Next Generation ACO Model
Skilled Nursing Facility (SNF) Three-Day Rule Waiver

December 2018

Currently, in traditional fee-for-service (FFS) Medicare, beneficiaries are eligible for Medicare covered skilled nursing facility (SNF) services when a beneficiary is admitted within 30 days of either (1) an inpatient hospital stay of three consecutive days or more (i.e., qualifying hospital stay), starting with the day the hospital admits the beneficiary as an inpatient, but not including the day they leave the hospital; or (2) a previous SNF stay. The time a beneficiary is in the hospital being observed or in an emergency room before they are admitted does not count toward the three-day qualifying inpatient hospital stay. However, the Next Generation ACO (NGACO) waiver allows an aligned beneficiary to be eligible for Medicare covered SNF services when admitted to a SNF without a three-day qualifying inpatient hospital or previous SNF stay, including beneficiaries who are in the hospital for fewer than three days or admitted directly from a physician's office.

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Frequently Asked Questions

Q1: **What is the SNF three-day rule waiver?**

A: The SNF three-day rule waiver makes available to approved Next Generation ACOs (NGACOs) and their skilled nursing facilities (SNFs) a waiver of the rule requiring a three-day stay in an inpatient hospital, acute-care hospital, or critical access hospital (CAH) with swing-beds prior to admission to a skilled nursing facility (SNF). In other words, this benefit enhancement allows for beneficiary admission to approved NGACO Next Generation Participant or Preferred Provider SNFs either directly or with an inpatient hospital stay of fewer than three days.

Q2: **Who is eligible to use the waiver?**

A: The waiver is available to Next Generation Participants and Preferred Providers for ACO-aligned beneficiaries to use if: (1) the beneficiary does not reside in a nursing home or SNF for long-term custodial care at the time of the decision to admit to a SNF; and (2) the beneficiary meets all other CMS criteria for SNF admission, including:

- being medically stable;
- having confirmed diagnoses (e.g., does not have conditions that require further testing for proper diagnosis);
- not requiring inpatient hospital evaluation or treatment; and
- having an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

Next Generation Participant or Preferred Provider SNFs must also have, at the time of provider list submission, an overall rating of three or more stars for seven of the past 12 months under the CMS Five-Star Nursing Home Quality Rating System. ACOs are responsible for verifying each year that SNFs remain eligible for the Next Generation Participant or Preferred Provider list. ACOs can retrieve historical star ratings for each SNF by selecting "Get Archived Data" at the following link: https://data.medicare.gov/data/nursing-home-compare.

For more information about beneficiary eligibility requirements, including the exclusion of patients in long-term custodial care, please refer to Appendix I in Section 4 of the Participation Agreement.

Q3: **Will critical access hospitals (CAH) that are certified to provide the Medicare SNF benefit be considered eligible SNF applicants under the waiver?**

A: If you are working with a CAH that bills for SNF services and meets all other requirements under the waiver, that provider would be eligible for the waiver. The waiver will apply to SNF providers that use 18x, 21x, and 28x bill types. Please be sure that the CMS Control Number (CCN) you submit for such a provider is the one applied to SNF claims; CMS checks CCNs (not National Provider Identifiers, or NPIs) when approving SNF waiver claims. Typically, this CCN is different than the one the CAH submits for non-SNF services. Without the correct CCN, the three-day rule will not be waived.

Q4: **When can additional SNFs be added to the Next Generation Preferred Provider list?**

A: Participating ACOs have the opportunity to add additional SNFs (i.e., Preferred Providers) at designated points during the performance year, which are announced in the Next Generation ACO Model Newsletter.

Q5: **If a participating SNF waiver facility falls below a three-star rating, is there a formal process to remove it from our Next Generation Participant and Preferred Provider list?**

A: Star ratings are reviewed at the time of Next Generation Participant or Preferred Provider list submission. Once the SNF has been approved for inclusion on the list for a given performance year, it is not removed during the performance year if the star rating declines unless requested by the ACO. If an ACO would like to remove a SNF from its Next Generation Participant or Preferred Provider list, the ACO should follow the process for submitting a provider termination to CMS.

