Medicare Care Choices Model

Resource Manual

Revised November 2019

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Introduction

I. Model Overview

The Medicare Care Choice Model (MCCM) Resource Manual provides basic guidance for key aspects of MCCM beneficiary service and care for MCCM participating hospices. The Resource Manual is not intended to be the sole source of information for MCCM participating hospices. Hospices should also refer to the Portal User Guide, the Frequently Asked Questions, and the signed Participation Agreement (see **Appendices A, B, and C**).

MCCM provides Medicare beneficiaries who qualify for coverage under the Medicare or Medicaid hospice benefit (MHB), the option to receive supportive care services typically provided under the MHB, while continuing to receive care by other Medicare providers for their terminal condition. The MHB requires that beneficiaries forgo payment for curative care related to their terminal illness. Often, beneficiaries and their families do not obtain the maximal benefit from hospice because they elect the hospice benefit very late in the end-of-life trajectory. The MCCM represents a fundamental change in the delivery of care for persons with specific advanced illnesses.[1]

The Center for Medicare and Medicaid Innovation (CMMI) will study whether access to designated hospice support services improves quality of care and beneficiary and family satisfaction with care provided, and has an effect on Medicare utilization and enrollment in the MHB. There may be a reduction in total Medicare expenditures for participating beneficiaries related to emergency department visits, ambulance services, acute care hospital stays, or diagnostic tests and procedures.[2]

A. Objectives

The purpose for conducting the MCCM is to test whether the model will:

1. Increase access to supportive care services provided by hospice;
2. Improve quality of life and beneficiary/family satisfaction with care; and
3. Inform new payment systems for the Medicare and Medicaid programs.

[1] Section 1115A of the Social Security Act authorizes CMMI to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries.
[2] Center for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. Report to Congress. December 2014, Pg. 41.

B. Hallmarks

Under the MCCM, participating hospices provide services for routine home care and respite that cannot be billed separately under Fee for Service (FFS) Medicare Parts A and B. These services include nursing, social work, hospice aide, hospice homemaker, volunteers, chaplain, bereavement support, nutritional support, and in-home respite services. There are six hallmarks in the model's design as follows.

1. Care Coordination and Case Management

There is an increased recognition that care coordination and case management are fundamental for improvement in healthcare outcomes. Effective and efficient care coordination and case management have the potential to improve outcomes in attaining optimal well-being and quality of life given the limitations of particular health conditions. Quality of life is important during all stages of the life-cycle, but it has particular importance during the last phase of life. MCCM participating hospices assist in the coordination of, access to, and utilization of both treatment for the terminal condition and select hospice services, facilitated by shared decision-making between the beneficiary, family, and his/her providers (42 CFR §418.56).

Care Coordination, as defined by the Agency for Healthcare Research and Quality (AHRQ):

> *"…involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people and that this information is used to provide safe, appropriate, and effective care to the patient."*[3]

Case Management, as defined by the AHRQ:

> *"…case management [is] a process in which a person (alone or in conjunction with a team) manages multiple aspects of a patient's care. Key components of case management include planning and assessment, coordination of services, patient education, and clinical monitoring."*[4]

This activity requires coordination from within the MCCM participating hospice, as well as between the MCCM participating hospice and the providers/suppliers furnishing treatment for the terminal condition. Care coordination activities have the goal of achieving person-centered outcomes and supporting shared decision-making. The MCCM participating hospice's care coordination and case management may overlap with other care coordination and case management received by an

[3] Agency for Healthcare Research and Quality. (2014). *Care Coordination.* Retrieved from: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/.
[4] Agency for Healthcare Research and Quality. (2011). Comparative Effectiveness of Case Management for Adults with Medical Illness and Complex Care Needs. Retrieved from https://effectivehealthcare.ahrq.gov/products/case-management/research-protocol.

MCCM beneficiary. The MCCM participating hospice will identify these partners and facilitate coordinated, complementary care.

2. 24/7 Access to Hospice Team

Access to MCCM services on a 24 hour basis, 7 days a week, and to MCCM participating hospice professionals is a key aspect of the MCCM, adhering to 42 CFR §418.100(c) (2).

3. Person and Family Centered Care Planning

Person and family centered care (PFCC) defined by the National Quality Forum (NQF) is:

> *"An approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values."*[5]

At the heart of this concept is the goal to empower the individual to become a partner with healthcare providers and healthcare systems.

An emphasis on PFCC in healthcare means an individual's preferences are acknowledged and health outcomes and goals are person-specific rather than reflecting what healthcare professionals or the healthcare system may present as the 'best' alternative. Person-centered goals should drive the delivery of care.

End-of-life care and the hospice philosophy both reflect the concept of holistic care, defined as care that focuses on the whole individual, encompassing their physical, emotional, spiritual and psychosocial well-being. These values are reflected in the MCCM through adherence to 42 CFR §418.52 and §418.54, delineating patient's rights and requirements for an individualized plan of care.

4. Shared Decision-making

Shared decision-making is a process of communication, deliberation, and decision-making that includes sharing with the beneficiary information that outlines treatment options, including harms, benefits, and alternatives. It also elicits and supports the beneficiary's values and preferences. Shared decision-making encompasses person-centered care, and is an interactive and meaningful dialogue between the beneficiary and their care providers, based on the best medical evidence, tailored to the individual's conditions, values, and preferences.

[5] National Quality Forum. (2014). NQF Priority Setting for Healthcare Performance Measurement: Addressing Performance measure Gap in Person-Centered Care and Outcomes Final Report. (pp. 2). Retrieved from: https://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Person-Centered_Care_and_Outcomes.aspx

5. Symptom Management

MCCM participating hospices ensure management of the MCCM beneficiary's pain and other symptoms based on 24-hours/7 days a week availability and periodic comprehensive assessments and individualized plans of care (42 CFR §418.54).

MCCM beneficiaries may also need interventions and support for symptoms other than pain. Common symptoms at the end-of-life include, but may not be limited to:

- Dyspnea (shortness of breath)
- Nausea
- Vomiting
- Fatigue
- Compromised skin integrity
- Functional/cognitive deficits
- Anxiety
- Lack of appetite/malnutrition
- Fear
- Depression
- Bowel dysfunction (constipation or diarrhea)

The MCCM participating hospices provide care for these symptoms and assist MCCM beneficiaries and family members to attain optimal comfort and dignity. Symptom management starts with screenings and assessments, concentrating on timeliness and appropriate interventions. This allows an opportunity for honoring individual preferences, acknowledges need for re-assessments and adjustments, and measures whether goals were met and how to better meet the beneficiary's needs.

6. Counseling

The MCCM participating hospices offer appropriate levels of counseling to MCCM beneficiaries and their families based on a comprehensive assessment and individualized plan of care in compliance with 42 CFR §418.64 (c) and (d) (1),(2),(3).

Counseling entails a wide range of interventions that can include bereavement, dietary, and spiritual counseling. Additionally, bereavement counseling begins at the time of admission to help beneficiaries and their families and caregivers cope with the individual's life-ending disease. Comprehensive assessment, subsequent comprehensive assessments, care planning, advance care planning, and communication are essential elements of care to meet these needs.

C. Length of MCCM Demonstration

Hospices selected to participate in the model were randomly assigned to one of two cohorts:

- Cohort 1: January 1, 2016 – December 31, 2020 (5 years)
- Cohort 2: January 1, 2018 – December 31, 2020 (3 years)

Beneficiary enrollment ends 6 months before the model's end date (June 30, 2020). MCCM services will continue for enrolled beneficiaries through December 31, 2020, including transition of active enrollees to the appropriate level of care. Evaluation of the model will continue through the claims-run out period for all MCCM services provided through December 31, 2020.

II. Services Covered by MCCM

The MCCM participating hospices provide select supportive services included in the MHB while allowing for the continuation of care by other Medicare providers for the terminal condition.

The MCCM participating hospices may not operate a reduced or modified version of the model. All services delineated in this section must be available to every MCCM beneficiary, depending on their person-centered goals and individualized plan of care.

A. Specific Services Covered by MCCM

The supportive services provided through the model are available 24 hours a day, 7 days a week. Participating hospices are expected to utilize care coordination to ensure that there are no duplicative Medicare services or payments. MCCM services include:

- Nursing
- Social Work
- Hospice Aide
- Hospice Homemaker
- Volunteer (direct services only)
- Chaplain
- Bereavement
- Nutritional Support
- Respite Care (in home only)

B. Services Not Paid/Covered by MCCM PBPM Payment

The MCCM per beneficiary per month (PBPM) payment does not cover those services and supplies covered and billable under Medicare Parts A, B, and D.[6] **Tables II-B-1, and II-B-2** depicts services and payment sources for the beneficiary enrolled in the MCCM.

The MCCM participating hospice's role in the model differs significantly from the hospice's role in the MHB. The role of the MCCM participating hospice is to provide supportive care and to integrate care with the beneficiary's community practitioners through case management, care coordination, shared decision-making, and symptom management.

Certain items and services normally paid through the MHB such as drugs, durable medical equipment (DME), speech language pathology services, occupational therapy, physical therapy, and ambulance transports are not paid through the model. If an MCCM enrolled beneficiary needs any of these items or services, a qualified provider or supplier may furnish them to the beneficiary and bill the appropriate part of Medicare subject to all existing rules and requirements.

Medicare beneficiaries enrolled in MCCM remain eligible for all medically necessary services normally covered by Medicare including home health (HH). When the individual's needs extend beyond the usual hospice interventions, the beneficiary-identified community practitioner's judgment and the individual's best interests and preferences are paramount. If HH services are needed, it must be initiated by a non-hospice practitioner. In cases where the plan of care includes HH, the MCCM participating hospice should continue to fulfill its obligations under the MCCM to provide in-home support services including nursing and aide services. There is a risk that services may be duplicative, which may be harmful if not carefully coordinated. It is expected that in cases where an MCCM beneficiary is receiving HH services, the MCCM hospice and the Home Health Agency (HHA) will work together to provide services that are complementary and not redundant. The MCCM RN/RN Care Coordinator is responsible for documenting the collaboration of the complementary services in the beneficiary's medical record.

