

Next Generation ACO Model

Skilled Nursing Facility (SNF) Three-Day Rule Waiver

May 2017

Currently, in traditional fee-for-service (FFS) Medicare, beneficiaries are eligible for Medicare covered skilled nursing facility (SNF) services when a beneficiary has a an inpatient hospital stay of three consecutive days or more (i.e., qualifying hospital stay), starting with the day the the hospital admits the beneficiary as an inpatient, but not including the day they leave the hospital. 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 in fewer than three days or directly from a physician's office.

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 under the CMS Five-Star Nursing Home Quality Rating System.

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. 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: 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. 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.

Q5: 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.

Q6: 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.

Q7: 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.

Q8: 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.

Q9: 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.

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.