Q6: **What happens if a beneficiary is excluded from an ACO's alignment during an SNF stay?**

A: If a beneficiary is excluded from an ACO's alignment list during the year, SNF waiver claims submitted within 90 days of the effective exclusion date will be paid.

Q7: **Does the physician or provider who refers the beneficiary to an eligible SNF waiver facility have to be a Next Generation ACO Participant or Preferred Provider?**

A: No. The physician or provider who refers the beneficiary to an eligible SNF waiver facility does not need to be a Next Generation ACO Participant or Preferred Provider; only the SNF needs to be an approved SNF waiver facility.

Q8: **Suppose a beneficiary is admitted to an eligible SNF under the three-day rule waiver. After six days, the patient or a family member requests a transfer to a SNF that is closer to their home. The second SNF is not an eligible SNF. Is the second SNF eligible for Medicare payment?**

A: The second SNF is eligible for payment because the beneficiary was initially admitted to an eligible SNF under the three-day rule waiver.

Q9: **Suppose a beneficiary was admitted to an eligible SNF under the three-day rule waiver. On day 10, the beneficiary is discharged to his or her home. On day 20, the beneficiary is admitted to a non-eligible SNF under the three-day rule waiver. Is the second SNF stay eligible for payment?**

A: The second SNF stay is eligible for payment because the beneficiary was initially admitted to an eligible SNF under the three-day rule waiver. Further, Medicare's Benefit Policy Manual reads, "After you leave the SNF, if you re-enter the same or another SNF within 30 days, you may not need another qualifying three-day hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days." Therefore, since the beneficiary was in an eligible SNF at the beginning of the scenario, the stay at the ineligible SNF waiver facility will not require a qualifying three-day hospital stay.

Q10: **Can a patient be admitted to a SNF from an observation stay?**

A: Yes, that would be considered a SNF-waiver admission since there was no preceding three-day hospital stay.

Q11: **Do SNFs need to include demonstration or condition codes on waiver-related claims?**

A: No, SNFs admitting waiver patients do not need to apply demonstration or condition codes to the claims. The FFS system has been configured to recognize Next Generation ACO SNF waiver claims, so SNFs do not need to do anything different than they do when they submit regular FFS claims.

Q12: **What if a beneficiary's care is part of the Bundled Payments for Care Improvement (BPCI) Initiative?**

A: The BPCI Initiative, sometimes referred to as "bundles," includes four models of care that link payments for various services beneficiaries receive during a specific episode of care. This Initiative has its own SNF three-day rule waiver, so NGACO beneficiaries whose care is covered through one of the bundles are **not** considered part of the NGACO SNF three-day rule waiver.

For more information about the BPCI Initiative, please refer to CMS's website: https://innovation.cms.gov/initiatives/bundled-payments/.

Q13: **How can I check beneficiary and SNF eligibility to use the waiver in real-time?**

A: An ACO can use the ACO User Interface (ACO-UI) to check beneficiary and SNF eligibility to use the SNF waiver. The ACO can also provide access (with restricted view, access) to their SNFs to use this tool to check eligibility. The ACO-UI is the same system you use to add or terminate Participant and Preferred Providers, and select Benefit Enhancements for your providers. You can find the ACO UI user guides on the Connect Site by searching in the Library for: ACO_UI_External_User_Guide_Quickstart or ACO_UI_User_Guide.

Q14: **Do SNF advertising materials used by Next Generation Participants and Preferred Providers that relate to the waiver need to be approved by CMS?**

A: Yes, ACOs must have descriptive ACO materials reviewed and approved by CMS before Next Generation Participants and Preferred SNFs can use them. Refer to the Next Generation ACO Model Participation Agreement for further information about "Descriptive ACO Materials and Activities."

Q15: **Does the waiver affect the number of allowable rehabilitation days under Medicare?**

A: No, the waiver does not affect CMS requirements or regulations regarding the maximum allowable annual rehabilitation days.

Preadmission Screening and Resident Review (PASRR)

Q1: **What is the difference between a Level I screen and Level II evaluation?**

A: There are two components of PASRR: Level I screens and, if the person tests positive in the Level I screen, a Level II evaluation and determination. Level I screens could be done online and result in an immediate indication that a Level II may or may not be needed.