The Medicare Administrative Contractors (MACs) will review a random selection of 20 percent of applicable cases where a beneficiary receives both MCCM and HH services.[7] The review pertains only to the hospice clinical record and does not entail review of the HHA record. The MCCM hospice must document in the beneficiary's record services provided by MCCM and by the HHA, specifically describing care coordination efforts and how the services of the MCCM and HHA intersect to work in the beneficiary's best interest. Each entity should adhere to the

[6] Stand-alone Part D Definition: Beneficiaries obtain a Part D drug benefit through a stand-alone Prescription Drug Plan (PDP). This drug coverage is not part of a public Part C health plan that jointly covers all hospital and medical services covered by Medicare Part A and Part B at a minimum, and typically covers additional healthcare costs not covered by Medicare Parts A and B including prescription drugs (MA-PD).

[7] At the initiation of the model this was set at 100 percent of cases where MCCM services and Medicare home health services were being provided at the same time. This was reduced to 20 percent of cases in January 2018.

MCCM requirements or CMS regulations, according to their certification and written agreements, as well as follow local and state laws.

Table II-B-1: MCCM Services

Payment: Services covered under MCCM PBPM	Services available 24 hours a day, 7 days a week to model beneficiaries
• The provider will be paid $200 if the beneficiary is enrolled into the model for less than 15 days of service during the calendar month; and $400 if 15 or more days during the calendar month • The provider will be paid $400 for the claim submitted in the month of discharge, even if the day of discharge is the only day of service within that month. • MCCM excludes services that can be billed separately under Medicare Parts A, B, and D	• Nursing, including case management and care coordination • Social Work • Hospice Aide • Hospice Homemaker • Volunteer (direct services only) • Chaplain • Bereavement • Nutritional Support • Respite Care (in home only) **** As with MHB, chaplain, volunteer and bereavement services are not paid for under MCCM PBPM, but are expected to be provided.**

Table II-B-2: Non-MCCM Service Medicare Payment Alternatives

Payment: Services billed directly to Medicare	Services not covered by MCCM, that may be billed to Medicare if medically necessary
Beneficiary services not covered under the MCCM PBPM and typically covered by Medicare Parts A, B, and/or D may be directly billed by providers or suppliers through regular Medicare FFS claims processing procedures	• Physical or occupational therapy • Speech language pathology • Drugs for the management of pain or other symptoms for the terminal illness or conditions • Certain medical equipment and supplies • Any other service that is specified in the beneficiary plan of care for which payment may otherwise be made under Medicare (for example, ambulance transports) • Inpatient care for pain or symptom management which cannot be managed in the home environment • Physician services • Home Health (if eligibility requirements are met)

III. Beneficiary Eligibility and Enrollment

The MCCM is an option for individuals who are eligible for the MHB, but wish to continue to receive care from other Medicare providers or suppliers for their terminal condition. Individuals choosing to enroll in the MCCM retain the option of electing the MHB at any time. Once an MCCM beneficiary is discharged from the model, they may not return to the model at a later date. Participating hospices will not enroll MCCM-eligible beneficiaries within the last six months of the model (July 1, 2020 through December 31, 2020), and should plan for the transition of active enrollees by December 31, 2020.

MCCM participating hospices respond to a referral from a community practitioner, specialists, hospital discharge planners, emergency departments, and other sources, including self-referral, based on the hospice's policies and procedures. If the beneficiary is eligible, the hospice representative explains the model, and asks if the individual wants to enroll in MCCM. If the beneficiary does not want to enroll, the hospice informs the referring healthcare provider that the patient decided not to proceed with choosing MCCM.

If the beneficiary chooses to enroll, the hospice initiates MCCM enrollment, including obtaining the signature of the beneficiary on the Medicare Care Choices Beneficiary Enrollment Form and any additional form(s) the MCCM participating hospice may choose to use. Upon obtaining the signed certificate of terminal illness from the referring provider and the beneficiary's written consent to participate in the MCCM, the hospice registers the beneficiary in the MCCM Portal and conducts the initial and comprehensive assessments (within 48 hours and 5 days of enrollment, respectively), following the MHB Conditions of Participation (CoPs) 42 CFR §418.

A. Eligibility Criteria[8]

There are four areas of eligibility: 1) diagnosis(es) and medical coverage, 2) office visits and hospitalizations, 3) hospice use, and 4) beneficiary residence requirements. An Eligibility Checklist is located on the MCCM Portal.
Location: **MCCM Eligibility Checklist (***Log in to Portal (https://www.mccm.cms.gov/home/)* → *Resources* → *Reports and Reference Documents* → *Filter Search By "Forms & Templates"* → *MCCM Eligibility Checklist)*

1. Diagnosis(es) and Medicare Coverage

- Enrolled in Medicare ***Parts A and B*** as primary insurance for the past 12 months
- ***Not enrolled*** in a Medicare managed care plan, including but not limited to Medicare Advantage, Health Care Pre-Payment Plan, or Program of All-inclusive Care for the Elderly

[8] Note: Eligibility criteria were updated twice — April 2016 and January 2017.

- Certification by the community-based provider of six months or less to live if the end-stage condition runs its usual course, in accordance with §418.22, and is co-signed by the hospice medical director
- Has a diagnosis as indicated by MCCM qualifying ICD-10 codes for advanced cancer, COPD, HIV/AIDS, or CHF
  Location: **MCCM ICD 10 Codes (***Log in to Portal (https://www.mccm.cms.gov/home/) → Resources → Reports and Reference Documents → Filter Search By "Care Coordination & Patient Management" → MCCM ICD 10 Codes)*

2. Office Visits and Hospitalizations

- Had at least one hospital encounter in the last 12 months for ER/ED visit, observation stay or admission
- Had at least three office visits with any Medicare-certified provider within the last 12 months

3. Hospice Use

- Has ***not elected*** the Medicare or Medicaid hospice benefit within the last 30 days

4. Beneficiary Residence

- Lives in a traditional home now and continuously for the last 30 days[9]
- Beneficiary's address is within the service area of the participating hospice

In addition to the delineated eligibility criteria, beneficiaries must sign a Beneficiary Enrollment Form that attests to their understanding and agreement to actively participate in the person-centered planning process to meet their individual goals and other stipulations (see **Appendix D**).

The Centers for Medicare & Medicaid Services (CMS) recognizes that the illness trajectory of beneficiaries enrolled in the MCCM may not be linear; health may improve or the beneficiary may live longer than 6 months. MCCM, unlike the MHB, does not require recertification. Support services provided by the MCCM participating hospice continue during all phases of the terminal illness even if the beneficiary is no longer considered to be terminally ill.

[9] The MCCM defines home as a location or residence, other than a hospital or other facility, where the beneficiary receives care. MCCM defines a group home as a residence with shared living areas where individuals receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). MCCM defines a boarding home as a home or facility (often a larger converted residence) where an individual rents a room and receives no supportive services. However, a beneficiary who is in a skilled nursing facility or assisted living, SNF or inpatient rehab, that is not their permanent residence, can be enrolled into the model after discharge without waiting 30 days.

B. Overview of Forms

There are three forms related to enrollment of a beneficiary in MCCM:

- Beneficiary Eligibility Checklist (may be used by the participating hospice but is NOT required)
- Medicare Care Choices Model Beneficiary Enrollment Form (see **Appendix D**)
- Referring Provider Attestation and Certification of Terminal Illness (CTI) (see **Appendix E**)

Beneficiary Eligibility Checklist: The MCCM participating hospice staff may utilize this checklist to determine that a beneficiary meets all eligibility requirements to enroll in the MCCM. This tool provides the MCCM eligibility requirements a column to record the date of validation and a reference column for source of validation, e.g., common working file (CWF), State Medicaid agency, etc. The MCCM team has made this tool available on the Portal to aid the participating hospices in validating the eligibility requirements of the beneficiary. The MCCM participating hospice may retain the Beneficiary Eligibility Checklist for their record but the checklist is not part of the enrolled beneficiary's clinical record.
Location: **MCCM Eligibility Checklist (***Log in to Portal (https://www.mccm.cms.gov/home/) → Resources → Reports and Reference Documents → Filter Search By "Forms & Templates" → MCCM Eligibility Checklist)*

MCCM Beneficiary Enrollment Form: The MCCM Beneficiary Enrollment Form contains a description of MCCM and the services provided under the model. Participating MCCM hospices will verbally explain the information on the document to the beneficiary and, as applicable, the family. If the beneficiary chooses to enroll in MCCM, the hospice representative obtains the beneficiary's signature on the MCCM Beneficiary Enrollment Form. The hospice gives a copy of the signed enrollment form to the beneficiary and retains the original in the beneficiary's hospice clinical record.
Location: **MCCM Beneficiary Enrollment Form (***Log in to Portal (https://www.mccm.cms.gov/home/) → Resources → Reports and Reference Documents → Filter Search By "Forms & Templates" → MCCM Beneficiary Enrollment Form)*

Referring Provider Attestation and CTI Form: A community practitioner designated by the beneficiary as having the most significant role in the determination and delivery of the individual's medical care, completes and signs the MCCM Referring Provider Attestation and CTI Form. This MCCM document states that the beneficiary has interest in participating in MCCM and has one or more of the four MCCM qualifying diagnoses, verified by the appropriate ICD-10 code. The community practitioner further certifies that the beneficiary is terminally ill with a life expectancy of six months or less if the qualifying disease runs its normal course using supporting documentation within the narrative portion of the CTI. A community practitioner and the medical director of the MCCM participating hospice must sign and date the Referring Provider Attestation and CTI Form.

Location: **MCCM Provider Attestation (***Log in to Portal (https://www.mccm.cms.gov/home/) → Resources → Reports and Reference Documents → Filter Search By "Forms & Templates" → MCCM Provider Attestation)*

IV. Marketing and Recruitment

Marketing is the development of key messages to inform and educate referral sources and others (collectively 'the target audience') about the added value of the model. Through marketing, participating hospices open a communication pathway for those who may be eligible and interested in the model and to the general community. This communication includes responding to inquiries for additional information and clarification of purpose, eligibility criteria, services, referral, and enrollment processes, as well as assuring community practitioners and beneficiaries that there is no additional cost to the beneficiary or loss of Medicare benefits due to services provided by the MCCM participating hospice. However, the MCCM enrolled beneficiary is still responsible for cost sharing related to non-MCCM services billed to Medicare Parts A, B and D.

A. Marketing Strategy

Participating hospices should develop a marketing plan and materials within their resources, consistent with generally recognized principles of marketing, considering their service area and target audience. Marketing could be as simple as altering current marketing materials by adding information about the hospice's other service lines such as MCCM. Two key audiences for MCCM are: 1) beneficiaries/family/caregivers and 2) referring physicians/providers, known in the model as the community practitioner.

