

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Jill Darling
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2:00 p.m. ET

Operator: Good afternoon. My name is (Stephanie), and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Introduction to the Medicare Care Choices Model Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you'd like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Thank you. Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you (Stephanie), and welcome everyone. Welcome everyone on the East Coast and West Coast. My name is Jill Darling, in the CMS Office of Communications, and thank you for joining us today. We do apologize for the delay. We were just trying to get other folks to get in on the call.

I will hand off this forum to Cindy Massuda who is the Project Officer for the Medicare Care Choices Model. Cindy?

Cindy Massuda: Thank you very much, Jill. Good afternoon everybody, I am Cindy Massuda, I am the Lead Project Officer for this Medicare Care Choices Model. Thank you for joining us today for this open door forum to discuss this model.

We're very excited to present this model with and talk to you at this open door forum.

We will answer as many questions as time permits. And, if we cannot respond to all of your questions on this Webinar, then we will respond to them as FAQs on our Medicare Care Choices Model Web site. And, please continue to e-mail the Medicare Care Choices mailbox at carechoices – that's all one word – @cms.hhs.gov.

That is carechoices – C A R E C H O I C E S – all one word @cms.hhs.gov.

I want to introduce to you our key Project Officers for the implementation team for this model. Again, I am Cindy Massuda – my as – prior to working for CMS, I used my background as an attorney working in healthcare law. And I (focus) my practice on healthcare law with applying IT, information technology, in my practice.

I came to CMS about fifteen years ago. And I've worked on Hospital Payment Policy, I worked in our area of Information Technology in the Office of Information System and since 2004, I've worked on Hospice and (Palliative) Care Projects in the former Office of Research, Development and Information – known as ORDI or Ordi. And now, the Centers for Medicare and Medicaid Innovation – CMMI.

(Gigi Kabersy) is another Project Officer of – for the Implementation Team. She's a Registered Nurse. Prior to joining CMS, (Gigi) was a Director for Behavioral Health at both Acute Care and Research Facilities including the National Institutes of Health, NIH.

At CMS, (Gigi) worked at the Centers for Clinical Standards in Quality, the CCS Skills, in Survey and Certification. In CMMI, (Gigi) is a Project Officer for the Medicaid Emergency Psychiatric Demonstration. And this Medicare Care Choices model.

(Shannon Landonfield) – our third Implementation Project Officer – Key Project Officer – is a Nurse Case Manager. She has significant experience working for insurance companies. (Shannon) has worked with patients and their families on Hospice, (Palliative) Care and unique issues families address in rural areas.

(Shannon) is also a Professor of Nursing, teaching in Maryland. Additionally, this research model has (~~Lynn Meischer~~~~Miescier~~) – the Lead Project Officer who's with me today for the evaluation of this model. And I will now turn over to (~~Lynn~~) for her introduction.

(~~Lynn Meischer~~~~Miescier~~): Thank you Cindy – my name is (~~Min Meischer~~~~Lynn Miescier.~~) – I'm with the Research and Rapid Cycle Evaluation Group in the Innovation Center at the Centers for Medicare and Medicaid Services.

And as Cindy said, I'm the Project Officer for the evaluation of the Medicare Care Choices Model. My background is in health services research with a specialty in Hospice and (~~Palliative~~) Care services and Long Term Care.

Cindy Massuda: Thank you very much, (~~Lyn~~~~Lynn~~). We're excited about working with the hospice community on this model. This model is the first time (See) For Service Medicare is testing the concept of concurrent care between hospice and curative care providers.

The model is part of the Center for Medicare and Medicaid Innovation Centers portfolio of research projects that includes grants, models and demonstration. CMMI conducts these research models under the authority that requires models including the Medicare Care Choices Model to improve quality, improve care and reduce costs to Medicare and Medicaid.

As part of research, CMMI test new concepts. The Medicare Care Choices Model tests the ability to provide (palliative) care and hospice support services concurrently with curative care.

This is a new opportunity for hospices.

This design was determined to be the design that allows for hospices to provide services concurrently with curative care and meets CMMI's authority for testing a new model under Medicare and Medicaid.

I now want to talk about why we did not design a model that allows for the full Medicare Hospice Benefit concurrently with curative care.