If a Level II evaluation is considered necessary, it can be performed fairly quickly if the correct personnel are in place. Following that Level II evaluation, a formal determination must be still be made that a mental illness (or intellectual disability or related condition) exists. This entails distributing letters to the individual, his or her physician, and guardians (if relevant). (The distinction between Level II evaluations and Level II determinations is made more fully after question 1 above.) Determinations based on evaluations can often be made quickly, but they are not "immediately" because they must follow an evaluation. If in fact the determinations are immediate, we would be curious to know more about the situation.

Q2: **Are PASRR screens always required when someone is applying for admission to a Medicaid-certified nursing facility?**

A: PASRR screens (Level I) and evaluations (Level II, when necessary) are always needed when someone is applying for admission to a Medicaid-certified nursing facility. It doesn't matter whether an individual comes from an inpatient setting, an emergency department, or the community.

Q3: **Can states delegate authority to hospitals to do the PASRRs?**

A: Hospital staff—especially discharge planners—often conduct Level I preliminary screens. That's perfectly acceptable. States could also delegate the authority to conduct Level II evaluations. This is done less frequently because some hospitals may find that they don't perform enough Level II's to warrant training staff.

There are some restrictions on who may delegate and who may be delegated the different parts of PASRR. There are no federal requirements regarding who may perform the Level I screen, which is intended to identify all individuals who might have mental illness or intellectual disability. These may be done by hospital discharge planners, social workers, and even the nursing facility staff.

Level IIs have two components, the Level II evaluation and the Level II determination. Level II evaluations are designed to: (1) confirm whether an applicant has mental illness or an intellectual disability, (2) assess the applicant's need for nursing facility services, and (3) to assess whether the applicant needs specialized services or specialized rehabilitative services.

Level II determinations are legal documents issued to the individual, which (1) summarizes the evaluation information, (2) specifies whether a PASRR "target condition" (mental illness or intellectual disability) was present, (3) indicates if specialized services are necessary,

and (4) makes recommendations for specialized rehabilitative services if the individual was approved for nursing facility services. Copies of the determination document are forwarded to the individual's primary care physician, the nursing facility to which the individual applied, and (if applicable) to the referring Level I entity.

Level II evaluations are the responsibility of the State Medicaid agency; regulations prohibit the State mental health authority from doing evaluations. The State Medicaid agency may delegate the Level II evaluation to other entities, whether to hospital discharge planners, or to other staff working for other entities (so long as they do not have a direct or indirect relationship with the nursing facility).

The Level II determination is the responsibility of the State mental health authority, and the State mental health authority can choose to delegate this responsibility.

For individuals believed to have an intellectual disability, both the Level II evaluation and determination responsibility lies with the State intellectual disability authority, which may delegate this responsibility to other entities.

See Code of Federal Regulations (CFR) at 42 CFR 483.106 for the regulations on delegation.

Q4: **Is there a consistent definition on the severity of mental illness?**

A: The final determination of whether someone has a serious mental illness depends in part on meeting the criteria laid out in the 42 CFR 483.102 and 42 CFR 483.134. Variations in who is determined to have a mental illness can be caused by many factors, including variations in the quality of training.

Q5: **Should community mental health centers (CMHCs) conduct Level II evaluations?**

A: Per 42 CFR 483.106, CMHCs should not conduct Level II evaluations unless they operate independent of the state mental health authority (e.g., if they are non-profits). Even when they are independent, the contract should be between the Medicaid agency and the CMHCs, not between the state mental health authority and the CMHCs. This is because the state mental health authority does not have responsibility for Level II evaluations and therefore cannot delegate that function. The state mental health authority does, however, have responsibility for Level II determinations, which it can choose to delegate as it sees fit. The distinction between Level II evaluations and Level II determinations is explained more on the previous page.