The MCCM participating hospices educate providers about the model. This includes model objectives, services and advantages to the beneficiary, MCCM eligibility criteria, and the referral process. The community practitioner should inform his/her potentially eligible Medicare FFS and dually-eligible beneficiaries of the availability of the model. The beneficiary's community practitioner has the responsibility to certify in writing the beneficiary's terminal prognosis and qualifying condition in the Referring Provider Attestation and CTI Form (see **Appendix E**).

The MCCM beneficiary's community practitioner agrees to continue to be responsible for directing the usual care of the beneficiary, while enrolled in MCCM, to the extent that the beneficiary wishes. The community practitioner can ask the hospice medical director to consult in the beneficiary's care when appropriate.

V. Transitions of Care

Individuals with chronic illness and persons near the end-of-life experience have many care transitions. Beneficiaries often do not receive adequate care coordination, making these transitions difficult and sometimes harmful. It is common for beneficiaries to have multiple healthcare providers when they face a life-limiting illness and all providers may not be aware that transitions are occurring. Care transitions can be fraught with inadequate or incomplete

communication and lack person-centeredness. Poorly managed transitions between care settings may result in medication errors, disruption in care planning, uncoordinated care, and additional stress and/or confusion for the beneficiary and their caregivers. Lack of continuity of care adds additional burden to a beneficiary whose life is nearing its end, as well as to his or her family; a beneficiary who is seriously ill may be emotionally or physically fatigued, frail, and/or overwhelmed. Lack of care coordination during transitions may result in unnecessary ambulance use, emergency room visits, and acute care re-admissions. The Institute of Medicine (IOM) report, *Dying in America*, cites high rates of preventable hospitalizations in the last 90 days of life. These hospitalizations fragment the delivery of care and cause undue stress on the patient and his/her family.[10]

The MCCM participating hospice team will assure optimal facilitation of MCCM beneficiaries' care transitions across disease phases and settings by working with beneficiaries and their families, healthcare providers, community practitioners, and facility staff. Effective communication and actions result in continuity of care for the MCCM beneficiary.

A. Inpatient Admission

1. Acute Care Hospital

In the event an MCCM beneficiary requires an acute hospital stay, the MCCM care coordinator will communicate with all care teams to ensure the beneficiary's healthcare needs are met and all involved healthcare providers are aware of the beneficiary's preferences and goals. At the time of hospital discharge, if known, or following discharge, the MCCM care coordinator will collaborate, as needed, when the beneficiary is transitioned to the appropriate care setting.

2. Skilled Nursing Facility

MCCM beneficiaries may require a medically necessary short stay in a skilled nursing facility for rehabilitation following an acute hospital stay, prior to returning to a personal residence. The MCCM participating hospice team assures active communication and actions to achieve continuity of care for the MCCM beneficiary. This includes, but is not limited to, communication with skilled nursing facility staff regarding the MCCM beneficiary's treatment preferences, medications, previous functional ability, and the individual's person-centered goals, medication reconciliation and resumption of in-home services once the beneficiary is discharged to his/her residence.

[10] Institute of Medicine (2014). *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, (pp. 2:6-2:7). Washington, D.C. The National Academies Press.

B. Transfer to a Different MCCM Participating Hospice

It is possible that an MCCM-enrolled beneficiary may choose to transfer to another participating MCCM hospice. Beneficiaries may do so for any reason, and at any time.

If the beneficiary chooses to transfer to another participating MCCM hospice that serves the area where the beneficiary intends to reside, the MCCM participating transferring hospice (hospice #1) and the receiving/admitting MCCM participating hospice (hospice #2) will communicate and coordinate services in order to assure care continuity. This requires both verbal and written transfer of information that includes but may not be limited to the most recent beneficiary assessment(s), latest version of a Plan of Care, beneficiary's current medications and equipment, healthcare providers of care, treatment preferences, and possibly copies of the most recent encounter and interdisciplinary group documentation.

Since the MCCM participating hospice is assuming care and billing for these services, it is necessary for the MCCM participating hospice to have the MCCM enrollment documents re-signed by the beneficiary and the Referring Provider Attestation and CTI form signed by the community practitioner in the beneficiary's new service area. These forms are described in this resource manual within section IV.B, entitled "Beneficiary Eligibility and Enrollment - Overview of Forms."

There is no restriction on the number of changes an MCCM beneficiary may make in any period of time since there are no election periods in the MCCM, as there are in the MHB. The change in MCCM participating hospice is not a revocation of the MCCM election.

MCCM participating hospices will assure that the necessary documentation related to a change in MCCM participating hospice is complete as well as assure continuity of care by assisting beneficiaries and families with communication to all providers of care and services of the change.

C. Discharge from MCCM

Enrolled MCCM beneficiaries requiring a length of stay exceeding 90 days in a nursing home, assisted living facility, hospice inpatient facility, or other institutional setting with the exception of an acute hospital, must be discharged from the model. ***A beneficiary who leaves the MCCM, regardless of the reason, is not eligible to return to the model.*** Beneficiaries are not required to discharge from the model if their disease process no longer meets the six month prognosis.

The MCCM participating hospices must transfer beneficiaries to the most appropriate care setting when the model ends December 31, 2020. The MCCM participating hospices will assure continuity of care for all MCCM beneficiaries at that time.

1. Possible Reasons for Discharge from MCCM

1. **MCCM enrolled beneficiary no longer wishes to participate in the model:** If the beneficiary chooses to no longer participate in the model, the hospice notes this on the

applicable data entry fields of the Portal and thereafter, the MCCM participating hospice no longer reports on that beneficiary on the Service and Activity Log (SAL).

2. **MCCM enrolled beneficiary moves out of service area of the MCCM participating hospice:** An MCCM participating hospice will discharge from their services an MCCM beneficiary who moves outside the hospice's service area. If there is no other MCCM participating hospice in the service area the beneficiary is moving to, the MCCM participating hospice discharges the beneficiary to the most appropriate care setting.

3. **MCCM enrolled beneficiary dies:** The MCCM participating hospice discharges the beneficiary when the person dies. However, the MCCM participating hospice continues care to the family of the deceased through bereavement in compliance with 42 CFR§418.64(d)(1).

4. **MCCM enrolled beneficiary discharged for cause:** The MCCM participating hospice determines that the beneficiary's (or other persons in the beneficiary's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the beneficiary or the ability of the hospice to operate effectively is seriously impaired. This determination is under a policy set by the MCCM participating hospice for the purpose of addressing discharge for cause that meets the requirements of 42 CFR §418.26(a)(3).

5. **MCCM enrolled beneficiary no longer MCCM eligible:** If a beneficiary no longer has Medicare Parts A and B as primary (e.g., the beneficiary switches to another type of insurance or managed care, such as Medicare Advantage), CMS cannot process MCCM claims and the participating hospice can no longer receive the MCCM PBPM fee; the beneficiary must be discharged from the model. The hospice may choose to provide services without receiving the MCCM PBPM fee. This information should be in writing and be made clear to the beneficiary at the time of MCCM enrollment.

6. **MCCM beneficiary elects MHB:** An MCCM enrolled beneficiary may choose at any time during participation in the MCCM, to seek hospice care under the MHB. The beneficiary may not simultaneously participate in the model and in the MHB. The beneficiary is also not eligible to return to the MCCM if he/she later opts out of the MHB.
7. **Hospice voluntary withdraws from MCCM:** Hospices that wish to withdraw from MCCM must provide CMS with written notification of intent to withdraw from the Model 90 days prior to the effective withdrawal date. Upon receipt of the written notification, follow-up withdrawal procedures will be forwarded to the MCCM hospice. If there are no other MCCM participating hospices in the service area, the MCCM participating hospice discharges the beneficiary to the most appropriate care setting. A Notice of Termination or Revocation (NOTR) is needed and is required at the time of discharge from MCCM.

VI. MCCM Portal

The MCCM Portal provides secure data entry and a repository for hospice and beneficiary enrollment and service information, as well as access to model reports and references. Detailed information about the Portal can be found in the Portal User Guide, found in the Reports and Reference Documents section of the Portal.

Location: **Portal User Guide (***Log in to Portal (https://www.mccm.cms.gov/home/)* → *Resources* → *Reports and Reference Documents* → *Filter Search By "MCCM Portal"* → *Portal User Guide*)

A. MCCM Portal Data

Each hospice is responsible for entering data about the hospice, beneficiaries, and model services. MCCM Portal data, along with data from claims and other sources, serve as a foundation for the model's management and evaluation. It is imperative that hospices are diligent about the timeliness and accuracy of data entry for these purposes.

1. Data Elements

The MCCM Portal data submission is based on the use of four forms:

- **Hospice Information Form (HIF):** The HIF collects information about the MCCM participating hospice, including contact information, identification numbers, and information on its MCCM personnel. This form is completed once and can be edited for hospice changes.
- **Patient Baseline Information Form (PBIF):** The PBIF collects basic information about all beneficiaries who are referred to MCCM, both those who enroll and do not enroll in the model. Information gathered includes beneficiary demographics and characteristics, information about the referring provider, and information about baseline beneficiary assessments. The PBIF is completed once, when the beneficiary enrolls in the model. The PBIF can be edited if information about the beneficiary changes or if there is an error.
- **Service and Activity Log (SAL):** The SAL tracks the services provided to the MCCM participating hospice's beneficiaries, as well as changes in the beneficiary's living situation, changes in health status, and metrics associated with quality of care. The MCCM participating hospice completes this form once for each beneficiary encounter, including family members or caregiver, and includes administrative telephone calls (DME, supplies, oxygen, care coordination, care management, etc.) or in-person visits.
- **The Patient Discharge Form (PDF):** The PDF collects information about when and why an MCCM participating hospice transfers, discharges or disenrolls a beneficiary from the model, as described in Section VI.C. The MCCM participating hospice completes this form once for each beneficiary upon discharge.

B. MCCM Technical Assistance, Data Submission, and Reports

1. Technical assistance for the MCCM Portal is available by phone or email.

- To submit questions by email, send questions to cmsmccm@lewin.com. A model support person will reply to the email within one business day. Please do not submit protected health information (PHI) such as beneficiary names or Medicare numbers by email, as this communication route is not secure.
- For phone support, call 703-269-5915 between the hours of 9 AM and 5 PM Eastern Time, Monday through Friday. Responses to telephone calls will occur within one business day if the support person is not available at the time of the call.

