier payments, which will not be included in Model 4 prospective payment amounts, are paid appropriately to providers during the life of BPCI.

B. Policy:

Bundled Payments initiative Model 4 hospitals will receive a prospectively established bundled payment for agreed upon MS-DRGs. This will not apply to claims that are paid on a transfer per-diem basis. This payment will include both the DRG payment for the hospital and a fixed amount for the Part B physician services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made. Participating Model 4 Bundled Payments Initiative hospitals receiving payment will take responsibility for distributing payment to providers who would otherwise be paid separately for professional services under the physician fee schedule (PFS). Claims from physicians must be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment. Physicians' incentive payments will not be affected by participation in the Bundled Payments initiative.

Payment rates may be updated quarterly to allow for changes made to the PFS and Inpatient Prospective Payment System (IPPS). Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments to Model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model, as will outlier payments and hospital capital payments. Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative,

which will be higher as it includes payment for Part B services as well as the base DRG payment. The regular Part A deductible and daily coinsurance amounts (when applicable) will continue to be applied to the claim. A fixed Part B copayment will be applied to the claim. The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable. Additionally, the beneficiary will be responsible for paying a fixed Part B copayment, calculated as an approximation of what the Part B coinsurance would have been in the absence of this Model. Both the copayment and the deductible to be paid by the beneficiary for the Part B services must appear on the Medicare Summary Notice along with the Part A deductible and any applicable coinsurance.

Hospitals will not be paid for a readmission to the same hospital under this model unless the DRG is expressly excluded as unrelated. Unrelated readmissions will be defined by CMS, and a list of DRGs defining unrelated readmissions will be provided for each included MS-DRG. Physicians' services provided during a related readmission to the original treating hospital will not be paid separately. Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians' services during related readmissions to hospitals other than the original treating hospital, will be reconciled retrospectively by a BPCI payment reconciliation contractor and payment recouped, as applicable.

Hospitals participating in this initiative must submit a Notice of Admission (NOA) when a beneficiary expected to be included in the model is admitted. This policy was included in CR 7784, issued as part of the October 2012 release. Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed. If the patient ultimately does not qualify for an episode payment based on a MS-DRG excluded from the Model 4 Bundled Payment Initiative, the $500.00 NOA payment will be recouped. Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered to be not subject to episode payment and the $500 will be recouped.

Payment of physician services included in the Model 4 Bundled Payments initiative will not affect eligibility for and calculation of incentive payments.

As part of performance monitoring and evaluation of this initiative, analyses of BPCI Model 4 claims shall be performed by contractors to CMS. A contractor also will monitor for unbundling by inappropriate shifting of Medicare services outside of the acute inpatient hospitalization.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8196.1	FISS shall add two new fields to the claim record, for non-PIP providers only, in order to store the net figures (for the Y1 and Y2 values) and send on the 837 to HIGLAS.							X				
8196.1.1	FISS shall calculate the net HI amount for a Model 4 claim with an NOA as follows:							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	Y1 Amount minus (A1, 06, 09, 11, 08, 10) plus (IME, DSH, Total Capital, Outlier)***minus $500.***											
8196.1.2	FISS shall calculate the net HI amount for a Model 4 claim without an NOA as follows: Y1 Amount minus (A1, 06, 09, 11, 08, 10) plus (IME, DSH, Total Capital, Outlier)							X				
8196.1.3	FISS shall calculate the net SMI amount as follows: Y2 Amount minus (Y5, Y3)							X				
8196.2	Downstream systems shall accept and store the new fields for net HI and SMI amounts.											HIGLAS, PS&R, Cost Reporting, IDR
8196.2.1	When a Model 4 claim is adjusted as a reversal to a non-Model 4 claim, FISS shall send the Mother claim with value code Y1 and Y2 and the adjustment claim will be sent without value codes Y1 and Y2.							X				
8196.2.2	FISS shall populate the two new amount fields with the Net HI and Net SMI amounts on the Mother Claim. The adjustment claim will not have the two new amount fields populated as the adjusted claim is not a model 4.							X				
8196.2.3	FISS shall populate the adjusted amount on the Provider Reimbursement Amount field.							X				
8196.2.4	HIGLAS shall use the Trust Funds appropriately for the adjustment											HIGLAS
8196.3	FISS and HIGLAS shall participate in conference calls as needed to refine the business requirements.							X				HIGLAS
8196.4	FISS shall treat outlier payments the same as IME, DSH and Capital payments are treated for Model 4 BPCI claims (ie. Outside of the Model 4 bundled							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	payment).											
8196.5	FISS shall calculate the net reimbursement for a Model 4 (demo code 64 present) claim that has a finalized NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment) - $500.00+ IME+DSH+Total capital.+Outlier							X				
8196.5.1	FISS shall calculate the net reimbursement for a Model 4 (demo code 64 present) **PIP** claim that has a finalized NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment) - $500.00+ IME+DSH+Total capital.+Outlier + New Technology+Hemophilia							X				
8196.6	FISS shall calculate the net reimbursement for a Model 4 (demo code 64 present) claim that does not have a finalized NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment) + IME+DSH+Total Capital+Outlier.							X				
8196.6.1	FISS shall calculate the net reimbursement for a Model 4 (demo code 64 present) **PIP** claim that does not have a finalized NOA as follows: (Part A Demonstration Amount + Part B Demonstration Amount) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment) + IME+DSH+Total Capital+Outlier+New Technology+Hemophilia							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8196.7	FISS shall calculate the net reimbursement for readmissions (readmission indicator = 1) as follows: (IME+DSH+ Total Capital+Outlier) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment).							X				
8196.7.1	FISS shall calculate the net reimbursement for **PIP** readmissions (readmission indicator = 1) as follows: (IME+DSH+ Total Capital+Outlier + New Technology+Hemophilia) – Part A deductions (deductible, blood deductible, coinsurance and LTR amount) – Part B deductions (deductible and copayment).							X				
8196.8	FISS shall validate the changes made with CMS CR 7887 with HIGLAS.							X				
8196.9	FISS shall accept a Model 4 claim from a PIP provider and process under Model 4 methodology but reimburse outlier, new technology, and hemophilia if applicable. FISS shall not send value codes Y1 and Y2 or the net HI and net SMI.							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR 7784: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - Implementation Phase One
	CR 7887: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - Implementation Phase Two
	CR 8070: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - Implementation Phase 3

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sarah Shirey-Losso, 410-786-0187 or Sarah.Shirey-Losso@cms.hhs.gov, Cami DiGiacomo, 410-786-5888 or cami.digiacomo@cms.hhs.gov, Pamela Pelizzari, 410-786-5937 or pamela.pelizzari@cms.hhs.gov, Val Ritter, 410-786-8652 or Valeri.Ritter@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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