We carefully considered designing that model to provide the full Medicare Hospice Benefit concurrently with curative care. While this model may be the easiest model for hospices to consider, a review of the Medicare Claims Data with the current billing practices shows that such a model could not result in savings to Medicare at this time. And, thereby does not meet CMMI's authority to test such a model at this time.

The concurrent care design being tested allows the hospice industry to consider a new business model that enables them to work with hospice, eligible beneficiaries and their families before they've considered or (left at) the Medicare hospice benefits.

I now want to discuss the hospice provider in this model.

In this Medicare Care Choices Model, hospices are being viewed in new ways. First, hospices are not at the end of the care trajectory but are integrated with curative providers. This is an important distinction – so let me repeat it.

In this model, the hospices are (is) – be working and integrated with the curative providers. In the Medicare Care Choices Model, we want the hospices to think of themselves (interfering) – (interrelate) – with the curative care and their providers.

This means that hospices are not the only provider for the beneficiary. This is a major distinction from hospices under the Medicare Hospice Benefit, where

they are the provider for care related determined diagnosis and related condition.

In this model, the curative providers are the primary provider. The hospice eligible beneficiaries are still seeking care from their curative providers. The hospices therefore, providing services meant to support these patients and their families at this difficult time in their life.

The patient views (their) curative provider as their primary care provider not the hospice provider. The hospice in this model, provides support services and information to complement the needs of the hospice eligible beneficiary and their family.

These services include the social worker who assists the patient and family, facing life-limiting illnesses. Spiritual support, case management and nursing services – these services made available in the Medicare Care Choices Model are meant to wrap around the services the beneficiary sees from the curative provider.

I now want to turn to the beneficiary – I now want to talk about the hospice case manager.

The hospice case manager is working both within the hospice and across the curative providers responsible for the patient care. This includes care coordination and case management input from the curative providers as part of the interdisciplinary group team meeting and plan of care.

It also includes conversations with the patient and family regarding their patient (center goals) – and up to date and keep it – and maintain (meditation) (center goals) up to date and revised as needed.

As part of this model, the hospice nurse care coordinator would provide case management to the patient and the family to discuss their options available based on their patient's (center goals).

If the patient become – when – if the patient becomes homebound and needs home help – the model does not exclude it – but the request for application makes clear that the services provided by the hospices should not be redundant. And we will be tracking the project for such issues.

And we are also working on an FAQ, since that is an issue that keeps – that people have addressed in our mailbox. And we are – to addressing that, through an FAQ that we will be posting within the next few days.

I now want to turn to a hospice eligible beneficiary in the model. The beneficiary in the Medicare Care Choices Model is a patient diagnosed with cancer, congestive-obstructive pulmonary disease – COPD, congestive heart failure – CHF, and or HIV AID who meets the definition of hospice-eligible under the Medicare Hospice Benefit.

These patients though have not elected the Medicare Hospice Benefit. These are patients that continue to see care from the curative provider. There may be a patient where test results show that curative care is no longer changing their prognosis and they meet Medicare Hospice Eligibility.

The beneficiary determines his or her care and the beneficiary still seeks care from the curative provider. However, these patients face many issues as they face time-limited life for themselves and with their families.

While these patients are still going about their life, driving to appointments, visiting friends – even working – they seek information and services that currently are not available in (See) For Service Medicare for Hospice Eligible (Location).

This is where the Medicare Care Choices Model participating hospices provide their skills as the (See) For Service Medicare provider that views these beneficiaries holistically and comprehensively.

The hospice staff that includes the social worker, nurse care coordinator, nurses, spiritual counselors, nurses' (A), doctors and volunteers – and their

related services. Along with a focus on patient-center goals are the services that research shows patients with life-limiting illnesses benefit from.

I now am going to talk a little about the research for this model.

The (footnote) – research such as – the research done by (Randy Craftshauer) for the – that was called Opportunities to Improve the Quality of Life for Advanced Illness. Which was in Health Affairs in 2009 is some of the research that shows that when patients receive case management 24/7, 365 days for your (access) to staff and patient-centered goals – are documented results.

And those patient-centered goals are documented – results in patients and their families making more informed decisions that can lead to choosing the right care at the right time.

For these hospice-eligible patients, the right care at the right time may be less aggressive care or (palliative) only care. Other research shows that when pain and symptoms are well managed, hospice eligible patients are more likely to find this care to be the right care at the right time.