2. What to Do When the Portal is Unavailable

While the MCCM Team does not anticipate Portal outages, unforeseen circumstances may cause the Portal to be unavailable for short periods of time. Additionally, occasional scheduled downtime for routine maintenance is communicated to hospices as early in advance as possible. Should the Portal be unavailable to users for any reason, hospices are advised to implement the following back-up plan:

- Continue to use your standard procedures for data collection and maintenance according to your local business continuity plans. Hospice leaders should ensure that all staff are familiar with local continuity plans.
- Standard paper-format versions of the Patient Baseline Information Form (PBIF) and Service and Activity Log (SAL) are available and can serve as an optional means of manual MCCM information collection. Hospices are encouraged to download these documents and save them in a local location for use in the event of a Portal outage. *Location:* **PBIF Paper Form or SAL Paper Form (***Log in to Portal (https://www.mccm.cms.gov/home/)* → *Resources* → *Reports and Reference Documents* → *Filter Search By "Forms & Templates"* → *PBIF Paper Form and SAL Paper Form*)
- Beneficiary information and service information that is collected during the Portal outage should be entered into the MCCM Portal by hospice personnel when Portal function is restored.
- Hospices who use Comma Separated Value (CSV)-import functionality for submitting beneficiary data should continue to collect all beneficiary data in their electronic medical record (EMRs) according to usual methods. CSV files should be uploaded to the Portal after restoration of Portal function.

3. Data Submission Timeframes

Hospice-related Information: MCCM participating hospices must complete the HIF as soon as possible, following initial Portal orientation and prior to entering referred or enrolled beneficiaries into the model.

Beneficiary Information: All beneficiary-related information, including the PBIF, the SAL and the PDF, must be entered into the Portal manually or PBIF and SAL imported from a CSV file no later than the seventh day of the month after the relevant beneficiary encounter. For example, if the MCCM participating hospice enrolls an MCCM beneficiary on February 15th, the MCCM participating hospice will enter the PBIF and any additional SALs no later than March 7th. If the MCCM beneficiary then died on March 10th, the MCCM participating hospice will then submit a PDF no later than April 7th.

4. Portal Data Reports

Analytic reports derived from aggregated Portal data and Medicare claims data are provided to MCCM participating hospices to assist their implementation efforts, and to improve the quality of care provided to MCCM beneficiaries.

VII. Quality Reporting

A. MCCM Quality Measures

One of the primary objectives of the MCCM is to determine if the model enhances or at least maintains current levels of quality of care, including beneficiary and family satisfaction, while reducing or maintaining costs. Quality measures were established and are monitored throughout the model's lifecycle for management and evaluation.

The quality measures pertain to usual hospice areas of care, including managing pain and symptoms associated with chronic illness and end-of-life, such as pain, dyspnea, bowel/elimination management, as well as spiritual and emotional well-being. Additionally, beneficiary and family preferences and satisfaction with care are monitored, including advance care planning, screening and addressing social and emotional needs, and ensuring shared decision making.

Quality measures are monitored through a variety of periodic data analyses by the implementation and evaluation contractors using data from the MCCM Portal, claims, the CMS Chronic Disease Warehouse, and hospice model reports. The MCCM team reviews the findings of these analyses to plan Learning & Diffusion strategies (where CMS devises means for informing and interacting with MCCM hospices to improve the model) and model adjustments.

The MCCM implementation contractor (IC) provides a quarterly dashboard to inform hospices of their status relative to aggregate measures of other hospices in the model. **Table VII.A** below lists the MCCM quality measures.

Table VII.A: MCCM Quality Measures[11]

Measure Title
Treatment Preferences
Spiritual/Religious Discussions
Advanced Care Planning Discussions
Given a Bowel Regimen When Treated with an Opioid
Dyspnea Screening, Treatment and Effectiveness
Pain Screening, Assessment and Effectiveness
Shortness of Breath Screening and Treatment
Psychological/Emotional Well-being Screening and Treatment
Unplanned Hospital Admissions or Re-admissions
Emergency Department Use without Hospitalization

B. Hospice Progress Reports[12]

MCCM participating hospices are required to submit electronic Hospice Progress Reports (HPRs) using an MCCM online template by the middle of the month following the calendar quarter. See **Appendix F** for a description of this report. See table VII.B for the delivery schedule.

Table VII.B: Delivery Schedule for HPRs

Bi-Annual Progress Report	Due Date
Quarter 1 and Quarter 2 Progress Report: January— June	**July 15th**
Quarter 3 and Quarter 4 Progress Report: July— December	**January 15th**

VIII. Billing and Payment of Model Services

Although similar to billing for the MHB, the MCCM billing process has some notable differences. Similar to services under the hospice benefit, MCCM also requires a Notice of Election (NOE) to turn the payment system on and a Notice of Termination or Revocation (NOTR) to turn the payment system off. However, due to interoperability of software systems, it may be necessary for the hospice to enter MCCM claims information directly into the Medicare software and not use

[11] Medication Reconciliation, Treatment Preference Followed and Timely Transmission of Transition Record quality measures were deleted effective 1/1/2018 to coincide with the MCCM Portal 2.0 update.
[12] Hospice Progress Reports, formerly Hospice Quarterly Progress Reports are required to be submitted twice annually beginning January 1, 2019. Prior to January 2019, hospices were required to submit reports quarterly.

organizational billing software that connects with the Medicare claims software, as some software systems are hardwired for hospice information only and are unable to be changed.

A. Completing an MCCM specific NOE or claim

A sample MCCM Claim Form is located in **Appendix G** of this document.

Step 1: Enter Hospice information

a. Please include the hospice National Provider Number (NPI) used for the MCCM

b. Type of bill (TOB)

Step 2: Please add beneficiary demographics into the system as you would a hospice NOE or claims.

a. Name

b. Address

c. Medicare Beneficiary Identifier (MBI); or Health Insurance Claim Number (HICN) number may be used if MBI not available until December 2019

d. MCCM approved diagnosis code (a list of MCCM approved ICD-10 codes can be found on the MCCM Portal)

e. Date of enrollment

f. NPI of primary physician

Step 3: Remove Occurrence Code '27' from the MCCM NOE or claim (this identifies the submission as a hospice NOE or claim).

Step 4: For claims submission, add at least one line of services rendered as '0659' with a specified G-code for MCCM (see **Appendix H**). The G-codes designate the services rendered during the month the beneficiary is enrolled in MCCM.

a. At least one line of the services for a claim must have a designated G-code with the '0659' code for routine care.

b. '0659' and 'G9476' designates a volunteer service rendered in a routine MCCM setting.

c. For example, the '0659' determines that the services are being rendered at the routine level.

d. Do not add the fee for the MCCM such as the $400 or $200 fee (the system does not recognize this information and will return the claim).

Step 5: Place the model code '73' in the treatment authorization code area that identifies the claim as associated with the model (found on tab 5 of the Medicare Claims system).

Note: There is not a 5 day submission rule for the MCCM NOE.

MCCM recognizes that there may be times when the NOE or the claims will be Returned to Provider (RTP) for correction, or even rejected. If the hospice is unable to make the needed corrections to the RTP, you should contact the designated Medicare Administrative Contractor (MAC) to assist with the process as soon as possible. If the hospice is unable to resolve the problem with the MAC, the hospice should submit a 'Billing Issues Report (BIR)' (see **Appendix I**) to cmsmccm@lewin.com to receive assistance from the CMS MCCM Team. By filling out the BIR this will assist our team in tracking the billing issues within the model. It is expected providers will follow the Medicare Claims Processes which are located: https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html.

B. Change Request

CMS uses a series of standardized transmittals to communicate new or changed policies or procedures that will be incorporated into the CMS Online Manual System (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals). These transmittals summarize and specify the changes that are necessary in the various systems to process information such as claims. One such transmittal is known as Change Request (CR). There are two CRs for MCCM— CR 9136 and CR 10094, which can be found in the previous hyperlink provided in the CMS Online Manual System.

IX. Roles/Responsibility of CMS/CMMI & Associated Contractors

The Center for Medicare and Medicaid Innovation (CMMI) models generally entail the collaboration of internal and external partners. In addition to the MCCM participating hospices, the MCCM partners include the CMS CMMI team, an implementation contractor and an evaluation contractor.

A. The CMS CMMI Team

The CMS CMMI Team consists of a directing manager, a model lead, project officers (POs), contract officer representatives (CORs) and other supporting staff, as well as CMMI-wide support services.

The role of the CMS PO is to provide direct consultation and assistance to MCCM participating hospices concerning program policy and operations. The CMS PO is a liaison between MCCM participating hospices and CMS. Specifically, the PO will:

- Be familiar with the hospice's approved operational plan and innovative strategies
- Assist with problem solving for the successful implementation of the model
- Provide their assigned hospices ongoing support for the duration of the model

- Work with the hospice to identify potential or existing problems or issues impacting progress
- Document strengths and weaknesses, lessons learned, barriers, and problem-solving solutions in order to inform future Medicare programming
- Facilitate communication between the MCCM hospices and with CMS
- Work collaboratively with other POs and MCCM contractors to ensure the effective operation of the model

Additionally, the PO might conduct site visits as warranted by model needs; and/or, as requested by a participating hospice. These visits may serve many purposes, including substantiating progress and providing or arranging for technical assistance if needed.

B. Implementation Contractor

The Lewin Group is the implementation contractor (IC) for the MCCM. The IC primarily provides technical assistance and model support to the CMS CMMI Team and MCCM participating hospices. The IC facilitates communication and information exchange through web-based interfaces and print and electronic methods. Additionally, the IC conducts data analysis and reports, assists in the development and delivery of educational sessions for participating hospices (in-person and via webinar), and performs one-on-one phone support and other technical assistance defined in the contract.

A primary function of the IC is to oversee the development and maintenance of a web-based Portal which houses model documents and is a repository for beneficiary-level information on the services provided by hospices. The IC ensures the integrity of the Portal, including routine maintenance, managing access and adherence to CMS' information system security protocols.

C. Medicare Administrative Contractors (MACs)

MCCM specific activities by the MACs include claims processing, claims reports (details of numbers and outcomes of claims), and chart review. Each hospice submits one claim per month for each enrolled beneficiary for whom they provide at least one service in a month. On a monthly and quarterly basis, MACs provide reports to the MCCM team to assist in the management and development of the model.

The MAC chart review consists of a random selection of beneficiary records to support quality data submitted via the MCCM Portal. MACs contact participating hospices for copies of beneficiary records to complete these reviews. The IC provides Portal data to the MACs on a quarterly basis.

D. Evaluation Contractor

Abt Associates serves as the MCCM evaluation contractor in partnership with consultants and researchers from Brown University, GDIT, L&M Policy Research, RAND, and Oregon Health &

Science University. Abt is conducting a mixed-methods evaluation of the MCCM to assist CMS in determining whether the model increases access to supportive care services offered by hospices, improves end-of- life care, and reduces Medicare and Medicaid expenditures.

