In this Session We Will Provide:

- Information about the federal waiver for Accountable Care Organizations (ACOs) for the Medicare 3-day patient admission rule for Medicare Part A coverage of post acute rehabilitation in a Skilled Nursing Facility.
- We will explain observation status, how it impacts the Medicare 3-day requirement, what an ACO is and under what circumstances they may apply for a waiver of the requirement,
- This presentation is targeted for consumers and their caregivers.
- This presentation is not intended to provide guidance to providers, insurers, or health care professionals.

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What is Observation Status?

- It is a category used in Medicare for care for certain patients while they are in a hospital and is considered by Medicare as outpatient care (even though the patient may be staying overnight in the hospital for their care.
- It is paid under Part B (outpatient services).
- It was invented over a decade ago in the US to save Medicare money by paying for less intensive patient care while a hospital is determining if an emergency room patient needs to be admitted as an "inpatient" (inpatient is paid under Part A).
- Recent studies have shown it does not reduce hospital or nursing home days and does not save the system costs.
- It has increased costs for many patients needing post acute rehab.

For Example:

1. A patient presents to the hospital with chest pains and nausea.
2. The hospital will run tests before deciding if they should admit them or send them.
3. While they are waiting to determine the diagnosis, they place the patient into "observation status".

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What do Observation Services Include?

- Hospital care provided intended as “outpatient services” for monitoring purposes or to determine whether a person should be admitted as an inpatient.
- They include ongoing short-term treatment, assessment, and reassessment and other services needed before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.
- Often these services are ordered for patients in an emergency room, or observation unit, or general hospital who need a significant period of monitoring to make a decision concerning admission or discharge.

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Observation Services Are Classified Outpatient Services

- Only in rare and exceptional cases are outpatient services supposed to span more then 48 hours.
- Hospitals in USA were eventually required to inform patients with a Medicare Outpatient Observation Notice (MOON) within 36 hours if the patients are receiving observation services as an outpatient for 24 hours.
- It is important to always ask the hospital staff before, during and after being treated in the hospital if you are in observation status or being admitted.

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Due To Pressure From Advocates CMS IMPLEMENTED A LIMIT ON OBSERVATION STATUS PLACEMENT

- **Two-Midnight benchmark**, Hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation.
- **Medicare Part A payment is generally not now considered** appropriate for hospital stays expected to span less than two midnights unless they can document the need for inpatient care. (more and more this includes almost any type of care).
- Hospitals are penalized if they admit a person and CMS auditors feel they should have been placed into Observation Status

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What Is The Difference Between Observation Status And Inpatient Status? Why Is This A Problem For Patients Needing Rehab In A Skilled Nursing Facility (SNF)?

- Essentially there is no difference in terms of the type, scope, intensity, or quality of care. It is the same care provided to those with "inpatient status".
- Observation care is an outpatient service paid under Part B. Inpatient hospital care is paid for under Part A.
- Many beneficiaries entering a hospital are placed into observation status unless there is documentation provided by an admitting doctor that the beneficiary merits inpatient care.
- There are many instances where it is clear that inpatient care is needed, but the lines are becoming blurred.

EXAMPLE:

An **amputation or an organ transplant** would be good examples of persons that should clearly be placed into inpatient status.

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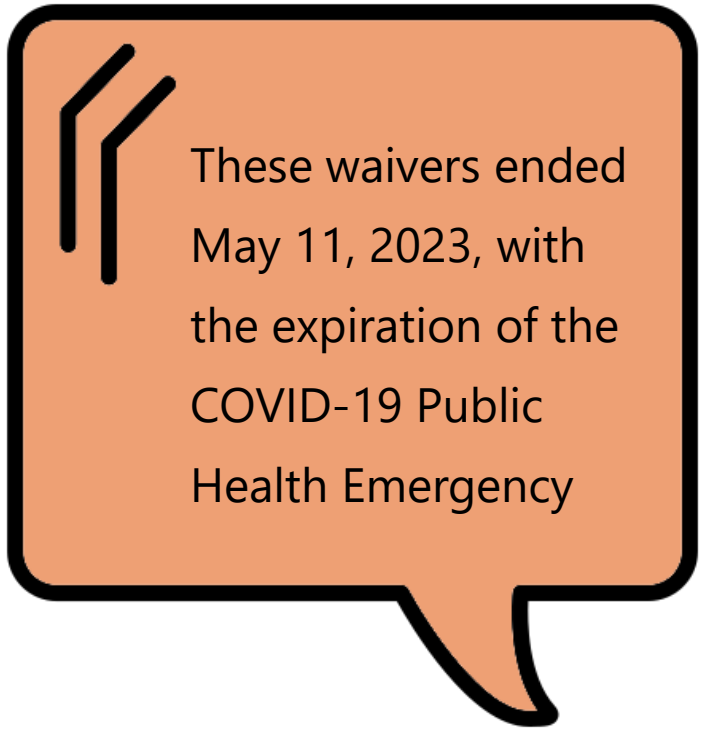
During Covid 19 the 3-midnight requirement was waived

