Benefit Enhancements

Effective Date: 01/01/2018

Policy

It is the policy of the ACO to abide by all rules and regulations set forth by the Centers for Medicare & Medicaid Services (CMS) in regards to the Benefit Enhancements available to the ACO under the Next Generation ACO Model.

A. The ACO shall take all necessary steps to ensure compliance with the rules of any and all applicable Benefit Enhancements it opts to employ.

Applicability

This policy and procedure applies to the ACO and all its Next Generation Participants, Preferred Providers, Next Generation Professionals and other individuals or entities performing functions or services related to the ACO's activities.

Procedure

A. The ACO may elect to provide one or more Benefit Enhancements for a Performance Year. For each Benefit Enhancement elected, the ACO shall submit an Implementation Plan. The available Benefit Enhancements are:

    1. 3-Day SNF Rule Waiver Benefit Enhancement,
    2. Tele health Expansion, and
    3. Post-Discharge Home Visits.

B. 3-Day SNF Rule Waiver Benefit Enhancement: allows SNF Services furnished by Eligible SNFs to be covered under Medicare Part A for Eligible Beneficiaries who are admitted to the SNF without a prior inpatient hospital stay ("Direct SNF Admission") or who are discharged from a hospital to the SNF after an inpatient hospital stay of fewer than three days, as long as other coverage requirements for such services are satisfied.

    1. The ACO shall maintain and provide to its Next Generation Participants and Preferred Providers an accurate and complete list of Eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF eligibility. This list shall also be furnished to a Beneficiary, upon request.
    2. In order to be eligible to submit claims for services furnished to Beneficiaries pursuant to the 3-Day SNF Rule Waiver Benefit Enhancement, an entity must be:
        a. A Next Generation Participant or Preferred Provider;
        b. A skilled-nursing facility ("SNF") or a hospital or critical access hospital that has swing-bed approval for SNF services ("Swing-Bed Hospital");

c. Designated on the Participant List or the Preferred Provider List as participating in the 3-Day SNF Rule Waiver Benefit Enhancement; and

d. Approved by CMS.

3. In the event that an Eligible SNF provides SNF Services under this Waiver to a Beneficiary who is not eligible to receive services under the waiver: CMS shall make no payment to the Eligible SNF for such services and the ACO shall:

a. CMS may, in some limited circumstances make payment but recoup the payment from the ACO, payable as Other Monies Owed for the Performance Year. In most cases, CMS will make no payment.

b. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services;

c. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary; and

d. The ACO shall indemnify and hold the Beneficiary harmless for payment of any such services provided to the Beneficiary.

4. The ACO will conduct periodic reviews to ensure that admission of Eligible Beneficiaries to Eligible SNFs under this waiver are medically appropriate and consistent with the terms of the Waiver.

5. In the event that a CNS or Swing-Bed Hospital is not approved by CMS for participation in the 3-Day SNF Rule Waiver, but is otherwise eligible to participate in the ACO, the ACO will have 30 days after the date of the notice from CMS to:

a. either remove the provider from the Participant List or Preferred Provider List, or

b. simply amend the relevant list to reflect that the provider will not participate in the 3-Day SNF Rule Waiver.

C. Tele health Expansion: Waives certain provisions of section 1834 of the Social Security Act, and 42 C.F.R. Section 410.78 and 414.65 with respect to tele health services furnished in accordance with the requirements of the Tele health Expansion Benefit Enhancement.

1. In order to be eligible to bill for tele health services furnished to Beneficiaries pursuant to the Tele health Expansion Benefit Enhancement, an individual or entity must be:

a. A Next Generation Professional or Preferred Provider who is a physician or other practitioner;

b. Authorized under relevant Medicare rules and state law to bill for tele health service;

c. Designated on the Participant List or Preferred Provider List as participating in the Tele health Expansion Benefit Enhancement; and

d. Approved by CMS.

2. The ACO shall ensure that Next Generation Participants and Preferred Providers do not substitute tele health services for in-person services when in-person services are more clinically appropriate.

3. The ACO shall ensure that Next Generation Participants and Preferred Providers only furnish Medically Necessary tele health services and do not use tele health services to prevent or deter a Beneficiary from seeking or receiving in-person care when such care is Medically Necessary.

4. In the event that technical issues with telecommunications equipment required for tele health services cause an inability to appropriately furnish such tele health services, the Eligible tele health Provider shall not submit a claim for such tele health services.

5. All tele health services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining portions of section 1834(m) of the Social Security Act and 42 C.F.R Sections 410.78 and 414.65.