The MCCM evaluation includes an analysis of:

- Medicare and Medicaid claims
- MCCM services & activities and quality metrics submitted by participating hospices via the MCCM Portal
- Case studies with participating hospice staff, interviews with enrolled beneficiaries and/or their caregivers, as well as referring physicians
- Two survey-based data collection strategies:
    - Organizational Survey of hospice leadership for both the MCCM participant and comparison hospices to further understanding of hospice business changes needed to facilitate model implementation
    - The Caregiver Experience of Care Survey (CECS) for MCCM caregivers, administered following the death of the participating beneficiary and administered in conjunction with the Hospice Consumer Assessment of Healthcare Providers.

X. Learning and Diffusion

Learning and diffusion is a signature activity of CMS' CMMI and creates integrated opportunities for learning. Models are unique laboratories for trying new approaches, evaluating their impact, refining strategies and creating purposeful, positive change. Learning and diffusion of new approaches and ideas is an integral part of that process.

Throughout the life of a model at CMMI, an implementation team and an evaluation team monitors the model's progress and interacts with the participating providers to share learning, bolster sustaining and disseminating success, and document both negative and positive impacts.

The MCCM IC utilizes a series of tools to accomplish its learning and diffusion. These include webinars, bimonthly email communications, and regular 'TouchPoints' with participating hospices. Webinars and other materials useful to hospices in the model are maintained on the MCCM Portal for easy reference and ongoing education. MCCM participating hospices are expected to attend webinars and scheduled calls, such as TouchPoints. If a hospice is unable to attend a webinar or a scheduled call, the hospice should make their project officer aware and keep abreast of information by reading the email-blast (E-blast) that is published no later than the first E-blast of the following month (earlier depending on the timeline of the TouchPoints and the E-blasts). The TouchPoint slides with the narrative recording are posted monthly on the Portal.

Location: **(***Log in to Portal (https://www.mccm.cms.gov/home/)* → *Resources* → *Reports and Reference Documents* → *Filter Search By "TouchPoint Summaries"*)

XI. Appendices

This section in the Resource Manual contains copies of the model's primary operating documents including:

A. Participation Agreement

B. Participation Agreement Addendum for Cohort 1

C. Participation Agreement Addendum for Cohort 2

D. Beneficiary Enrollment Form

E. Referring Provider Attestation and Certification of Terminal Illness

F. Hospice Progress Report description

G. Sample MCCM Claims Form

H. MCCM-specific HCPCS and Corresponding Revenue Codes

I. Billing Issues Report (BIR)

J. Dictionary of MCCM Terms

K. Dictionary of MCCM Forms, Reports, and Other Model Resources

Appendix A: The Medicare Care Choices Model - Participation Agreement

The Medicare Care Choices Model

PARTICIPATION AGREEMENT

Parties: The Centers for Medicare & Medicaid Services (CMS) enters into this Medicare Care Choices Model (MCCM or model) Participation Agreement (Agreement) with (the Hospice) to set forth terms and conditions for the model and the parties' respective obligations under the model.

Goals and Objectives: Under Section 1115A of the Social Security Act, the Center for Medicare and Medicaid Innovation (the Innovation Center) is authorized to test innovative payment and service delivery models that have the potential to reduce Medicare Medicaid, or Children's Health Insurance Program (CHIP) expenditures while maintaining or improving the quality of care for Medicare beneficiaries. Through the Medicare Care Choices Model, the Innovation Center will test new models of care for certain hospice-eligible Medicare fee-for-service beneficiaries and dual eligible beneficiaries to improve care coordination and case management, beneficiary satisfaction, and quality of care, as well as reduce Medicare expenditures. It would examine, among other things, whether Medicare beneficiaries who meet the model's eligibility requirements would elect to receive the palliative and supportive care services typically provided by a hospice earlier, if they could also continue to seek services from their curative care providers. Beneficiaries choosing to enroll in this model retain the option of electing the Medicare or Medicaid hospice benefit, as applicable, at any time.

Terms and Condition

Medicare Care Choices Model: The Hospice agrees to implement the MCCM in accordance with this Agreement and all applicable laws and regulations.

Entire Agreement: This Agreement, including all Attachments hereto, constitutes the entire agreement between the parties. Nothing in this Agreement transfers any right, title, or interest to any party.

Phased Implementation: The Medicare Care Choices Model is a 5-year model that will be implemented in two phases. Following receipt of the signed agreements from all hospices electing to participate in the model, CMS will randomly select 65 eligible hospices to be included in the first phase, or cohort. The first phase of MCCM participants will begin to provide services under the model to eligible beneficiaries on January 1, 2016. The remaining group of the eligible hospices will be included in the second phase, or cohort, of the MCCM and will begin to provide palliative care services on January 1, 2018. Performance period protocols will be provided to all hospices after the signed participation agreements are received.

Dates: The effective date of this Agreement is the date on which the final signatory executes this Agreement. The period of performance term of this Agreement is the period during which the

Hospice is delivering services the beneficiaries under the model, from January 1, 2016, for Phase I and from January 1, 2018, for Phase 2, through December 31, 2020, unless sooner terminated in accordance with ***Termination by CMS*** Section of this Agreement.

Reimbursement: With the exception of the first month, the hospice agrees to be paid $400 per beneficiary per month (PBPM) to provide to the hospice support and care coordination services that are covered under the demonstrations. In the first month of enrollment, the Hospice will be paid $400 per beneficiary for beneficiaries who are enrolled before the 16th day of the month, and $200 for the beneficiaries who are enrolled on or after the 16th day of the month. Enrollment is effective on the date the beneficiary or his/her authorized representative signs the model Enrollment Form. The PBPM amount is the total payment from Medicare to hospice for all MCCM services provided to beneficiary covered under the demonstration.

Recoupment: If as a result of any later inspection, evaluation, investigation, or audit, it is determined that the amount of payments made to the Hospice pursuant to the Reimbursement section of this Agreement have been made in error, CMS shall recoup any overpayments in accordance with the regulations at 42 C.F.R. § 405.371. The Medicare regulations governing suspension of payment and recovery of overpayments (42 C.F.R. §§405.370-405.378) shall apply to any payments made pursuant to this Agreement.

Implementation Plan: The Hospice agrees to submit to CMS an implementation plan for the model at a time prescribed by CMS (approximately 5 months before it begins delivering services under the model). CMS's approval of Hospice's implementation plan or any amendment thereto shall not preclude CMS or any other government authority from enforcing any and all applicable laws, rules, and regulations. Such approval does not relieve Hospice from its obligation to comply with the terms of this Agreement and all applicable laws, regulations, and guidance.

Model Attestation and Education: While the referring healthcare provider is responsible for identifying eligible beneficiaries for referral to a hospice delivering services under the MCCM, the Hospice is responsible for obtaining a copy of the referring provider's attestation that the providers' attestations shall be maintained in accordance with the Maintenance of Records provision of this Agreement. The Hospice is also responsible for educating the beneficiary and the referring provider about the model.

Monitoring and Reporting: After it begins providing services to enrolled beneficiaries, the Hospice agrees to cooperate fully with CMS and its contractors by submitting baseline and periodic reports to CMS or its designated implementation contractor. CMS or its designated implementation contractor will provide guidance and training concerning the required format and content of the progress reports. The Hospice is responsible for ensuring the accuracy and completeness of the information contained in all documents, reports, and data submitted.

Education and Outreach Materials: The Hospices shall submit to the CMS PO for review and approval, copies of all press releases, education and outreach materials that reference the model, including, but not limited to, brochures; letters to physicians and/or beneficiaries; media advertisements; and any other press releases, education or outreach materials that include model results or financial information, projections of payments under the model, projected values of model services, or projected or actual savings.

Evaluation: In September 2016, CMS awarded a contract to Abt Associates to study the design and implementation of the model and to evaluate outcomes under the model. The Hospice shall cooperate fully with the evaluation team. This will include, but is not limited to, allowing site visits as requested and providing information and data, including beneficiary-specific information hospice level data, including agency operations and processes; and beneficiary interventions and communications. The Hospice shall submit the requested information no later than the date specified by the independent evaluator. The Hospice also shall cooperate fully with any audit of submitted data that may be required by CMS. The Hospice is responsible for ensuring the accuracy and completeness of the information contained in all documents, reports, and data submitted.

CMS shall have full rights to use any data obtained pursuant to the MCCM to disseminate quantitative results, as well as successful care management techniques to other providers and the public and to evaluate the MCCM. Data to be disseminated may include results of patient experience of care and quality of life surveys as well as measures based on claims and medical records. Hospices will be permitted to comment on evaluation reports for factual accuracy but will not be permitted to edit conclusions or control the dissemination of reports.

Presentation of Statistical or Analytical Material: The Hospice shall obtain CMS review and approval prior to release for presentation of any report or statistical/analytical material based on information, obtained through participation in the MCCM. Presentation includes, but is not limited to, papers, articles, professional publication, speeches, and testimony. These materials shall be submitted to the CMS PO no later than 60 days prior to publication or release.

Beneficiary Discharge: When delivering services under the model, the Hospice shall notify the CMS PO one day, or as soon as reasonably possible, prior to initiating the process of discharging a model beneficiary for cause. As outlined in 42 C.F.R. § 418.26 (a)(3), the Hospice shall have a policy in place to address discharge for cause and shall take the steps outlined below before initiating this process as per 42 C.F.R. § 418.26 (a)(3)(i-iv):

a) Advise the beneficiary that a discharge for cause is being considered;

b) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;

c) Ascertain that the beneficiary's proposed discharge is not due to the beneficiary's use of necessary hospice services; and

d) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

In addition, as outlined in 42 CFR 418.26(b), the Hospice shall obtain a written physician's discharge order from the Hospice's medical direction prior to discharging a patient for cause. If a patient has an attending physician involved in his or her care, this physician should also be consulted before discharge and his or her review and decision included in the discharge note.

Compliance with Laws: The Hospice shall comply with the applicable terms of this Agreement and all applicable statutes, regulations, and guidance, including without limitation (a) federal criminal laws; (b) the federal False Claims Act (31 U.S.C. §3729 et seq.); (c) the federal anti-kickback statute (42 U.S.C. §1320a-7b(b)); (d) the federal civil monetary penalties law (42 U.S.C.§1320a-7a); and (e) the federal physician self-referral law (42 U.S.C. §1395nn).

