

Acute Care Episode (ACE) Demonstration

Medicare Part A

The purpose of the ACE Demonstration is to align hospitals' and physicians' incentives to work together to provide coordinated, cost-effective care by:

- Bundling all related services into an episode of care.
- Paying a single global payment that can be used as the providers of care deem most appropriate.

Five sites were selected:

- Baptist Health System, San Antonio, Texas.
- Exempla St. Joseph Hospital, Denver, Colorado.
- Hillcrest Medical Center, Tulsa, Oklahoma.
- Lovelace Health System, Albuquerque, New Mexico.
- Oklahoma Heart Hospital, Oklahoma City, Oklahoma.

Demonstration DRGs

All admissions for eligible beneficiaries with stays classified into one of the demonstration Diagnosis-Related Groups (DRGs) will be processed under the demonstration payment rules.

Claims for beneficiaries not eligible should be submitted with condition code B1.

Eligible Beneficiaries

To be eligible, the beneficiary must:

- Be entitled to both Part A and Part B.
- Not be enrolled in a Medicare Advantage or other Medicare health plan.
- Not be receiving Medicare due to Railroad Retirement or United Mine Workers of America.
- Have at least one lifetime reserve day at the time of admission.

Eligible Beneficiaries (Cont.)

Beneficiaries who are transferred to another acute hospital paid under the inpatient prospective payment system with a length of stay short enough to cause the demonstration hospital's payment to be reduced are not eligible for the demonstration.

Notice of Admission (NOA)

Prior to claim submission, a Notice of Admission (NOA) must be submitted via Direct Data Entry (DDE).

NOA Required Fields

- Type of Bill (TOB) 11A.
- National Provider Identifier (NPI).
- Health Insurance Claim (HIC) Number.
- Beneficiary's:
 - First and Last Name.
 - Date of Birth.
 - Address.
 - Sex.
- Admit Date.
- Treatment Authorization Code 54.

MAP1701

TRAILBLAZER HEALTH ENTERPRISES, LLC
MAIN MENU FOR REGION ACMMA551

- 01 INQUIRIES
- 02 CLAIMS/ATTACHMENTS
- 03 CLAIMS CORRECTION
- 04 ONLINE REPORTS

ENTER MENU SELECTION: 02

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

NOA DDE (Cont.)

MAP1703

TRAILBLAZER HEALTH ENTERPRISES, LLC CLAIM AND ATTACHMENTS ENTRY MENU

CLAIMS ENTRY

INPATIENT	20
OUTPATIENT	22
SNF	24
HOME HEALTH	26
HOSPICE	28
NOE/NOA	49
ROSTER BILL ENTRY	87

ATTACHMENT ENTRY

HOME HEALTH	41
DME HISTORY	54
ESRD CMS-382 FORM	57

ENTER MENU SELECTION: 49

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

NOA DDE (Cont.)

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MAP1711    PAGE 01    TRAILBLAZER HEALTH ENTERPRISES, LLC    ACMAA851 06/08/09
NM49495    SC          INST CLAIM ENTRY    C2009300 14:10:13
HIC XXXXXXXXXXXX    TOB 11A    S/LOC S B0100 OSCAR    SV:    UB-FORM
NPI XXXXXXXXXXXX    TRANS HOSP PROV    PROCESS NEW HIC
PAT.CNTL#:    TAX#/SUB:    TAXO.CD:
STMT DATES FROM    TO    DAYS COV    N-C    CO    LTR
LAST XXXXXXXX    FIRST XXXXXXXX    MI    DOB 00000000
ADDR 1 123 XXXXXX    2 TOWN, ST
3    4    CARR:
5    6    LOC:
ZIP XXXXX    SEX X MS    ADMIT DATE XXXXXX    HR    TYPE    SRC    D HM    STAT
COND CODES 01    02    03    04    05    06    07    08    09    10
OCC CDS/DATE 01    02    03    04    05
06    07    08    09    10
SPAN CODES/DATES 01    02    03
04    05    06    07
08    09    10    FAC.ZIP
DCN
VALUE CODES - AMOUNTS - ANS I MSP APP IND
01    02    03
04    05    06
07    08    09
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
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NOA DDE (Cont.)