I am now going to discuss the \$400 payment to the Medicare Care Choices Model participating hospices. The model pays \$400 to the hospices for the services they provide in this model. This model departs greatly from the Medicare Hospice Benefit for services provided by the hospice. While the hospice must continue to meet the conditions to participation, the (COP), the hospice in this model is no covering the cost of any services or supplies that can be billed under Medicare Parts A, B and D.

In fact, in this model, CMS insists that these services and supplies be billed and done under the appropriate part of Medicare Parts A, B and D.

Further, the services the hospice provides in this model are to be provided in the method reasonable for the Medicare beneficiaries needs and goals. This

means, if the services can be provided telephonically, then they can be provided in that manner.

From experience with hospice eligible patients, and CMS's ongoing (palliative) care demonstrations, shows that these patients and families do not necessarily need face-to-face services multiple times per week or want them.

These experiences, along with payments made in these demonstrations – CMMI's grants and in some managed care companies providing program for terminal patients – analyze against the cost to providing skilled nursing services under the Medicare hospice benefit. Where services are typically provided more frequently and the care needs are greater.

With the clear understanding that CMS pays significantly less than \$400 per member, per month – where the services in the (palliative) care models and in the – (pushed) them in the grants that we're doing in the (med) – in the innovation center.

The Medicare Care Choices Model hospices in the – in our model – are not the primary provider. They're not providing all of the services – all of the services supplies and care. They're not responsible for the payment – the financials payment for the services (we applied).

So, we determined to set this model – as more (analogous) to our (palliative) care model – that pays significantly less than \$400 per beneficiary per month. The Medicare Care Choices Model increased the per beneficiary per month's fee to \$400 because the hospices must meet the hospice COP.

I'm now going to provide a summary of the model design that is also in the request for application that is on page five of the RFA.

The following summarizes the model and this is to help give a perspective since that's something that people have asked for on our last Webinar – and it's in our Request For Application.

The following summarizes the model – once a hospice-eligible patient now meets the model criteria stated in this Request for Application – signs and agrees to participate in the model. Then the hospice will conduct a comprehensive assessment that follows the hospice COP.

The hospice must also complete the initial discussion and related documents to achieve patient-centered goals within three days of enrolling a beneficiary into the model as further explained in the patient-centered goals process section of this RFA.

The patient-centered goal plan must be reviewed, revised and (dock-attended) – upon re-assessment of functional need at least every thirty days or when the individual circumstances or needs change significantly or at the request of the individual.

The plan of care, which (revokes) from the interdisciplinary group meeting – and must also follow the hospice COP – determines the services that hospices must provide and must be reviewed – (legalized) and documented – at least every fifteen calendar date – as required by the hospice COP.

The hospice services or all the services available as explained in the Table 2 and are in the Medicare Benefit for Routine Homecare and In-Patient (Rested) Levels of Care. They cannot be separately billed under Medicare Parts A, B and D – and are to be available 24/7, 365 calendar days per year.

These services are broken out in Table 1 of our Request for Application. The patient in this model still seeks curative care service and that provider is the patient's primary care provider – not the hospice as occurs under the Medicare Hospice Benefit.

Based on the fact that the hospice is not the primary provider responsible for patient's care on this model – and the breakdown of services between the hospice services and the services that other providers can bill for separately under Medicare Parts A, B and D. The hospice will be focused more on managing the care.

The hallmark of the design is coordination and case management of the hospice-eligible patient to meet the patient's goals. These patients are still going about their lives and seeking a cure from the medical community.

Their need for face-to-face is expected to be limited as long as they're still getting services from their physicians – the oncologist, cardiologist, pulmonologist and infectious disease specialist.

Instead these patients and their families are more likely to be information – so that the patient could determine what care they want, that fits their patient-centered goals.

These source of services can be provided telephonically from its – telephonically.

From experience with other demonstrations, phone calls with someone they have a trust relationship with – are the preferred way patients and families want to receive these sorts of communication.

The patients and family are further supported by having 24/7 access to the hospice professionals – that further builds a rapport along with access to care 24/7, 365 days per year.

As curative care fails to change the prognosis, and the model patient's condition worsen, we assume the patient will likely be not be in a position to tolerate as much curative care or begin to need (mortality services) to maintain their comfort.

The patient's plan of care will reflect this change in (health desk) – and require more home visits by nurses – the continuous home care (engine) – generally in-patient levels of care – they are only available under the Medicare Hospice Benefit.

