CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 216	**Date: December 21, 2018**
	Change Request 10907

Transmittal 215, dated November 25, 2018, is being rescinded and replaced by Transmittal 216, dated, December 21, 2018 to add the CWF maintainer as a responsible party to business requirements 10907.1.1, 10907.1.2 and 10907.1.3. All other information remains the same.

SUBJECT: Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS

I. SUMMARY OF CHANGES: This Change Request (CR) provides instruction to Medicare payment contractors to implement new Healthcare Common Procedure Coding System (HCPCS) codes for an existing benefit enhancement - the Post Discharge Home Visit waiver. Claims for Post Discharge Home Visit Waiver shall be processed for reimbursement and paid when they meet the appropriate payment requirements as outlined in this CR.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2019

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	N/A

III. FUNDING:
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 obligated 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:

Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 216	Date: December 21, 2018	Change Request: 10907

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SUBJECT: Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS

EFFECTIVE DATE: January 1, 2019
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I. GENERAL INFORMATION

A. Background: The aim of the Next Generation ACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare Fee-for-Service (FFS). The benefit provides greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS is issuing the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the Next Generation ACO Model. An ACO may choose not to implement all or any of these benefit enhancements. Applicants will be asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

Participants in the Next Generation ACO Model are required to provide implementation information to CMS, which, upon approval, will enable the ACO's use of the optional benefit enhancements. Each optional benefit enhancement will have such an "implementation plan" requiring, for example:

(1) descriptions of the ACO's planned strategic use of the benefit enhancement;

(2) self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and

(3) documented authorization by the governing body to participate in the benefit enhancement.

RTI International is the specialty contractor creating the Next Generation ACO provider alignment files.

B. Policy: Section 1115A of the Social Security Act (the Act) (added by section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the Center for Medicare & Medicaid Services (CMS) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