- Beneficiaries needing post acute rehab in an SNF were able to have part A cover the costs of allowable days.
- This meant that all new SNF stays beginning on or after May 12,2023 once again were required to have a 3-midnight qualifying hospital stay before Medicare Part A coverage for facility-based rehab care.



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CMS Has Provided Some Special Waivers for the 3-Midnight Requirement

- Medicare allows Accountable Care Organizations who successfully apply for waivers to provide Part A coverage of the transition to SNF for rehab without 3 inpatient days. (Few of the ACOs publicize it and you must ask them. Don't assume they cover it automatically).
- Medicare Advantage Plans were also allowed to waive the requirement. We are not going to discus the use of this flexibility by Medicare Advantage Plans in this presentation.
- CMS also allows hospitals participating in the Transforming Episode Accountability Model (TEAM) to waive the 3-day requirement. We are not going to discuss the use of the Waiver under the TEAM model.
- We are going to focus on Accountable Care Organizations use of the CMS waiver.
- The Waiver is intended to provide participating ACOs with flexibility to increase quality and decrease cost (for example by assuring a patient needing rehab receives it in a timely manner, can return home and does not have to return to the hospital).

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Waivers for Approved Accountable Care Organizations (ACOs)

- What the heck is an ACO?
- ACO is an acronym for yet another category of health organizational configuration.
- It is a group of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs.
- ACOs may be in a specific geographic area and/or focused on patients who have a specific condition, like chronic kidney disease.
- An ACO is not an insurance plan. Patients who have Original Medicare and have doctors in an ACO retain all of their rights and privileges under Original Medicare, including the freedom to see any health care provider that accepts Medicare, even if that provider is not part of an ACO.

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How Does an ACO Get Paid by CMS?

- Medicare, through what they call the "Shared Savings Program", offers providers and suppliers (e.g., physicians, hospitals, and others involved in patient care) an opportunity to create an Accountable Care Organization (ACO). This model is intended encourages to encourage better coordination, quality and efficiency.

- An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.

- The Shared Savings Program has different participation/payment options (tracks) that allow ACOs to select an arrangement that makes the most sense for their organization.

- The reimbursement available varies based on the amount of risk the ACO is willing to share in the outcomes of the patient. It is complicated but if they assume some of the risk for patient care they have an opportunity to make more money if they meet the requirements that CMSs sets forth.

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What Types of Providers are in an ACO?

Health care providers may agree to work together as a group, forming an Accountable Care Organization (ACO) to help coordinate their patients' care. ACOs may consist of:

- primary care doctors
- nurse practitioners
- physician assistants
- specialists
- pharmacies
- hospitals and hospital systems
- skilled nursing facilities and home health agencies
- other members of the health care team who offer and coordinate medical-related services and other supports

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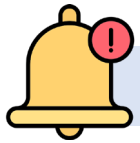
How Do I Know if I am Receiving Care From An ACO?

- It is not always known to a Medicare fee for service beneficiary.
- There physician is required to send them a standardized letter (a beneficiary information notification) explaining that they are part of an ACO and what that means. CMS provides a template to ACOs to use for this purpose. The physician is supposed to d0 a follow up communication within 180 days. They must place posters for patients about the ACO in their facilities.
- Most consumers do not know what the ACO acronym means as it is a government term and designation.
- Apparently over 50% of traditional Medicare beneficiaries are receiving care from an ACO.