By this time, the patient's more likely to appreciate the benefits of what the hospice can offer, be less resistant to the idea of hospice and be more prepared to discontinue curative care.

The relationship (built) between the patient and the hospice will aid in these discussions, they reflect the patient's goals. (Reflect) – we expect this transition to occur in the model before the patient reaches at or near the point of actively dying. Which is when so many of them now turn to hospice.

If the patient's primary care provider and hospice want to incorporate technology into this model – then that is an option. The use of technology like smart phones redesigned for capturing health data would be part of patient and family education and biofeedback to the patients and family as a mean of maintaining the patient as stable as possible for as long as possible.

These services re-integrated with our primary care provider in coordination with the hospice through the hospice nurse care coordinator. The model tracks the patient using a monthly service and activity log. And capture each beneficiary's Medicare claims data.

The data captured about each hospice that includes this business model – the model beneficiaries demographic, the model beneficiaries primary diagnosis and (term) morbidity and geographic information – will enable the evaluation team to study and analyze the hospice in multiple ways that include by business model – that include – the pay – (fit differently).

The patient care will be tracked to include the disease category, information from the service and activity log that includes the services provided, the staff categories along with services, the number of visits and length of each visit. And, Medicare claims data for all services provided once in this model.

Further, the service activity log is being designed to allow direct comparisons with the data required by hospices under the Medicare hospice benefit.

This will enable the evaluation to track and analyze care and services before and after any Medicare hospice selection. Over time, the data should provide patterns that inform CMS and could impact policy.

Random audits of the patient's medical records to compare the plan of care to the service and activity log will provide CMS with the assurance that needs that services provided recently matched the plan of care and (meet educate) the patient-center goals.

Hospices must submit quarterly quality data as further described in the request for application and participating (calls) with CMS project officers.

Technical assistance will be provided to assist hospices with implementing the models. CMS will conduct an evaluation of this model and further explain – as solutions – further explain in the RFA and later on this call with (Lyn Meischer).

We will now look at the application criteria.

Because the model was set up for the hospices to be applying using the application criteria that is also in the Request for Application. And I am not going to go through in detail that's in Table 2. But, I want to make clear and make sure that those four – looking at the Request for Application – are aware of the selection criteria and weight.

That begins on page 16 of the RFA – and is broken into four – (tri-sec) – four criteria which is – and all of them had equal weight of 25 points for a total of a 100 points.

Because this model is a competitive model where the applicant are all applying and we will be selecting based on how you score in your application that you submit to us by the June 19th 2014 deadline.

The criteria are the model design, which has 25 points. Organizational structure and capability – that also has 25 points. Implementation plan of the

model design – and model impact. And, all of those are detailed in Table 2 of the request for application – which I’m not going to go into on this call.

But I want to make people aware of – that the request for application details the criteria that you need to apply – that you need to address in your 40-page application.

And that 40-page application limit – is – for is a – to be priced in times new roman font – using a font size of 12 – of Microsoft – print using Microsoft Word – and may not exceed 40 double-spaced pages including visual (age), actual – the identified example – and diagrams – can be included to provide a comprehensive picture of existing programs and potential model design.

The 40-page limit is exclusive of the one-page cover letter, up to two pages for the executive summary, resumes, and the letters of support from all referring providers or suppliers that includes how the providers furnished care coordination and – or case management with the applicant.

And that is all detailed in our request for application.

Our Medicare Care Choices Team is a team and we work collaboratively and the number one entity on this team are the hospices, the Medicare Care Choices Model hospices. And, we can’t emphasize how much we enjoy looking forward to working with you in this model.

The other team member on this is our contactors. And our contractors, we have contractors for implementation as I’ve talked about it a little bit. And contractors for our evaluation. And they provide technical support to our hospices – to the participating hospices to aid them in the successful implementation of this model.

And this will – the goal is to assist the hospices with technical support, with site visits, phone calls, e-mails, and the goal there is to be successful – so that the hospice sites could be as successful as possible in implementing this model.

The third entity to this team is CMS and that's myself and our team for implementation as why I described at the beginning and our team members include myself, (Gigi Kaberski) and (Shannon Landerfeld). And the other key project officer is for the evaluation, and that is [Lynn Miescier](#)~~(Lyn Meirseher)~~ who I will turn this call over to now to discuss the evaluation.