This CR makes modifications to the operations of a current benefit enhancement offered by the Model.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10907.1	For dates of service 1/1/2019 and after, contractors shall allow NG ACO and VT ACO post discharge home visit claims for licensed clinicians under the general supervision of a VT ACO or NG ACO provider when this benefit enhancement is elected by the provider for the DOS on the claims and only when the claim contains the following HCPCS codes: • G2001 • G2002 • G2003 • G2004 • G2005 • G2006 • G2007 • G2008 • G2009 • G2013 • G2014 • G2015 This shall apply to Type of Bill: 85X, Rev Codes: 96X, 97X, or 98X **NOTE:** The requirements in CR 9151.26 and 9151.26.1 shall continue to apply to dates of service prior to 4/1/2019.	X	X			X	X			
10907.1.1	Contractors shall add HCPCS G2001 - G2004 to the MSN HCPC descriptor file with the following long descriptions: G2001: Brief (20 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) G2002: Limited (30 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	more than 9 times.) G2003: Moderate (45 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) G2004: Comprehensive (60 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) Type of Service 1 (TOS1) applies to these HCPCS Effective date of these HCPCS is 1/1/2019									
10907.1.2	Contractors shall add HCPCS G2005 - G2008 to the MSN HCPC descriptor file with the following long descriptions: G2005: Extensive (75 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) G2006: Brief (20 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) G2007: Limited (30 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	within 90 days following discharge from an inpatient facility and no more than 9 times.) G2008: Moderate (45 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) Type of Service 1 (TOS1) applies to these HCPCS Effective date of these HCPCS is 1/1/2019									
10907.1.3	Contractors shall add HCPCS G2009, and G2013 - G2015 to the MSN HCPC descriptor file with the following long descriptions: G2009: Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) G2013: Extensive (75 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times. G2014: Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) G2015: Comprehensive (60 mins) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	discharge from an inpatient facility.) Type of Service 1 (TOS1) applies to these HCPCS Effective date of these HCPCS is 1/1/2019									
10907.1.4	Contractors shall process and flag NG ACO and VT ACO Post Discharge Home Visits claims with benefit enhancement indicator "3" when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claim, when the beneficiary is aligned for the submitted claim, and includes one of the following HCPCS codes: • G2001 • G2002 • G2003 • G2004 • G2005 • G2006 • G2007 • G2008 • G2009 • G2013 • G2014 • G2015	X	X			X	X			
10907.1.5	Medicare contractors shall apply a rate for HCPCS codes: • G2001 • G2002 • G2003 • G2004 • G2005 • G2006 • G2007 • G2008 • G2009 • G2013 • G2014 • G2015	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The rate will be displayed in the April 2019 Physician Fee Schedule update.									
10907.1.6	FISS shall reimburse the lesser of the billed charge or MPFS rate for CAH Method II providers billing on Type of Bill: 85X, Rev Codes: 96X, 97X, or 98X					X				
10907.1.7	The Shared System Maintainers (SSMs) shall consider a beneficiary aligned if the from date on the date of service on the claim is on or after the effective start date and on or before 90 days after the effective end date.					X	X			
10907.1.8	Contractors shall reject or return as unprocessable a claim line with HCPCS G2001 - G2009, or G2013 - G2015 that do not fall on or within the effective start date and effective end date of the provider on the Next Generation ACO or Vermont ACO participant or preferred provider file with benefit enhancement indicator "3" Post Discharge Home Visits. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					X	X			
10907.1.8.1	Medicare contractors shall assign Claim Adjustment Reason Code (CARC) 96 (Non-covered charge(s) with Remittance Advice Remark Code (RARC) N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO (contractual obligation).	X	X							
10907.1.9	Contractors shall reject or return as unprocessable a claim line with HCPCS G2001 - G2009, or G2013 - G2015 that do not fall on or within the effective start date and effective end date and on or before 90 days after the effective end date of the beneficiary alignment. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					X	X			
10907.1.9.1	Medicare contractors shall assign CARC 96 (Non-covered charge(s) with RARC N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(contractual obligation).									
10907.1.10	Contractors shall display the following message on all NG-ACO Post Discharge Home Visits claims: MSN Message 61.3 English You received this home visit service from your Next Generation Accountable Care Organization (ACO) provider. You may have been able to receive this care because of your relationship with the ACO. Ask your doctor to tell you more about your ACO. Spanish Ha recibido el servicio de visita a la casa de parte del proveedor de su nueva generación de organización responsable del cuidado de salud (ACO). Es posible que recibió esta atención a causa de su relación con la ACO. Pregúntele a su médico que le diga más sobre su ACO.	X	X			X	X			
10907.1.10.1	Contractors shall display the following message on all VT-ACO Post Discharge Home Visits claims: MSN Message 61.7 English You received this home visit service from your Vermont Accountable Care Organization (ACO) provider. You may have been able to receive this care because of your relationship with the ACO. Ask your doctor to tell you more about your ACO. Spanish Ha recibido el servicio de visita a la casa de parte del proveedor de su nueva generación de organización responsable del cuidado de salud (ACO). Es posible que recibió esta atención a causa de su relación con la ACO. Pregúntele a su médico que le diga más sobre su ACO.	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10907.1.11	CWF shall apply a reject at the claim level if the Beneficiary has a Home Health Episode present with or without the DOEBA/DOLBA and the Dates of Service with Demo Code "74" or "89" and Benefit Enhancement Indicator "3" for NG ACO or VT ACO is during the Beneficiary's Home Health Episode. Note: The reject code will be created by BR10824.4.11								X	
10907.1.11.1	Medicare contractors shall reject or return as unprocessable a claim and assign Claim Adjustment Reason Code (CARC) 96 (Non-covered charge(s) with Remittance Advice Remark Code (RARC) N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO (contractual obligation).	X	X							
10907.1.12	Contractors shall process and flag NG ACO Post Discharge Home Visits claims with benefit enhancement indicator “3” when this benefit enhancement is elected by the provider for the DOS on the claim, when the beneficiary is aligned for the submitted claim, and for dates of service prior to 4/1/2019, and has one of the following HCPCS codes: • 99324-99337 • 99339-99340 • 99341-99350	X	X			X	X			
10907.2	Contractors shall reject or return as unprocessable if a claim or if separate claims with the same date of service contains a Post Discharge Home Visit HCPCS code and a Care Management Home Visit HCPCS code.					X				IOCE, NCCI/MUE
10907.3	The Single Testing Contractor (STC) shall provide to ACO-OS the provider and beneficiary data to create the test files by December 16, 2018. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS, STC, VDC
10907.3.1	The ACO-OS shall provide the provider alignment and beneficiary alignment test and final files to STC									CMS, STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	on or before the week of January 18, 2019. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									
10907.3.2	The Medicare Administrative Contractors (MACs) shall provide to ACO-OS the provider and beneficiary data to create the test files on or about the week of February 1, 2019. These sample beneficiaries and providers shall be provided in a single excel file using the layout of HICNs, TINs, and NPIs. The ACO-OS shall provide a template of this Excel document. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov	X	X							CMS
10907.3.3	The ACO-OS shall push the test files to the Virtual Data Centers (VDCs) on or about the week of March 4, 2019 and transmit the test files with the MACs. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS
10907.4	The Fiscal Intermediary Standard System (FISS) shall interrogate all possible Provider NG ACO alignment records for the CCN/NPI billed on the claim to determine a match, when multiple CCN/NPI alignment records exist.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10907.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Drew Kasper, 303-562-7013 or Drew.Kasper@cms.hhs.gov , Karin Bleeg, 202-365-4347 or karin.bleeg@cms.hhs.gov (Karin Bleeg will be available for questions on this CR until mid-October. Please contact Brede Eschliman or Drew Kasper after mid-October.) , Brede Eschliman, brede.eschliman@cms.hhs.gov , Fatema Salam, 202-549-7619 or fatema.salam1@cms.hhs.gov (Vermont ACO POC)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 obligated 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.

ATTACHMENTS: 0