This Agreement does not provide any waivers of laws, and individuals and entities participating in the MCCM must comply with all applicable laws and regulations, except as explicitly provided in any separate waiver that may be granted pursuant to section 1115A of the Social Security Act specifically for the MCCM.

Audits: The Hospice agrees that the Government, including CMMI, CMS, HHS, and the Comptroller General or their designee(s), has the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the Hospice that pertain to its compliance with, and right to payments under, this Agreement and the model.

None of the provisions of this Agreement limit or restrict any other Government authority that is permitted by law to audit, evaluate, investigate or inspect the Hospice.

Maintenance of Records: The Hospice shall maintain and give the Government, including CMMI, CMS, HHS, and the Comptroller general or their designee(s), access to all books, contracts, records, documents, and other evidence (including data related to utilization and costs, quality performance measures, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the Hospice's compliance with, and right to any payments under, the Agreement. Hospice shall maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless (a) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Hospice at least 30 calendar days before the normal disposition date; or (b) there has been a termination, dispute, or allegation of fraud or similar fault against the Hospice, in which case the records shall be maintained for an additional 6 years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

Withdrawal by Hospice: The Hospice may withdraw from the model at any time by providing the CMS PO with 90 calendar days' advance written notice.

CMS will not be liable for any close- out or additional costs that are borne by the Hospice for withdrawal. In such a circumstance, this Agreement shall terminate upon the effective date of the Hospice's withdrawal from the model.

Termination by CMS: CMS may immediately or with advance notice terminate this Agreement for any reason, including but not limited to, its determination that –

a) CMS no longer has the funds to support the model;

b) The model must be terminated pursuant to Section 115A(b)(3)(B) of the Social Security Act;

c) The initial or any subsequent program integrity screening of the Hospice reveals a program integrity issue or an affiliation with individuals or entities that have a program integrity issue. Including but not limited to, a history of improper or suspect Medicare billing; or

d) The Hospice –

   a. Has failed to meet performance targets;

   b. Has failed to comply with any term of this Agreement, or any other Medicare program requirement, rule, or regulation;

   c. Has failed to cooperate with CMS or its contractors;

   d. Has taken any action that threatens the health or safety of patients;

   e. Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the model;

   f. Is subject to sanctions or other actions of an accrediting organization, or Federal, State or local government agency; or

   g. Is subject to action by HHS (including OIG and CMS) or the Department of Justice to redress an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action.

Effect of Termination: Termination of this Agreement under the Termination by CMS or Withdrawal by Hospice provisions shall not affect the rights and obligations of the parties accrued prior to the effective date of the termination or expiration of this Agreement, except as provided in this Agreement. The following provisions shall survive termination of this Agreement: Privacy and Security, Evaluation, Audits, Maintenance of Records, Recoupment, Education and Outreach Materials, Public Release of Information, Presentation of Statistical or Analytical Material, Order of Precedence, and Bankruptcy.

Dispute Resolution: The Medicare regulations governing appeals 42 CFR 405, Subpart 1 shall apply if the parties fail to reach agreement on any request for equitable adjustment, claim, appeal or action arising under or relating to this Agreement. The Hospice shall proceed diligently with performance under this Agreement, pending final resolution of any dispute arising under the Agreement.

Remedial Action: The Hospice agrees that if CMS determines that any terms of this Agreement have been violated, CMS may take any or all of the following actions if it determines that immediate termination of the Agreement is not warranted:

a) Notify the Hospice of the violation.

b) Require the Hospice to provide additional information to CMS or its designees.

c) Conduct on-site visits, interview Medicare beneficiaries, or take other actions to gather information.

d) Place the Hospice on a special monitoring plan.

e) Request a corrective action plan from the Hospice. If CMS requests a corrective action plan, the following requirements apply:

    1) The Hospice must submit a corrective action plan for CMS approval by the deadline established by CMS.

    2) The corrective action plan must address what actions the Hospice will take within a specified time period to ensure that all deficiencies will be corrected and that the Hospice will remain in compliance with the terms of this Agreement.

    3) If the Hospice does not comply with the corrective action plan within the specified time period, CMS may take appropriate remedial action up to and including termination of this Agreement.

The failure by CMS to require performance of any provision of this Agreement shall not affect CMS's right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

Program Integrity Screening and Ongoing Monitoring: CMS will complete an initial review of Hospice's program integrity history after execution of this Agreement. In addition, the Hospice will be subject to ongoing program integrity screening and compliance monitoring throughout the term of this model. United States law will apply to resolve any claim of breach of this agreement.

Order of Precedence: Any inconsistency in this agreement shall be resolved by giving precedence to the model documents in the following order:

a) This model Agreement

b) The Hospice's Implementation Plan

Bankruptcy: If the Hospice enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Hospice shall furnish, by certified mail, written notification of the bankruptcy proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, and identity of the court in which the bankruptcy petition was filed.

Prohibition on Assignment: Hospice shall not assign any of the rights or obligations under this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, unless CMS consents to such assignment in writing. Any purported assignment of this Agreement without such written agreement of CMS is void.

Severability: In the event that any one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, any invalidity, illegality or unenforceability shall not be affect any other provisions of this Agreement, but this Agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

Amendment: The parties may amend this Agreement or any Attachment hereto at any time by mutual written agreement; provided, however, that CMS may unilaterally amend this Agreement or any Attachment hereto for good cause or as necessary to ensure compliance with applicable federal or State laws or regulations. To the extent practicable, CMS shall provide the Hospice with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the effective date of the amendment. The Hospice may request a change to this agreement by submitting it in writing to the CMS Project Office (PO).

Authority for Signature: The Hospice representative signing this Agreement certifies to the best of his or her knowledge, information, and belief that the information contained in this Agreement is accurate, complete and truthful and that he or she is authorized by the Hospice to execute this Agreement and to legally bind the Hospice to its term and conditions.

By signing this Participant Agreement, the Hospice agrees to participate in the model and understands that the start date on which it may begin to deliver services under the model will be provided a later date consistent with its assignment to Phase 1 or Phase 2, as will be determined using the randomization approach described above under the Phased Implementation provision of this Agreement.

Signature of Acceptance of Terms and Conditions Model

Site Participating in the Medicare Care Choices Model

Hospice legal name:	
Hospice DBA name:	
Address:	
Medicare CCN:	
Signature:	**Date:**
Name:	**Title:**
(Print Name and Title)	
Signing for the Centers for	**Medicare & Medicaid Services**
By:	**Date:**

Deputy Director
Center for Medicare and Medicaid Innovation

Appendix B: The Medicare Care Choices Model - Participation Agreement Addendum – Cohort 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Centers for Medicare and Medicaid Innovation
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

The Medicare Care Choices Model
Participation Agreement Addendum

Parties: The Centers for Medicare & Medicaid Services (CMS) enters into this Medicare Care Choices Model (MCCM or Model) Participation Agreement Addendum (Agreement Addendum) with _____ (the Hospice), _____ (CCN) to set forth terms and conditions for the Model and the parties' respective obligations under the Model.

Objectives: The objective of this Agreement Addendum is to:

- Further outline the reimbursement provided to hospices for services provided in the MCCM demonstration. .
- Specify the phased implementation and performance period
- Outline evaluation requirements.

Participant Agreement Addendum

Medicare Care Choices Model: The hospice agrees to implement the MCCM in accordance with this updated Agreement and all applicable laws and regulations.

Entire Agreement: This Agreement Addendum, including all attachments hereto, constitutes the amended sections of the agreement between parties. Nothing in this Agreement Addendum transfers any right, title, or interest to any party. The original Participation Agreement except for these Amended sections is still enforce.

Reimbursement: The Per Beneficiary per Month amount is the total payment from Medicare to the hospice for all MCCM services provided to beneficiaries covered under the Model. The date the beneficiary signs the Model enrollment form, becomes the starting point for their enrollment into MCCM (the start of care date). If the beneficiary's start of care date provides them with less than 15 calendar days of services, the hospice will be paid $200 for that beneficiary's first month of service. If the start of care date provides 15 or more calendar days of service for the first month of service, the hospice will be reimbursed $400. Each subsequent month, the hospice will be paid the $400 per beneficiary per month up to and including the discharge date even if the date of discharge is the only date of service provided that calendar month.

Phased Implementation: As a Phase 1 participant, your organization will begin to provide services under the Model to eligible beneficiaries on January 1, 2016 and end on December 31, 2020.The ramp up period for the Model begins July, 2015 to January, 2016.

Evaluation: Hospices selected to be participants in Phase 2 of the Model, will be serving as a control group for the evaluation process. Beginning in early 2016, the CMS evaluator will

contact your organization as these evaluation activities are launched. The evaluator may ask hospices to participate in baseline data collection efforts such as allowing site visits as requested and providing information and data related to agency operations and processes, and beneficiary interventions and communications.

To assist in the evaluation of this Model, your hospice is required to avoid participating in any MCCM-related activities during the first two years of the Model. If your organization is part of a corporate and/or network structure these entities must refrain from offering or implementing model services or providing Model-related interventions. (e.g., technical assistance, patient recruitment efforts, data sharing) to the agencies that are part of Phase 2. The data we collect from your hospice, acting as a control group for the evaluation during the first two years of the Model, will assist CMS with conducting a robust evaluation to determine the potential expansion of this Model.

Authority for Signature: The Hospice representative signing this Agreement Addendum certifies to the best of his or her knowledge, information, and belief that the information contained in this Agreement Addendum is accurate, complete and truthful. The representative is authorized by the Hospice to execute this Agreement Addendum and to legally bind the Hospice to its terms and conditions.

Signature of Acceptance of Terms and Conditions
Model Site Participating in the Medicare Care Choices Model

Hospice Legal Name: _____

Medicare CCN: _____

Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____

Signing for the Centers for Medicare & Medicaid Services:

_____ **Date:** _____

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Appendix C: The Medicare Care Choices Model - Participation Agreement Addendum – Cohort 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Centers for Medicare and Medicaid Innovation
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Medicare Care Choices Model
Participation Agreement Addendum

Parties: The Centers for Medicare & Medicaid Services (CMS) enters into this Medicare Care Choices Model (MCCM or Model) Participation Agreement Addendum (Agreement Addendum) with _____ (the Hospice), _____ (CCN) to set forth terms and conditions for the Model and the parties' respective obligations under the Model.

Objectives: The objective of this Agreement Addendum is to:

- Further outline the reimbursement provided to hospices for services provided in the MCCM demonstration. .
- Specify the phased implementation and performance period
- Outline evaluation requirements.