MAP1715 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 05

SC INST CLAIM ENTRY

HIC TOB 11A S/LOC PROVIDER

INSURED NAME REL CERT-SSN-HIC SEX GROUP NAME DOB INS GROUP NUMBER

A LAST FIRST
XXXXXXXXXA

B

C

TREAT. AUTH. CODE

54

TREAT. AUTH. CODE

TREAT. AUTH. CODE

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT

NOA DDE (Cont.)

MAP1741
SC

M E D I C A R E A O N L I N E S Y S T E M
CLAIM SUMMARY INQUIRY

NPI

HIC PROVIDER S/LOC P TOB 11A
OPERATOR ID FROM DATE TO DATE DDE SORT

MEDICAL REVIEW SELECT

HIC	PROV/MRN	S/LOC	TOB	ADM DT	FRM DT	THRU DT	REC DT
SEL	LAST NAME	FIRST INIT	TOT CHG	PROV REIMB	PD DT	CAN DT	REAS NPC #DAYS
			P B9997	11A	010109	010109	010609
					010809	37227	
			P B9997	11A	011509		010709
					010909	37227	
			P B9997	11A	030109	030109	010909
					011309	37227	
			P B9997	11A	010309	010309	011209
					011409	37227	
			P B9997	11A	010109		011209
					011409	37227	

PROCESS COMPLETED --- PLEASE CONTINUE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD

Cancel NOA Required Fields

- TOB 11D.
- NPI.
- HIC Number.
- Beneficiary's:
 - First and Last Name.
 - Date of Birth.
 - Address.
 - Sex.
- Admit Date.
- Treatment Authorization Code 54.

Cancel NOA DDE

MAP1701

TRAILBLAZER HEALTH ENTERPRISES, LLC
MAIN MENU FOR REGION ACMMA551

- 01 INQUIRIES
- 02 CLAIMS/ATTACHMENTS
- 03 CLAIMS CORRECTION
- 04 ONLINE REPORTS

ENTER MENU SELECTION: 02

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Cancel NOA DDE (Cont.)

MAP1703

TRAILBLAZER HEALTH ENTERPRISES, LLC
CLAIM AND ATTACHMENTS ENTRY MENU

CLAIMS ENTRY

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Cancel NOA DDE (Cont.)

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MAP1711    PAGE 01    TRAILBLAZER HEALTH ENTERPRISES, LLC    ACMMA851 06/08/09
NM49495    SC        INST CLAIM ENTRY    C2009300 14:10:13
HIC XXXXXXXXXXXX    TOB 11D    S/LOC S B0100 OSCAR    SV:    UB-FORM
NPI XXXXXXXXXXXX    TRANS HOSP PROV    PROCESS NEW HIC
PAT.CNTL#:    TAX#/SUB:    TAXO.CD:
STMT DATES FROM    TO    DAYS COV    N-C    CO    LTR
LAST XXXXXXXX    FIRST XXXXXXXX    MI    DOB 00000000
ADDR 1 123 XXXXXX    2 TOWN, ST
3    4    CARR:
5    6    LOC:
ZIP XXXXX    SEX X MS    ADMIT DATE XXXXXX HR    TYPE    SRC    D HM    STAT
COND CODES 01    02    03    04    05    06    07    08    09    10
OCC CDS/DATE 01    02    03    04    05
06    07    08    09    10
SPAN CODES/DATES 01    02    03
04    05    06    07
08    09    10    FAC.ZIP
DCN
VALUE CODES - AMOUNTS - ANS I MSP APP IND
01    02    03
04    05    06
07    08    09
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
  
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Cancel NOA DDE (Cont.)

MAP1715 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 05

SC INST CLAIM ENTRY

HIC TOB 11A S/LOC PROVIDER

INSURED NAME REL CERT-SSN-HIC SEX GROUP NAME DOB INS GROUP NUMBER

A LAST FIRST
XXXXXXXXXA

B

C

TREAT. AUTH. CODE

54

TREAT. AUTH. CODE

TREAT. AUTH. CODE

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT

Payment rates were negotiated with CMS to be facility-specific. The rates include:

- All claims for professional services from date of admission through date of discharge.
- All claims for services under arrangement.
- All claims for preadmission services, which would normally be included on the inpatient claim.

Global Payment (Cont.)

There is no additional payment for outlier on demonstration claims.

Payment for Indirect Graduate Medical Education (IME), Disproportionate Share (DSH) new technology and direct medical education will be paid according to traditional processing.