Q6: **Has the Physician-Focused Payment Model Technical Advisory Committee (PTAC) received feedback from states in how to improve turnaround times for evaluations and determinations?**

A: PTAC has heard from states that electronic systems tend to speed up evaluations and determinations considerably. Having family members available to help provide input can be valuable, and can help evaluators develop person-centered evaluations. Including individuals' representatives or families in the Level II evaluation to the extent possible is also a requirement of 42 CFR 483.128.

Q7: **The hours of operation of the vendor PASRR can be an enormous barrier. What can ACOs do to improve the hours of operation by the vendor PASRR?**

A: In PTAC's experience, vendors are most effective when they have staff available after hours and on weekends. Many states struggle (to varying degrees) with the issue of timeliness. While neither CMS nor PTAC has conducted a systematic review of how states deal with this problem, our contacts with states lead us to believe that hiring a qualified vendor with expertise in PASRR can hasten the process dramatically. One reason is that vendors often contract with staff who are available on weekends or at other times when governmental staff (state, county, or local) would not be available. These requirements can be set out in a request for proposals, and made an enforceable part of the contract between the vendor and the relevant state agency.

Quarterly Data Submission

Q1: **Which SNF admissions should be included in the Excel-based data submission tool?**

A: Data should be submitted for all SNF admissions that meet the following criteria:

- Admitted to a SNF under the three-day rule waiver before or during the reference period (that is, the start and end date of the current quarter)
- SNF discharge occurred within the reference period

For example, if a patient is admitted to the SNF on January 15, 2018, and discharged on March 30, 2018, they should be submitted in the 2018 Q1 data collection tool. If the patient were instead discharged in the next quarter (for instance, on April 2, 2018), they would be submitted in the 2018 Q2 data collection tool.

Because each three-day rule waiver admission should be entered into the tool, patients with multiple waiver admissions would be included multiple times. Do not include SNF admissions that did not require the three-day rule waiver, including admissions for patients whose care is covered by the BPCI Initiative ("bundles").

Q2: **Each waiver admission must be categorized by type based on patient's location before SNF admission. How do I determine whether to categorize a waiver admission as an observation, ED/community, or short inpatient admission?**

A: These categories are mutually exclusive and are based on the following definitions:

- **Observation admissions.** Patients admitted to the SNF from observation status. It is possible that some of these patients were in the ED before they transitioned to observation status. SNF admissions for patient seen in an observation unit embedded within an emergency department (ED) or inpatient facility but not considered to be in observation status should be included in the other categories.
- **ED/other.** Patients admitted to the SNF from the emergency department (ED), the community (meaning a physician's office or the patient's home), or another location (such as an urgent care center). The patients' SNF admission was *not* immediately preceded by an inpatient stay or time spent in observation status.
- **Short inpatient.** Previously labeled "<3 day inpatient," these patients were admitted to the SNF from an inpatient hospital stay of less than three days.

Q3: **Suppose a patient is admitted to a SNF under the three-day rule waiver, transferred to the ED, and then transferred back to the SNF. Should this scenario count as a single admission or two separate admissions?**

A: The three-day rule waiver affects SNF admission requirements but does not change Medicare coverage after the patient has been admitted to the SNF. For more information, see Chapter 8 of the Medicare Benefit Policy Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf). In this scenario, if the SNF considers the treatment to be a single episode of care (i.e., the SNF is paid for a single stay), then it should be counted as a single admission under the waiver for data collection purposes.

Q4: **I noticed the data submission tool contains multiple worksheets. Am I required to complete all the worksheets, including entering admission-level data into the "data entry" worksheets?**

A: No, you are only required to submit the "summary report" worksheet, which contains aggregated data. Completing the admission-level "data entry" worksheets is optional. If your ACO has not already calculated aggregated data, the admission-level "data entry" worksheets may help with data collection efforts.

The two options for submitting data are:

1. Enter data directly into the "summary report" worksheet. (To overwrite the formulas that link the two "data entry" worksheets to the "summary report" worksheet, go to the "review" tab in the ribbon at the top of your screen and click on the button labeled "unprotect sheet.")

   OR

2. Enter admission-level data into the three worksheets labeled "data entry–ED/other," "data entry–short inpatient," and "data entry–observation." These admission-level data will automatically populate the "summary report" worksheet with predefined, locked formulas.