Participant Agreement Addendum

Medicare Care Choices Model: The hospice agrees to implement the MCCM in accordance with this updated Agreement and all applicable laws and regulations.

Entire Agreement: This Agreement Addendum, including all attachments hereto, constitutes the amended sections of the agreement between parties. Nothing in this Agreement Addendum transfers any right, title, or interest to any party. The original Participation Agreement except for these Amended sections is still enforce.

Reimbursement: The Per Beneficiary per Month amount is the total payment from Medicare to the hospice for all MCCM services provided to beneficiaries covered under the Model. The date the beneficiary signs the Model enrollment form, becomes the starting point for their enrollment into MCCM (the start of care date). If the beneficiary's start of care date provides them with less than 15 calendar days of services, the hospice will be paid $200 for that beneficiary's first month of service. If the start of care date provides 15 or more calendar days of service for the first month of service, the hospice will be reimbursed $400. Each subsequent month, the hospice will be paid the $400 per beneficiary per month up to and including the discharge date even if the date of discharge is the only date of service provided that calendar month.

Phased Implementation: As a Phase 2 participant, your organization will begin to provide services under the Model to eligible beneficiaries on January 1, 2018 thru December 31, 2020.

Evaluation: Hospices selected to be participants in Phase 2 of the Model, will be serving as a control group for the evaluation process. Beginning in early 2016, the CMS evaluator will

contact your organization as these evaluation activities are launched. The evaluator may ask hospices to participate in baseline data collection efforts such as allowing site visits as requested and providing information and data related to agency operations and processes, and beneficiary interventions and communications.

To assist in the evaluation of this Model, your hospice is required to avoid participating in any MCCM-related activities during the first two years of the Model. If your organization is part of a corporate and/or network structure these entities must refrain from offering or implementing model services or providing Model-related interventions. (e.g., technical assistance, patient recruitment efforts, data sharing) to the agencies that are part of Phase 2. The data we collect from your hospice, acting as a control group for the evaluation during the first two years of the Model, will assist CMS with conducting a robust evaluation to determine the potential expansion of this Model.

Authority for Signature: The Hospice representative signing this Agreement Addendum certifies to the best of his or her knowledge, information, and belief that the information contained in this Agreement Addendum is accurate, complete and truthful. The representative is authorized by the Hospice to execute this Agreement Addendum and to legally bind the Hospice to its terms and conditions.

Signature of Acceptance of Terms and Conditions
Model Site Participating in the Medicare Care Choices Model

Hospice Legal Name: _____

Medicare CCN: _____

Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____

Signing for the Centers for Medicare & Medicaid Services:

_____ **Date:** _____

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Appendix D: Medicare Care Choices Model Beneficiary Enrollment Form

(Hospice to Insert Name Used for Model)

Medicare Care Choices Model Beneficiary Enrollment

I, (Patient's Name) (Medicare Number) understand that the (***Hospice to Insert Name and Used for Model***) will offer select hospice services for persons who have at least one of these eligible health conditions: cancer, chronic obstructive pulmonary disease (COPD), congestive heart failure, and/or HIV/AIDs.

What is the Medicare Care Choices Model (MCCM)?

The MCCM will offer select hospice services that are included in the Medicare Hospice Benefit (MHB) while allowing for the continuation of curative care services concurrently. Beneficiaries choosing to enroll in this model will retain the option of electing the Medicare or Medicaid hospice benefit at any time.

What services are provided under the model?

The model services include select services available under the MHB for routine home care and in-home respite levels of care that cannot be separately billed under Medicare Parts A and B; and must be available 24/7, 365 calendar days per year. These services are listed below.

Services available to model beneficiaries referred to MCCM services are available 24 hours a day, 7 days a week to model beneficiaries and may include the following:

- Counseling services to include:
  - Bereavement counseling
  - Spiritual counseling
  - Dietary counseling
- 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
- In-home respite care

While participating in the MCCM, beneficiaries would remain subject to any relevant cost-sharing requirements incurred as a result of curative care treatments.

1. There are no copays or deductibles for the services provided by the MCCM.
2. I may be contacted by Centers for Medicare and Medicaid Services (CMS) or its contractors to provide information for the evaluation of the model. Refusal to participate in the evaluation or respond to requests for information will not affect my Medicare or Medicaid benefits in any way.
3. I may elect the Medicare Hospice Benefit at any time. At that time, I would then no longer be eligible to participate in the MCCM.

4. I can stop participating in the MCCM at any time. If I do so, I cannot re-enroll in the model at a later date.

I wish to participate in and authorize services to be provided by the ***(Hospice to Insert Name and CCN Used for Model)***.

Print Name: **Signature:** **Date:**

Appendix E: Referring Provider Attestation and Certification of Terminal Illness

(Hospice to Insert Name Used for their MCCM Model)

Referring Provider Attestation and Certification of Terminal Illness

Referring Provider Attestation

(Patient Name _____ Medicare ID number _____) is interested in participating in the Medicare Care Choices Model in which some services normally covered under the Medicare and/or Medicaid Hospice Benefit are provided at the same time that the patient continues to receive curative care services. I have discussed with the patient the option of participating in the Medicare Care Choices Model.

I, as the referring provider, attest that the individual named above meets the following MCCM eligibility requirement: *(Please place checkmark for each criteria the patient meets.)*

- ☐ The patient has a terminal diagnoses identified by MCCM eligibility ICD9/10 codes *(Supply the applicable ICD9/10 code)*

Cancer Code	COPD Code	CHF Code	HIV/AIDS Code

Certificate of Terminal Illness

I certify that (Patient Name _____) is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Provider Narrative:

Printed Name of Referring Provider	Signature	Date

Printed Name of MCCM Hospice Director	Signature	Date

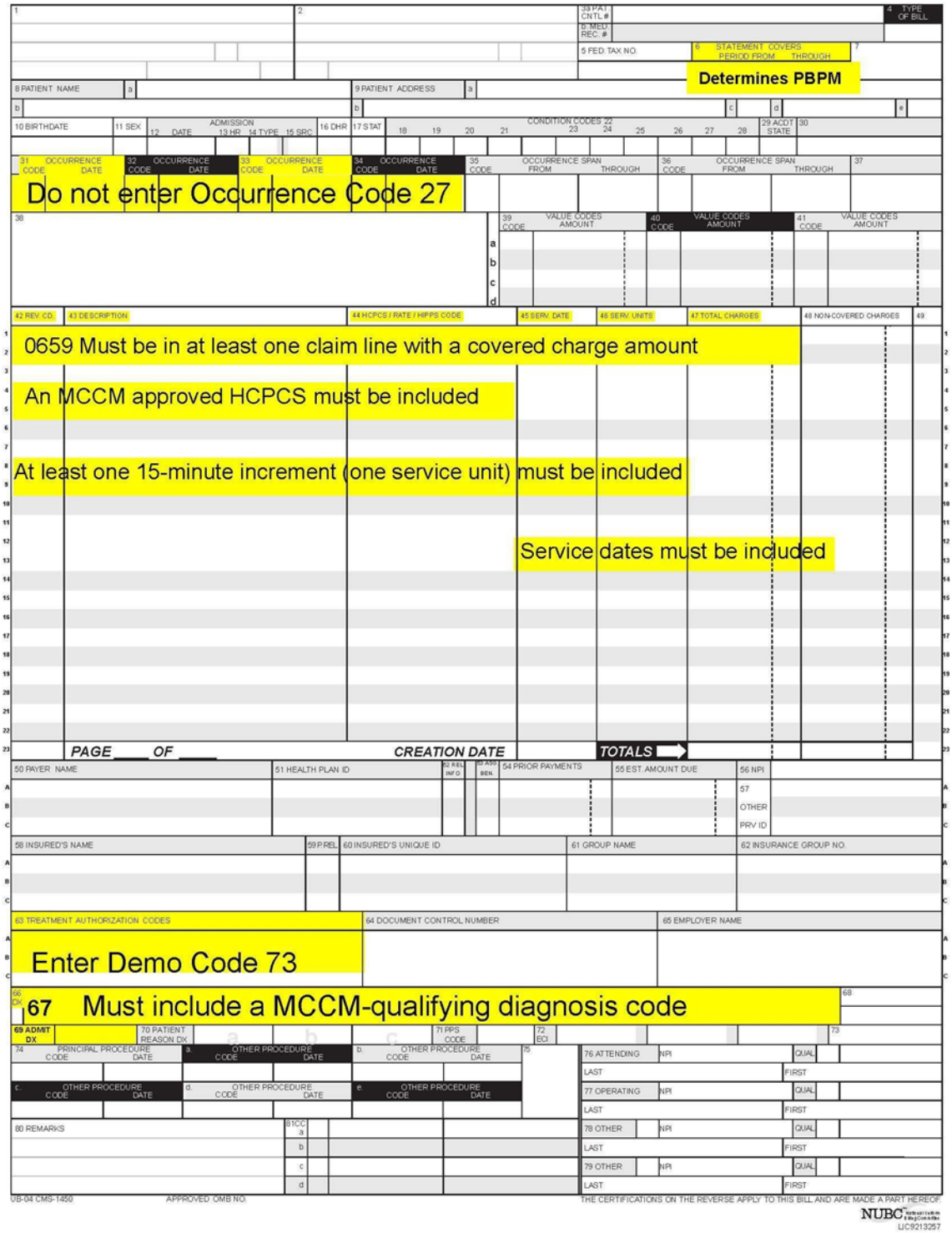
Appendix F: Hospice Progress Report

The MCCM Hospice Progress Reports (HPRs) provide an opportunity for MCCM staff to reflect on current or previous accomplishments, and challenges and identifies future priorities for the next reporting period. HPRs not only inform CMMI of the hospice's progress in implementing the model, but also provide valuable insights to support ongoing implementation, learning opportunities, and decisions for future refinements to the model. The purpose of the HPR is to track changes over time and to facilitate timely support from the MCCM Team.

Hospices are asked to focus on their agencies' experiences over the previous reporting period. Some survey questions may change each reporting period based on what is learned from the previous reporting period and emerging areas of interest.

Hospices are required to submit the HPR via the online survey platform. The MCCM team will review an analysis of the HPR and provide technical assistance as needed, based on the findings of the analysis.

