CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 173	**Date: May 19, 2017**
	Change Request 10094

SUBJECT: Medicare Care Choices Model - Per Beneficiary per Month Payment (PBPM) - Implementation (eligibility updates and clarification)

I. SUMMARY OF CHANGES: This Change Request contains instructions to the Medicare Administrative Contractor (MAC) related to changes to the eligibility criteria for enrollment to MCCM and education requirements to assist the participating hospices in submission of the Notice of Election (NOE) and claims for per beneficiary per month (PBPM) fee, and to clarify certain existing business rules. Changes are being made to the eligibility criteria for beneficiaries to participate in the Medicare Care Choices Model 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 Change Request 9136.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: This change request will serve to update the eligibility requirement and to clarify current business rules for the Medicare Care Choices Model. The Medicare Care Choices Model 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, patient, family, and caregiver satisfaction. Under the Model, participating hospices will provide 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.

Services under this model will be available to enrolled beneficiaries around the clock, 365 days per year. 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. 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 two 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 Change Request contains instructions to the Medicare Administrative Contractor (MAC) related to those changes to the eligibility criteria for enrollment to MCCM. This also clarifies the education requirements to assist the participating hospices in submission of the Notice of Election (NOE) and claims for per beneficiary per month (PBPM) fee, and to clarify certain existing business rules. Changes are being made to the eligibility criteria for beneficiaries to participate in the Medicare Care Choices Model 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 Change Request 9136.

B. Policy: Program Details and Considerations:

The following assumptions have been identified and must be taken into consideration when analyzing how to implement the PBPM payment for the MCCM:

- MCCM will last for 5 years.

- Implementation is set for January 2016.

- Funding is to come from the Medicare Part A Trust Fund.

- MCCM will consist of up to 141 participating hospices with up to 71 participating in the first year of the Model (2016) and up to 70 additional hospices entering the Model in Year 3 (2018). The number may decrease when a hospice chooses to withdraw or they have been terminated from the Model. The target number of beneficiaries over the life of the Model is 150,000. CMMI will send updates to the MACs via TDL if:

1. Identifying information (e.g., CCN, TIN) changes.

2. Hospices withdraw or are terminated.

3. 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 (note: Medicare beneficiaries cannot be enrolled in Medicare Advantage and receives Medicare FFS coverage as the primary payer at the same time therefore, the Medicare Advantage requirement has been removed); and,

- Has a diagnosis as indicated by certain ICD-10 codes for cancer, COPD, HIV, or CHF; and,

- Has had at least one hospitalization encounter (emergency room, observation stay, or inpatient stay) in the last 12 months prior to enrollment; and,

- Has had at least three office visits with any Medicare –certified provider within the last 12 months prior to enrollment; and,

- Meets hospice eligibility and admission criteria as stated in 42 CFR §418.20, Eligibility requirements, and §418.25[1], Admission to hospice care; and

1. Has not elected the Medicare hospice benefit or Medicaid hospice benefit within the last 30 days prior to their participation in the MCCM.

2. MCCM-specific Notice of Election will not turn off Part A, B, and D coverage so other providers can 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; plan-of-care; interdisciplinary group (IDG); care coordination/case management services; and 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; and 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).

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

4. 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 Notice of Election, 42 CFR 418.24 and would not be eligible to continue participating in the Model.

5. A beneficiary who leaves the Model for any reason would not be eligible to return to the Model at a later date.

6. The PBPM payment is $400 for each eligible beneficiary enrolled in the Model for 15 or more days as long as the participating hospice provides at least one service per calendar month and $200 for each eligible beneficiary enrolled in the Model for less than 15 days and the participating hospice provides at least one service in a calendar month. When identified, monies paid erroneously to providers will be recouped through the normal overpayment process.