D. Post-Discharge Home Visits: increases the availability to beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility by altering the supervision level for "incident to" services to allow personnel under a physician's general supervision (instead of direct supervision) to make home visits as long as certain requirements are met.

1. The services must be furnished to a Beneficiary who either does not qualify for Medicare coverage of home health services under 42 C.F.R Section 409.42 or who qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as provided in Medicare Benefit Policy Manual, Chapter 15 Section 60.4.

2. The services must be furnished in the Beneficiary's home after the Beneficiary has been discharged from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility.

3. The services furnished under this Benefit Enhancement may not be furnished more than two times: one time in the first ten days following discharge and one additional time in the first 30 days following discharge.

4. In order to be eligible to submit claims for post-discharge home visits furnished to Beneficiaries pursuant to this Benefit Enhancement, the supervising physician or other practitioner must be:

a. Either

i. A Next Generation Professional or Preferred Provider [who is a physician or other practitioner], or

ii. Eligible under Medicare rules to submit claims for "incident to" services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and

b. Designated on the Next Generation Participant List or Preferred Provider List as participating in the Post-Discharge Home Visit Benefit Enhancement.

5. The individual performing services under this Benefit Enhancement must be either:

   a. "Auxiliary personnel" as defined at 42 CFR Section 410.26(a)(1); or

   b. Authorized under applicable state law to perform such functions.

6. The ACO shall ensure, through its contract with each Next Generation Participant and Preferred Provider that will be participating the Post-Discharge Home Visit Benefit Enhancement, that each Next Generation Participant or Preferred Provider shall be accountable for auxiliary personnel's compliance with the terms of the Next Generation ACO Model Participation Agreement and the policies of the ACO.

7. The services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. Section 410.26(b).

8. The ACO shall ensure that post-discharge home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

E. Responsibility for Denied Claims: In the event that CMS denies a claim under one of the Benefit Enhancements:

1. CMS may, in some limited circumstances make payment but recoup the payment from the ACO, payable as Other Monies Owed for the Performance Year. In most cases, CMS will make no payment.

2. The ACO shall ensure that the individual or entity that provided the Services does not charge the Beneficiary for the expenses incurred for such services;

3. The ACO shall ensure that the individual or entity that provided the Services returns to the Beneficiary any monies collected from the Beneficiary; and

4. The ACO shall indemnify and hold the Beneficiary harmless for payment of any such services provided to the Beneficiary.

F. Access to Up-to-Date Beneficiary Rosters: Compliance with the Benefit Enhancement requirements cannot be ensured if Next Generation Participants and Preferred Providers do not have access to the most up-to-date information regarding Beneficiary alignment to the ACO. Without this information, the Next Generation Participant or Preferred Provider may inadvertently refer an ineligible Beneficiary, or file an inappropriate claim under one of the Enhancements. As a result, the ACO has established appropriate procedures to ensure that Next Generation Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

Effective Date: 01/01/2018

D. Requirements for Termination of Benefit Enhancements: The ACO must obtain CMS consent before voluntarily discontinuing any Benefit Enhancement during a Performance Year. The effect of such termination shall be the date specified by CMS in the notice to the ACO.

1. Within 30 days after the effective date of termination, the ACO shall send notice in writing to the affected Beneficiaries. Such notification shall state that following a date that is 90 days after the effective date of termination or the end of the Performance year, whichever is sooner, the Benefit Enhancement will no longer be covered by Medicare and the Beneficiary may be responsible for the payment of such services.
2. CMS shall cease coverage of claims for a terminated Benefit Enhancement 90 days after the effective date of such termination.
3. In the event that the ACO elects to discontinue a Benefit Enhancement at the end of the Performance Year, the ACO shall notify all its Next Generation Participants and Preferred Providers no later than 30 days prior to the start of the subsequent Performance Year.

Reporting

A. The ACO is required to submit quarterly reports to CMS regarding the use of the Benefit Enhancements and to provide CMS with supplemental information upon request regarding their use. All Reporting submitted to CMS will also be shared with <insert appropriate committees> and the Governing Body of the ACO.

Related Documentation

A. Next Generation ACO Model Participation Agreement Section XI, Appendices I-K

Additional Guidance

Should the ACO determine that the use of a waiver is implicated in an activity it wishes to pursue; the ACO Governing Body should discuss the activity with its Executive Director. The ACO should always discuss prospective partnerships or other arrangements with the Legal Department prior to initiating any such agreements with organizations outside of the ACO.