~~(Lyn Meirseher)~~[Lynn Miescier](#): Thank you Cindy, my name is ~~(Lyn Meirseher)~~[Lynn Miescier](#) and I'm going to speak today about the independent evaluation of the Care Choices Model. The evaluation will examine the effect of the ~~M~~model on access to supportive services provided by hospice and quality of life for patients and their families.

Evaluation results will also help to inform new health care delivery and payments systems for Medicare and Medicaid. Participating hospices will be required to provide information on patient outcome as well as the cost of furnishing care to beneficiaries in the model.

This information will be compared to outcomes and costs for beneficiaries receiving similar services at other ~~models~~ participating hospices and at comparable hospices not participating in the model.

The evaluation will include a quantitative analysis using quality performance and monitoring measures in order to answer specific research questions. The evaluation will also include a qualitative study in order to capture and compare differences across models and to assess patient, family and provider perceptions, barriers to change and practice culture.

We look forward to your participation.

Cindy Massuda: Thank you, [Lynn](#)~~(Lyn)~~ and also now want to – before we open the call up to your questions – to make sure you're aware of important information.

The model is posted on the Medicare Care Choices Model Web site which is <http://innovation.cms.gov/initiative/medicare-care-choices/>. There's also a hotlink from the open door forum today to our Web site.

That Web site includes our FAQs, our request for application and any update to this – to materials we are providing for this model which, in essence, we are posting everything about this model on that Web site.

You can sign up for e-mails to get updates about the Medicare Care Choices Model at that Web site. Oh, but the bottom line is – it is your job to monitor the Web site for the latest about the Medicare Care Choices Model.

Applications are due June 19th 2014 and we highly encourage hospices of all geographic locations, sizes to apply and we highly encourage that. Because we need the model to be reflective of the industry as a whole. So, hospices from small to large should – are highly encouraged to be applying and we look forward to working with you in this model.

Jill Darling: Thanks Cindy, (Stephanie) we'll go into our Q&A session now please.

Operator: Certainly. As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Your first question comes from the line of Kim Waldman with (A Grace Hospice Care), your line is open.

Kim Waldman: Hi, yes. We were curious, what were the risks that CMS intends the competing hospices to be here in this model? For example, if the costs turn out to be say – \$200 a month or \$800 a month – who funds the excess? Or what would happen to the additional funding?

Cindy Massuda: Thank you – in this model, we're paying the \$400 per beneficiary per month and we do – it's a bundle payment and we expect that there will be times that

services will be minimal and we'll expect that there's times where there'll be more services needed.

But it's – the hospice is responsible for the services they provide and our payments are at \$400 per beneficiary per month.

Kim Waldman: OK, so it'll – in a sense – even out? Essentially?

Cindy Massuda: Well, it's – that's what the – as you look at your model that's what – I mean, that you have to determine...

Kim Waldman: OK.

Cindy Massuda: How.

Kim Waldman: OK, thank you.

Cindy Massuda: Sure.

Operator: Your next question comes from the line of Anthony Bolden with (CCH), your line is open.

Anthony Bolden: Yes, I just have a question regarding the – what page was it on – regarding the – collection of data. Yes, you were discussing the collection of data – that's something Medicare's doing. Is that correct? The applicant's not supposed to do that – you are?

Cindy Massuda: When you say collection of data, I mean we are going to be using our Medicare claims data...

Anthony Bolden: Yes.

Cindy Massuda: We are going to be – yes. So, that's on...

Anthony Bolden: OK, because that's on – OK – I just – I wasn't sure because it looked like there were – I just didn't know whose responsibility that was. And then, another question I have – do we – because this is just for fee for service Medicare patients you know.

In hospice, all of our patients are essentially fee per service. And, it seems like the majority of them at some point or another – had a managed Medicare. So, I guess my question is – do we anticipate that there – is there a large population of patients who have traditional fee for service Medicare?

Cindy Massuda: Yes, and actually, we talk about that in our request for application. The beneficiary criteria?

Anthony Bolden: Yes.

Cindy Massuda: The beneficiary is enrolled in Medicare Parts A and B and is enrolled in a stand-alone Part D plan – that is a prescription drug plan and...

Anthony Bolden: Right.