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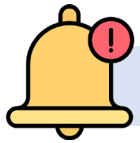
How Do I Know if my ACO has a 3-day waiver

- **It is not known as to how many beneficiaries are in ACOs that have a waiver of the 3-day rule approved.**
- It is even harder to determine if the ACO you are receiving care through has a waiver for the 3-day rule or which nursing homes you may use to take advantage of this waiver.
- There is no easily accessed public information available to ascertain this.
- Its is best to ask your primary care doctor if he is working with an ACO and if they have received a waiver of the 3-day requirement.
- CMS provides a template for ACOs to communicate this waiver availability to beneficiaries in their ACO



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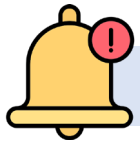
Beneficiary Notification

- ACO Assigned Beneficiaries Should Receive a Letter from Their ACO About the 3 Day Waiver (based on CMS standardized template)

<u>It should explain:</u>

- Eligible Medicare Patients Can Receive Skilled Nursing and Rehabilitation Care without a 3-Day Prior Hospital Stay at Eligible SNFs
- What the SNF 3_Day Rule Waiver Means to the Beneficiary



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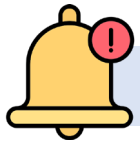
Explanation of the Waiver to the Beneficiary

- Historically, Medicare patients had to complete a medically necessary consecutive 3-day stay in a hospital before Medicare would pay for their SNF nursing and/or rehabilitation care.
- The SNF 3-Day Rule Waiver allows eligible SNFs that have partnered with an ACO -to bill Medicare for certain patients' SNF care, even if they haven't had a prior consecutive 3-day inpatient hospital stay before being admitted to the eligible SNF.
- This means that if you need skilled nursing and/or rehabilitation care, your physician who is participating in the ACO may admit you to an eligible SNF without you first having to go to the hospital or having a consecutive 3-day inpatient hospital stay.



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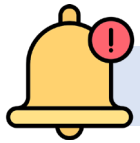
Information on how the rule helps admit you to a participating SNF w/o meeting the 3-day rule

- This means that if you need skilled nursing and/or rehabilitation care, your physician who is participating in the ACO may admit you to an eligible SNF without you first having to go to the hospital or having a consecutive 3-day inpatient hospital stay.
- This allows ["us"/"me"] to be more flexible with the care ["we"/"I"] recommend for you. The waiver is also available to beneficiaries who are admitted to the hospital, but do not have a full 3-day stay.



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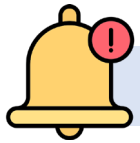
Includes explanation of how this affects their right to choose

- Your SNF benefit does not change. The SNF 3-Day Rule Waiver does not create a new Medicare benefit or eliminate any of the other requirements for Medicare coverage of SNF services. [Doctor/Practice Name OR "I"] will still determine if you need skilled nursing and/or rehabilitation care.
- -You still have your choice of doctors, hospitals, and SNFs. The SNF 3-Day Rule Waiver applies to eligible patients who get care from one of our SNF partners.
- **If you choose a SNF or other facility Beaumont ACO does not have an agreement with, normal Medicare coverage requirements apply. This includes the requirement for a consecutive 3-day inpatient hospital stay prior to your admission to a SNF.**



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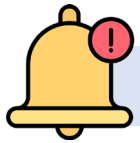
The Medicare Waiver of the 3-day Rule for Certain ACOs

- ACOs participating in Medicare Shared Savings Program that are participating in certain Medicare payment/reimbursement "tracks" may apply for a waiver.
- Tracks include Levels C, D, or E of the BASIC Track or the ENHANCED model for shared savings. Basically, the tracks very by how much shared risk an ACO is willing to undertake and how much of the potential savings they may share if they succeed.
- The waiver is not automatically given to an ACO and it is not mandatory for them to apply.
- An eligible ACO may apply for a waiver of the SNF-3 Day Rule
- "Affiliate SNFs" that the ACOs are working with must maintain an overall rating of 3 stars or higher in the CMS 5-Star Quality Rating System..



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To Be Approved An ACO Must Meet Certain Eligibility Criteria

- They must submit an application to CMS that shows they have the capacity to manage affected beneficiaries under the waiver.
- They must provide an approved “Affiliate List” of SNFs they work with.
- They must submit a SNF Affiliative Agreement for each affiliate.
- They must have a plan as to how the SNF 3-day Rule will be implemented (including a communication plan, a care management plan, a beneficiary evaluation and admission plan).

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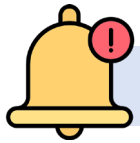
For a Beneficiary to be Eligible Under the ACO Waiver They Must:

- Be assigned to the ACO (an assignment list is provided by CMS quarterly)
- Not already be residing in an SNF or other long term care setting (this excludes independent living or Assisted Living facilities for purposes of eligibility).
- Be medically stable
- Not require inpatient or further inpatient hospital evaluation or treatment
- Have certain and confirmed diagnoses
- Have an identified skilled nursing or rehabilitation need that they cannot receive as an outpatient
- Have been evaluated & approved for admission to SNF w/1 3 days prior to the SNF admission by and ACO physician. This can be done via telehealth.