Appendix G: Sample MCCM Claims Form



Note: Do not include any Protected Health Information (PHI) or Personal Identifiable information (PII) in any communications to CMS and Lewin. (https://www.hhs.gov/hipaa)

Appendix H: MCCM-specific HCPCS and Corresponding Revenue Codes (new October 2015)

MCCM-specific HCPCs and Corresponding Revenue Codes (new)					
Code with preliminary assigned G-code number	**Long Descriptor**	**Short Descriptor**	**Fee Schedule**	**Effective Date**	**Revenue code**
G9473	Services performed by Chaplains in the hospice setting, each 15 minutes	Chap services at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9474	Services performed by dietary counselors in the hospice setting, each 15 minutes	Diet counsel at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9475	Services performed by other counselors in the hospice setting, each 15 minutes	Other counselor at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9476	Services performed by volunteers in the hospice setting, each 15 minutes	Volun service at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9477	Services performed by care coordinators in the hospice setting, each 15 minutes	Care coord at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9478	Services performed by other qualified therapist in the hospice setting, each 15 minutes	Other therapist at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9479	Services performed by qualified pharmacist in the hospice setting, each 15 minutes	Pharmacist at hospice	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
G9480	Admission to Medicare Care Choice Model (MCCM)	Admission to MCCM	(MCCM) Medicare Care Choices Model	Jan 1, 2016	0659
MCCM Approved HCPCs and Corresponding Revenue Codes (existing)					
G0155	Medical Social Service	Visit			0561
G0155	Medical Social Service	Phone Call			0569
G0156	Home Health Aide				0571
MCCM Approved HCPCs and Corresponding Revenue Codes (Revised)					
G0299	Skilled Nursing - RN	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting	Replaces G0145	Jan 1, 2016	0551
G0300	Skilled Nursing	Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting	Replaces G0145	Jan 1, 2016	0551

Appendix I: Billing Issues Report (BIR)

Medicare Care Choices Model (MCCM)
Billing Issues Report

The information on this form assists the MCCM Team to understand issues that may delay payment. Please complete this form with all pertinent information, ***after*** reaching out to your designated Medicare Administrative Contractors (MACs). Most issues can be resolved directly with your MAC. Submit ***only*** one billing issue report for each claim to: cmsmccm@Lewin.com.

Do not include any Protected Health Information (PHI) or Personal Identifiable information (PII) in or attached to this report. (https://www.hhs.gov/hipaa)

Hospice Name: _____ Hospice CCN: _____
Hospice Contact:
Name _____ Phone _____
Email _____
Date Report Submitted: _____

Claim Background

					Notes & Action
Type of Bill (Where 'X' is '1' for hospital based and '2' is non hospital)—Select one					Date of first submission of claim: _____
8XA	Notice of Election (NOE)		8X1	Admit thru discharge	Date of resubmission: _____
8XB	Notice of Termination/Revocation (NOTR)		8X4	Discharge claim	Date of resubmission: _____
8XC	Change of hospice		8XD	Cancel NOE/benefit period	Date of resubmission: _____
Dates of service for this claim:					
Enrollment: Month _____ Year _____ **Reference Claim** (the one related to this report): Month _____ Year _____ **Discharge (if applicable):** Month _____ Year _____					
Description of billing issue: (include reason code) RTP_____ Reject_____ Denied_____					

Hospice Actions

Hospice Action:	*Please provide a descriptive narrative of the issue as presented to the MAC.*
MAC Point of Contact: _____ MAC reference Number_____ Date of MAC contact_____ MAC phone #_____ MAC Email_____	

Note: Do not include any Protected Health Information (PHI) in this report or Personally Identifiable Information (PII) in or attached to this report. (https://www.hhs.gov/hipaa)

Revised July 2018

Note: Do not include any Protected Health Information (PHI) or Personal Identifiable information (PII) in any communications to CMS and Lewin. (https://www.hhs.gov/hipaa)

Appendix J: Dictionary of MCCM Terms

IA.1 Abt Associates:

Abt Associates (Abt) is the CMS awarded evaluation contractor, and is evaluating the MCCM independently. Researchers from RAND, L&M Policy Research, General Dynamics Information Technology (GDIT), Brown University, and the Oregon Health & Science University are also involved in the MCCM evaluation.

IA.2 Community Practitioner:

Also known as the 'primary community practitioner', or the 'beneficiary identified primary community practitioner', this individual is the community-based, non-hospice, Medicare-enrolled MD, DO or NP who is leading the MCCM beneficiary's care. This practitioner provides care to the beneficiary in collaboration with the MCCM hospice with the goal of achieving better person-centered outcomes and supporting shared decision-making. This individual can be, but is not necessarily, the same non-hospice physician who signs the Certification of Terminal Illness (CTI). For information on who can sign the CTI, please see FAQ IV.16.

IA.3 The Lewin Group:

The CMS awarded implementation contractor providing MCCM support including MCCM Portal management, technical support, and data collection.

IA.4 Medicare Administrative Contractor (MAC)[13]:

The MAC adjudicates and pays claims on behalf of Medicare. Additionally, MACs working with MCCM hospices review medical records based on model criteria for quality and program management.

IA.5 Primary Diagnosis:

For the purposes of the MCCM, the primary diagnosis is an approved ICD-10 diagnosis code that qualifies the beneficiary for the model and is stated on the CTI as the beneficiary's end stage condition. A current list of approved ICD-10 diagnosis codes is posted on the MCCM Portal.

IA.6 RAND Corporation:

RAND Corporation (RAND) is a sub-contractor to Abt Associates and is coordinating the administration of the MCCM Family Caregiver Experience of Care Survey (CECS), as a supplement to Hospice CAHPS (Consumer Assessment of Healthcare Providers and Systems). The CECS is part of the MCCM evaluation.

IA.7 Secondary Diagnosis(es):

[13] MCCM MACs include CGS Administrators (CGS), National Government Services (NGS) for jurisdictions J6 & JK, and Palmetto.

In MCCM, the secondary diagnosis(es) are comorbidities the MCCM beneficiary has in addition to the primary diagnosis.

Appendix K: Dictionary of MCCM Forms, Reports, and Other Model Resources

IB.1 Billing Issues Report (BIR):

This form is to be completed by hospices experiencing issues with MCCM payment, if not able to be resolved through the Medicare Administrative Contractor (MAC). The information in this completed form helps the MCCM Team to understand issues that may delay payment and to help the hospices in determining a path to resolution. Hospices should complete the revised January 2018 form and send it to the MCCM implementation contractor at CMSMCCM@lewin.com. *Location:* MCCM Portal *(https://www.mccm.cms.gov/home/)* → Resources → Reports and Reference Documents → *Filter Search By "*Billing" → MCCM Billing Issues Report.

IB.2 Hospice Information Form (HIF):

For security reasons, all MCCM hospices are required to review and update their MCCM HIF, which is accessible via the Hospice Information tab on the MCCM Portal. This form includes hospice contact, personnel, roster members, and Portal user information. This form is used to verify that hospice and Portal user contact information is current and accurate. Once per quarter, Lewin will request that hospices review and update this form. The accuracy of the contact information is critical to the security of the Portal and ensures that only authorized users have Portal access.

Location of HIF: MCCM Portal *(https://www.mccm.cms.gov/home/)* → *Hospice Information* → Search & Edit Hospices → Edit (hospice specific)

Location of Instructions: MCCM Portal *(https://www.mccm.cms.gov/home/)* → Resources → Reports and Reference Documents → *Filter Search By "*MCCM Portal" → MCCM Cohorts 1 and 2 Quarterly Contact Updates Instructions.

IB.3 Hospice-level Quarterly Reports (also known as Quarterly Aggregate Report and Quarterly Trend Report):

These are analytic reports derived from Portal and Medicare claims data. They are intended to help MCCM participating hospices identify areas for further focus and compare an individual hospice's activities to the model as a whole. These reports are uploaded to the Portal. Hospice-level Quarterly Reports contain data on MCCM enrollees, key quality measures, and utilization of other services, as well as comparisons to aggregate MCCM data.
Location: MCCM Portal → Resources →Reports and Reference Documents → Hospice-level Data → MCCM Quarterly Trend Report (CCN specific).

IB.4 Hospice Progress Report: On a bi-annual basis (twice a year), hospices are asked to complete the MCCM Hospice Progress Report (HPR) via the online survey. This report asks questions about the hospice's model experience in the previous two quarters. The HPR informs

CMMI of MCCM hospices' progress in implementing the model, and provides valuable insights to support ongoing implementation and learning opportunities. Survey questions may change with each survey and is based on emerging areas of interest.
Location: A link to the HPR online survey will be sent to hospices on a bi-annual basis.

IB.5 MCCM Resource Manual:

The Medicare Care Choices Model (MCCM) Resource Manual provides guidance for key aspects of MCCM beneficiary service and care for MCCM participating hospices. The Resource Manual is a valuable source of information for MCCM participating hospices on implementation and operation of the model.
Location: MCCM Portal *(https://www.mccm.cms.gov/home/)*→ Resources → Reports and Reference Documents →*Filter Search By* "Resource Manual" → MCCM Resource Manual.

IB.6 MHB to MCCM Comparison Table:

MCCM follows hospice Conditions of Participation (CoPs) with some exceptions. The MCCM to MHB Comparison Table provides a side-by-side display of Medicare hospice CoPs and MCCM exceptions to those CoPs. Only CoPs that differ between MHB and MCCM are listed on the MCCM to MHB Comparison Table. MCCM hospices can find additional clarification about how to apply the CoPs in MCCM FAQs and the MCCM Resource Manual, or by contacting their Project Officers.
Location: MCCM Portal *(https://www.mccm.cms.gov/home/)* → Resources → Reports and Reference Documents → *Filter Search By* "Model Overview & Additional Resources" → MHB to MCCM Comparison Table.

IB.7 Portal Data Integrity Check (PDIC) Reports:

These reports are uploaded to the Portal on a monthly basis and notify hospices of incomplete or inaccurate data that require correction, such as missing fields or invalid entries. Corrections must be made by the 7th of the following month. Hospices will receive an email when the monthly PDIC reports have been uploaded to the Portal and is ready for review. Only hospices that have PDICs to correct will be notified.
Location: MCCM Portal *(https://www.mccm.cms.gov/home/)* → Resources → Reports and Reference Documents → Hospice-level Data → Portal Data Integrity Check Report (CCN specific).

IB.8 Portal User Guide:

A comprehensive guide to use of the MCCM Portal, including registering for the Portal, entering beneficiary data, and accessing MCCM forms and resources.
Location: MCCM Portal *(https://www.mccm.cms.gov/home/)* → Resources → Reports and Reference Documents → *Filter Search By* "MCCM Portal" → MCCM Portal User Guide.