



Medicare Care Choices Model (MCCM) - Per Beneficiary per Month Payment (PBPM) - Implementation (Eligibility Updates and Clarification)

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Related Change Request (CR) # 10094

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R173DEMO

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PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for providers working with Medicare Care Choices Model (MCCM) participating hospices and submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries enrolled in MCCM.

PROVIDER ACTION NEEDED

CR10094 updates the eligibility requirements and clarifies the current business rules for the MCCM. The MCCM is designed to evaluate whether eligible Medicare and dually eligible beneficiaries would elect to receive supportive care services typically provided by hospice if they could also continue to receive treatment for their terminal condition, and how this flexibility impacts quality of care and patient, family and caregiver satisfaction. Under the Model, participating hospices will provide designated services that are currently available under the Medicare hospice benefit for routine home care and respite levels of care, but cannot be separately billed under Medicare Parts A, B, and D. These services include nursing, social work, hospice aide, hospice homemaker, volunteer, chaplain, bereavement, nutritional support and respite care services. Please make certain your staff is aware of the changes under the MCCM.

BACKGROUND

Services under the MCCM will be available to enrolled beneficiaries around the clock, 365 days per year. The Centers for Medicare & Medicaid Services (CMS) pays a per beneficiary per month (PBPM) fee of \$400 to participating hospices for beneficiaries enrolled in the Model for 15 or greater days in a calendar month, and \$200 for beneficiaries enrolled in the Model for less than 15 days in a calendar month (except in the month of discharge, where the payment is \$400 regardless of the number of days enrolled). Providers and suppliers continue to bill Medicare when furnishing reasonable and necessary services provided to beneficiaries who elect to

participate in the Model, including treatment of the beneficiary's terminal condition, which may include physical or occupational therapy, speech language pathology services, drugs for the management of pain or other symptoms from the terminal illness or related conditions, medical equipment and supplies any other service that is specified in the patient's plan of care for which payment may otherwise be made under Medicare (for example, ambulance transports), short-term inpatient care for pain or symptom management that cannot be managed in the home environment, and physician services.

CMS originally planned to select at least 30 Medicare-certified hospices to participate in the Model and enroll up to 30,000 beneficiaries throughout a 3-year period. Due to robust interest, CMS invited over 140 Medicare-certified hospices to participate in the Model and expanded the duration of the Model to 5 years.

Delivery of Model services will be phased-in over 2 years, with participating hospices randomly assigned to either Cohort 1 or Cohort 2. Cohort 1, made up of approximately half of the participating hospices, began providing services under the Model on January 1, 2016. Cohort 2, which consists of the remaining participating hospices, will begin to provide services under the Model starting January 1, 2018. This model is expected to conclude on December 31, 2020. Application for this Model is closed and all selected hospices have been notified and assigned to a cohort.

Due to the multiple changes in the eligibility criteria contained in CR 9136, this CR 10094 contains instructions to the MACs related to those changes to the eligibility criteria for enrollment to MCCM. CR10094 assists the participating hospices in submission of the Notice of Election (NOE) and claims for PBPM fees through clarification of certain existing and modified business rules. CMS is making changes to the eligibility criteria for beneficiaries to participate in the MCCM to increase enrollment, add the auxiliary file information to the eligibility screen and remove the Expert Claims Processing System (ECPS) Events associated with this change request. All other business rules will remain in effect for CR9136, which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141DEMO.pdf>.

KEY POINTS

MCCM will consist of up to 141 participating hospices with up to 71 participating since the first year of the Model (2016) and up to 70 additional hospices entering the Model in Year 3 (2018). The number may decrease as hospices choose to withdraw or are otherwise terminated from the Model.

The target number of beneficiaries over the life of the Model is 150,000. A beneficiary would be considered eligible if he/she meets all of the following criteria:

- Medicare Part A and B has been primary for at least the last 12 continuous months prior to enrollment in the MCCM

- Has a diagnosis as indicated by certain ICD-10 codes for cancer, chronic obstructive pulmonary disease (COPD), human immunodeficiency virus (HIV), or chronic heart failure (CHF)
- Has had at least one hospitalization encounter (emergency room, observation stay, or inpatient stay) in the last 12 months prior to enrollment
- Has had at least three office visits with any Medicare –certified provider within the last 12 months prior to enrollment
- Meets hospice eligibility and admission criteria as stated in 42 CFR section 418.20, Eligibility requirements, and section 418.25[1], Admission to hospice care
- Has not elected the Medicare hospice benefit or Medicaid hospice benefit within the last 30 days prior to their participation in the MCCM

MCCM-specific NOEs will not turn off Part A, B, and D coverage so other providers may bill for related services to treat the terminal condition. Model services covered by the PBPM fee include:

- Counseling services to the beneficiary and family (bereavement, spiritual, dietary). family support
- Psycho-social assessment
- nursing services
- medical social services
- hospice aide and homemaker services
- volunteer services
- comprehensive assessment
- Individualized plan-of-care
- interdisciplinary group (IDG)
- care coordination/case management services
- in-home respite care

Those services that can be billed as a separate claim under Parts A, B, or D include:

- Physical or occupational therapy
- Speech language pathology services
- Drugs for the management of pain or other symptoms from the terminal illness or related conditions
- Medical equipment and supplies
- Physician services
- Short-term inpatient care for pain or symptom management which cannot be managed in the home environment including other services that are specified in the patient's plan of care for which payment may otherwise be made under Medicare (for example, ambulance transports).

Other providers may continue to bill chronic care management (CCM) and care transitions codes.

If, during the course of participation in the Model, a beneficiary chooses to seek hospice care under the Medicare hospice benefit, the beneficiary would sign a hospice NOE, 42 CFR 418.24 and would not be eligible to continue participating in the Model. A beneficiary who leaves the Model for any reason would not be eligible to return to the Model at a later date.

Medicare will pay claims according to dates of service. Participating hospices will receive payment if they were on the list of approved participating hospices at the time services were rendered. Thus, if a quarterly update of participating providers is received and the provider is no longer on the list then he/she would receive the PBPM payment for dates of service prior to the quarterly update.

ADDITIONAL INFORMATION

The official instruction, CR10094, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R173DEMO.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

DOCUMENT HISTORY

Date of Change	Description
May 18, 2017	Initial Article Released

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