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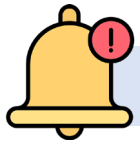
Does the Waiver Restrict Choice of SNF?

- A beneficiary's choice of provider or supplier is not restricted by this waiver.
- They still have the option to use any Medicare Fee for Service provider including an SNF that is not an affiliate of a shared savings program ACO.
- However, it they do, then the 3-day inpatient hospital rule will apply to SNF coverage.



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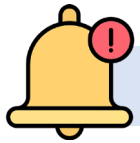
The Relationship Between the ACO and an Affiliate SNF

- The ACO shares information about assigned beneficiaries with the SNF to help identify and verify eligible beneficiaries.
- The ACO has to put in place a process to communicate the beneficiary evaluation and admission plan.
- In developing the plan the ACO must inform a beneficiary about their options for care settings.
- The ACO has to have a process to respond to questions and complaints related to the Affiliate SNF and the ACO
- The SNF has to have a designated person to admit the beneficiary and implement the care plan, including the discharge from the SNF.



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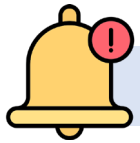
Some Protections for Beneficiaries

- The ACO has the flexibility to use the waiver to allow a beneficiary assigned to them to receive SNF services with out a prior 3-day hospital stay when clinically appropriate.
- In the event they admit a beneficiary who was never prospectively or preliminarily assigned to the ACO or one who was assigned but is later excluded CMS will not pay the SNF if the claim is rejected for a lack of a qualifying 3 day stay.
- The SNF may not charge the beneficiary and must return any monies collected for such services **even in cases where the beneficiary explicitly requested or agreed to being admitted to the SNF in absence of a qualifying 3-day inpatient stat, if all other coverage requirements are met.**



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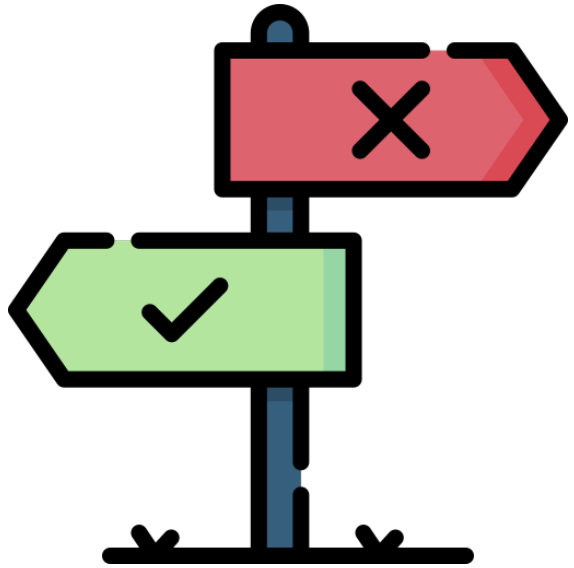
Beneficiaries Still Have The Right To Choose

During the discharge planning process, the hospital must inform the patient of their freedom to choose among Medicare-participating, post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit the pool of qualified providers from which the patient may choose.



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The CMS 3-Day Waiver Can Help Cover SNF Rehab Care for Beneficiaries in an Approved ACO

- If you are going into the hospital for care or are in the community and may require rehabilitation in a skilled nursing facility talk with your doctor to see if you are participating in an Accountable Care Organization.
- If so ask if they have a waiver of the 3-day in patient or hospital stay requirement for part A coverage of your rehab in the SNF.
- Ask if they can help develop a care plan for you in an Affiliate SNF of your choice.

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How many ACOs and Affiliated SNFs are approved in NYS?

- There are 198 ACOs currently approved to use the 3-day waiver in New York State.
- We want to thank the Regional Office of CMS for helping us find out what ACOs are approved for that waiver.
- Several are approved for care in multiple states
- There are 42 Affiliated SNFs approved.
- These numbers change as new organizations are approved.
- You can call 1-800-MEDICARE to ask whether you are associated with an ACO with an approved 3-day waiver.

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Next Teach In

- Our next Teach In will be on March 24 at 10 am
- We will discuss Medicare Advantage Plans Use of the 3-day rule waiver

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