7. Claims will be paid 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.

[1] In the MCCM, the community provider must sign an attestation of terminal illness, co-signed by the hospice medical director.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10094.1	CMS shall provide the MACs a TDL when hospices are terminated from the Model.			X						CMS
10094.1.1	The contractor shall RTP MCCM-specific NOEs and			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	claims for providers who are no longer a MCCM-participating provider (according to dates of service on the claim).									
10094.2	Upon receipt of the MCCM-specific NOE, the CWF shall verify that the beneficiary has had Medicare Part A and B, and has been primary for all services (excluding worker's comp, auto, and 3rd party liability and other diagnosis-specific coverage) for at least 12 months prior to election of the Model; [CMS is requesting modification to Edit 5191 and 5192 to ensure beneficiary has had Medicare A and B FFS and it has been primary and not MSP for all services (Exclude workers' comp, auto, and 3rd party liability and other diagnosis-specific coverage) at least 12 months prior to election of the Model]								X	
10094.2.1	CWF shall reject the NOE for beneficiaries not having both Medicare Part A and B as Primary for the last 12 months prior to election of MCCM. (currently edits 5191 and 5192)								X	
10094.2.2	CWF shall reject when the NOEs from date is not greater than 12 months from the last MSP (Medicare Parts A and B must be the primary payer source for the 12 months prior to election of MCCM).								X	
10094.2.3	The contractor shall RTP NOEs with the CWF reject that the from date is not greater than 12 months from the last MSP.			X						
10094.3	CWF shall reject the NOE when the Medicare Hospice Benefit has been active within the last 30 day PRIOR to the election date of MCCM (the term date of the last Medicare Hospice period must be greater than 30 days before election of MCCM).								X	
10094.4	The contractor shall RTP with the CWF reject when the MHB has been active in the last 30 days (PRIOR to election of MCCM)			X						
10094.5	The contractor shall RTP with the CWF reject when there is a previous MCCM-specific NOE (81A or 82A with demo code 73)			X						
10094.6	CWF edit 7304 will no longer require the MCCM								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	approved ICD9/10 be part of the criteria for the edit to assign Upon receipt of the MCCM-specific NOE, the CWF shall verify: There have been three office visits with a Medicare enrolled health care provider (not to exclude FQHC, RHC, CAH affiliated primary care sites) in the last 12 months; • Provider can be a physician or Advanced Practice Nurse; primary care or specialist; rendering or referring • claims can be paid or denied									
10094.7	The contractor shall RTP the claim with the CWF reject when there are not three Part B office visits in the beneficiaries claim history.			X					X	
10094.8	Upon receipt of the MCCM-specific NOE the CWF shall verify that there is there has been one hospital encounter for any reason in the last 12 months; • Encounters may include outpatient emergency room visit (rev codes 0450-0459), observation stay (0760 or 0762), or inpatient stay (not to exclude Maryland, nationwide cancer hospitals, etc. that receive Medicare payments under a unique system) • Claims can be denied or paid			X					X	
10094.8.1	CWF will reject and the contractors shall return to provider if there has not been a hospital encounter in the system within the last 12 months prior to election of the Model.			X					X	
10094.9	The contractor shall apply the override if providers notify them that the claims RTP'd contain remarks from the provider acknowledging that they have verified the following information: 1. there have been three office visits with a Medicare enrolled health care provider within 12 months prior to the election of the Model.			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2. there has been one hospital encounter (Emergency room, observation stay, or inpatient stay) in the last 12 months prior election of the Model.									
10094.10	When adjudicating claims for Model services, the contractor shall not pay for services for beneficiaries who do not have a current MCCM-specific NOE. Use Group Code = CO; CARC=96; RARC N30			X						
10094.11	The MCCM-specific NOE shall be terminated retroactively for the dates related to the reason for the following reject criteria: a. date of death b. date when Part A FFS is no longer the primary payer or is terminated c. date when Part B FFS is no longer the primary payer or is terminated d. date based on MSP established (exclude worker's comp, auto, and 3rd party liability and other diagnosis-specific coverage) e. date of enrollment in a Medicare managed care organization, including but not limited to Medicare Advantage plans (note: once a beneficiary elects a MA plan, Medicare FFS is no longer the primary payer) f. date of election of the Medicare hospice benefit (last paid MCCM claim should be one day prior to the start of the Medicare hospice benefit Notice of election)					X			X	
10094.12	When adjudicating claims for Model services, the contractor shall not pay for services for beneficiaries that are in a current Medicare hospice benefit period. Use Group Code = CO; CARC = B9.			X						
10094.13	When adjudicating claims for Model services, the contractor shall not pay for services for beneficiaries not having both Medicare Part A and B as the primary payer for the last 12 months prior to election of MCCM (currently edit 5192). Use Group Code = CO; CARC = 109.			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10094.14	The contractor shall assist the provider in answering questions related to the submission of MCCM NOEs and claims. NOTE: CMS will release all necessary information regarding how participating providers should submit claims.			X						
10094.15	The contractor shall allow the resubmission and reprocessing of claims that have previously been denied based on eligibility requirements bypassing enforcement of timely filing. • (edit 5191) Medicare Part A has been primary for at least the last 12 continuous months prior to enrollment • (edit 5199) Has not elected the Medicare hospice benefit or Medicaid hospice benefit within the last 30 days prior to their participation in the MCCM.			X						
10094.15.1	The contractor shall not reject claims beyond the timely filing date (one year from the date of service), the claim shall be overridden if service dates are within the life of the Model.			X						
10094.16	The contractor shall instruct the provider to resubmit the NOEs and claims for reprocessing of denied claims on the eligibility requirements related to the changes set forth in this Change Request. • Medicare Part A and B has been primary for at least the last 12 continuous months prior to enrollment • Has had at least one hospitalization encounter (emergency room, observation stay, or inpatient stay) in the last 12 months prior to enrollment; and, • Has had at least three office visits with any Medicare –certified provider within the last 12 months prior to enrollment; and, • Has not elected the Medicare hospice benefit			X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	or Medicaid hospice benefit within the last 30 days prior to their participation in the MCCM.									
10094.17	The contractor shall add the auxiliary file information to the eligibility screen so the provider may view the election of the MCCM. (CWF will add the Beneficiary's MCCM data for Provider Number, Start Date, Termination Date Revocation and Transfer Date on the following Beneficiary's eligibility screens for HIQA/ HIQH, EGLA/ELGH and HUQA)					X			X	
10094.18	Contractors shall remove the Expert Claims Processing System (ECPS) Event to Override Existing Eligibility Criteria for Enrollment of Beneficiaries as it pertains to this Change Request. there are ECPSs currently existing to override edits 7305 and 7304			X						
10094.18.1	Contractors shall not require an appeals process to utilize overrides.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10094.19	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
9136.10	Provided clarification for override information for verification of eligibility criteria
	N/A
9136.13	request to add informatio to the benefit eligibility sceen.
9136.32	updated information for adjudicating claims
9136.9	updated eligibility requirements for CWF verification

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Echoles, 410-786-8886 or Fred.Echoles@cms.hhs.gov , Shannon Landefeld, 410-786-0399 or shannon.landefeld@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0