Q5: **I tried to enter an admission or discharge date into one of the data entry worksheets in the data submission tool and got a pop-up error message. What does this mean?**

A: The worksheet for does not allow you to enter a SNF admission or discharge date for waiver admissions that are not part of the current quarter's analysis.

- If you the SNF admission or discharge date is after the end of the current quarter's reference period, download the next quarter's data collection tool from the NGACO Connect site and enter the information into that file.
- If you get this message because the discharge date is before the current quarter's reference period, delete the record—it no longer needs to be reported.

Q6: **I entered data into the data submission tool and noticed that some cells have turned red. What does this mean?**

A: The worksheet will automatically turn a cell red when the data entered are inconsistent, to flag a potential inaccuracy. For example:

> In the "summary report" worksheet, the total count of the primary reasons for observation admissions will turn red if it does not equal the total number of observation admissions.

Q7: **How can I use this tool to track patients admitted to SNFs under the waiver if they have not yet been discharged from the SNF or if they were discharged after the reference period ended?**

A: The "data entry" worksheets are designed to be used as tracking tool on an ongoing basis. Before submitting the completed tool to CMS for a given reference period, please take the following steps: (1) create a version of the tool that you will use for the next data submission, (2) delete the columns associated with data submission for past reference periods, and (3) retain the columns associated with SNF admissions for which the SNF discharge date is not yet known for the next data submission.

If you use the data collection tool in this manner, we recommend that you copy admissions over to the new quarter's data collection tool before submitting the data to CMS. This will ensure that you submit all of the required data for the relevant admissions.

Q8: **How are the primary and secondary reasons for admission different from the MS-DRGs found in the claims data?**

A: Primary and secondary reasons for admission are self-reported measures collected by ACOs and their partners, and are intended to capture the primary reasons for using the SNF three-day rule waiver. Although some of these reasons overlap with the clinical conditions noted by the MS-DRGs, these two measures are applicable to all SNF waiver admissions and the DRG data are only available for short inpatient admissions (previously labeled "<3 inpatient day").

Q9: **Our ACO does not have the data to complete some of these measures but the SNFs have this information. Can the SNFs complete these measures?**

A: Yes, SNFs can submit data for the following measures: timing of patient's arrival at the SNF, warm hand-offs, timely admitting exams, preliminary care plans, and discharge notes sent to the primary care provider. SNFs may enter admission-level data directly into the "data entry" worksheets or provide you with the relevant data to complete the data submission tool. Please ensure that the SNFs use secure file transfers if they are transmitting protected health information.

Q10: **How should I submit the completed self-monitoring measure data to CMS?**

A: Next Generation ACOs should email NextGenerationACOModel@cms.hhs.gov (subject line "Benefit Enhancements") to submit measures data**.** Please do not include any protected health information (for example, names, Social Security numbers, health insurance claim numbers, or birth dates). Mathematica Policy Research will complete the analysis of all of ACOs' quarterly data submissions.

Q11: **Where can I find materials related to the SNF three-day rule waiver, such as chartbooks, webinar recordings, and data collection tools?**

A: Materials can be found on the NGACO Connect site (https://app.innovation.cms.gov/NGACOConnect/CommunityLogin) within the library and noted on the SNF three-day rule waiver Group page. For Connect site support, please contact: CMMIForceSupport@cms.hhs.gov.

Q12: **How do I get access to the Connect site?**

A: The Next Generation ACO Connect site is equipped with self-registration functionality. Please follow the steps below to access the Connect site, and contact the CMMI Helpdesk with any questions (CMMIConnectHelpDesk@cms.hhs.gov, subject line "Connect Site"):

- Go to the NGACO Connect log-in page.
- Select "Click Here" next to "New User."
- Fill out your contact and organization information.
- CMMI will review your request and send an email with your log-in information, alerting you to sign in to Connect within 24 hours to activate your account.

Q13: **Who should I contact with questions about the measures and data submission?**

A: Next Generation ACOs should email NextGenerationACOModel@cms.hhs.gov (subject line "Benefit Enhancements"). We look forward to assisting you with any questions, and we welcome suggestions for improving the tool for future rounds of data collection.