Coinsurance and Deductibles

Each DRG has a fixed Part B copayment.

The global payment will be reduced by any applicable Part A deductible or coinsurance amounts and by the Part B coinsurance.

No Part B deductible will be applied.

Value Codes

Y1	Part A Demonstration Payment
Y2	Part B Demonstration Payment
Y3	Part B Coinsurance
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims
18	Disproportionate Share
19	Indirect Medical Education

Payment

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MAP1711          M E D I C A R E  A  O N L I N E  S Y S T E M          CLAIM PAGE 01
SC              INST CLAIM INQUIRY                               SV:
HIC            TOB 111  S/LOC P B9996          OSCAR              UB-FORM
NPI            TRANS HOSP PROV                PROCESS NEW HIC
PAT.CNTL#:     TAX#/SUB:                                TAXO.CD:
STMT DATES FROM 010309 TO 011309  DAYS COV 010  N-C          CO          LTR
LAST          FIRST                                MI          DOB
ADDR 1      2
   3        4
   5        6
ZIP          SEX M MS U ADMIT DATE 010309 HR 18 TYPE 1 SRC 1 D HM 23 STAT 01
COND CODES 01      02      03      04      05      06      07      08      09      10
OCC CDS/DATE 01      02      03      04      05      06      07      08      09      10
SPAN CODES/DATES 01      02      03
04          05      06      07
08          09      10      FAC.ZIP
DCN
  V A L U E  C O D E S  -  A M O U N T S  -  A N S I  MSP APP IND
01 A1      1068.00 PR 1    02 Y1      100000.00      03 Y2      25000.00
04 Y3      2500.00 PR 3    05 Y4      9337.78        06 18      1522.96
07 19      28.84          08 20      722.87        09
3719A
                                     <== REASON CODES
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT
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Payment (Cont.)

Y1	Part A Payment	\$100,000.00
Y2	Part B Payment	+ 25,000.00
A1	Part A Deductible	- 1,068.00
Y3	Part B Coinsurance	- 2,500.00
18	DSH	+ 1,522.96
19	IME	+ 28.84
	Total	\$122,983.80

Payment (Cont.)

MAP1716 M E D I C A R E A O N L I N E S Y S T E M CLAIM PAGE 06
SC INST CLAIM INQUIRY

HIC TOB 111 S/LOC P B9996 PROVIDER

MSP ADDITIONAL INSURER INFORMATION

1ST INSURERS ADDRESS 1

1ST INSURERS ADDRESS 2

CITY ST ZIP

2ND INSURERS ADDRESS 1

2ND INSURERS ADDRESS 2

CITY ST ZIP

PAYMENT DATA --- DEDUCTIBLE 1068.00 COIN CROSSOVER IND

PARTNER ID

PAID DATE PROVIDER PAYMENT 122983.80 PAID BY PATIENT

REIMB RATE RECEIPT DATE 012709 PROVIDER INTEREST

CHECK/EFT NO CHECK/EFT ISSUE DATE PAYMENT CODE

PRICER DATA

DRG 251 OUTLIER AMT TTL BLNDED PAYMT FED SPEC

GRAMM RUDMAN ORIG REIMBURSEMENT AMT .00 NET INL

TECH PROV DAYS TECH PROV CHARGES

OTHER INS ID CLINIC CODE

3719A <== REASON CODES

PRESS PF3-EXIT PF7-PREV PAGE

NOA Remittance Advice

PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG#
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD CAPCD
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT
Last F	XXXXXXXX		MA02	
XXXXXXXXXXA	XXXXXXXXXXXXXXXXXX		M27	
0/0/00 0/0/00	11A			.00
1				.00

Remittance Advice

PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG#
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD CAPCD
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT
Last F	XXXXXXXX	45	N83	219
XXXXXXXXXA	XXXXXXXXXXXXXXXX	1		
01/01/2009 01/06/2009	111	3		.00
1	5 5			.00

Remittance Advice (Cont.)

DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
NEW TECH/ECT	COVD CHGS	ESRD NET ADJ	PER DEIM RTE
MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
DEDUCTIBLES	DENIED CHGS	PRE PAY ADJ	NET REIMB
.00	500.00	.00	11000.00
.00	27000.00	.00	.00
.00	.00	.00	.00
1068.00	.00	.00	14432.00

Acute Care Episode (ACE) Demonstration

Thank you for attending.