Cindy Massuda: Is not enrolled in a Medicare Managed Care Organization including but not limited to Medicare Advantage Plan, Healthcare Pre-payment Plan or a program of all-inclusive care for the elderly, the (PACE) plan. And, I can go on – has not participated in a Medicare Managed Care Plan for at least the last two open-enrollment years. And, has a diagnosis as indicated by certain (ICD) 9 or 10 codes for terminal cancer, chronic-obstructive pulmonary disease, human immunodeficiency virus or congestive heart failure as listed in Appendix I or our RFA.

And, has had at least two hospitalizations in the last 12 months which were related to his or her Medicare territory disqualifying diagnosis and has had at least three hospices with his or her Medicare enrolled healthcare provider within the last 12 months which were related to his or her Medicare care choices not a qualifying diagnosis.

And a (pains) designed (invaded) certificate – certification of terminal illness from the Medicare enrolled healthcare provider described above and the hospice medical director. And, need to process eligibility and admission criteria as stated at 42 CFR Section 418.20.

Eligibility requirements and 418.25 – admission to hospice care. And, has not elected the Medicare Hospice Benefit or the Medicaid hospice benefit within the last thirty days prior to their participation in the Medicare Care Choices Model.

And, lives in a traditional home that is not a nursing home, assisted living facility, hospice in-patient facility or other institutional setting at the start of his or her participation – in the Medicare Care Choices Model.

And, agrees to participate to actually participate in patient-centered goals planning process as discussed in the patient-centered goals section. A copy of which will be provided to the (prospective) beneficiary by the hospice. And reviewed and discussed as the options of model participation with his or her Medicare enrolled healthcare provider.

And signs and dates the Medicare Care Choices Model beneficiary enrolment and referral provider attestation form for this model. Indicating that he or she wants to participate in the Medicare Care Choices Model. And that could be found on our Web site in the request for application.

Anthony Bolden: Thank you.

Operator: Your next question comes from the line of (Sharon Meister), with (MHCAH), your line is open.

(Sharon Meister): Thank you, I have two questions – I just want to clarify, with the \$400 reimbursement a month, does that include medications, equipment, the home visits?

Cindy Massuda: OK, let's separate this. The medication – things that can be billed under Medicare Parts A, B or D – like their medication and your supplies – are expected to be billed that way.

(Sharon Meister): OK.

Cindy Massuda: Nursing services are expect – are part of the model...

(Sharon Meister): Correct, correct.

Cindy Massuda: That are part of the \$400 per beneficiary per month. And, if you want I can go into detail but it's in Table I, laid out in the Request for Application.

(Sharon Meister): OK, that's fine. Because that – that kind of hits on my other question was – if you had a patient that meets this criteria – and a lot of times when they come home from the hospital and they just aren't ready for the curative care – or to give up curative care – they go into home care and not hospice.

Now, if they were in home care, then, could this model also apply to them?

Cindy Massuda: I'm – I was – we have spoken about it in the Request For Application...

(Sharon Meister): Oh.

Cindy Massuda: That this (request) – this model does not preclude home healthcare. And I think you're looking at this field, nursing services specifically. But, we are also – and we caution in our Request for Application – that there's a good chance for redundancy.

And if we – or do not expect to see redundant services between what is provided in home health and in our model. And so, we go through in our Request for Application – a discussion about the need to be able to document the distinction. And what's – as what services the hospice is providing (essence) – if there is home health services also being provided. And, we will be tracking that.

And we – in addition to that – because this is an issue that has come up more than multiple times – we are preparing an FAQ that will be posted on our Web site in the next few days. To clarify so that this issue should be clear to interested parties for this model.

(Sharon Meister): OK, that makes sense. Because I don't understand if they do not meet the hospice criteria regarding that they – they are want – they're still speaking curative care, and you say that the equipment and medications can be billed to Part A. But, unless they're under homecare, you can't bill that you know with the pharmacy you, probably, so I think they could buy their own.

But – I'm – I guess I – if they're not in homecare, I don't know how you can bill it under Part A. Some of the other equipment and services.

Does that make sense? Or...

Cindy Massuda: I hear you.

(Sharon Meister): OK. I mean, there's no place to bill it. They would have – it would have to be the \$400 that we would get because there's no other place to bill Part A to – unless it's homecare. So, I'm just – that's the only thing I can't get clear in my head.

Cindy Massuda: Yes, OK. But, I mean – we don't – the subject matter experts specific for (DME) are not in the room – but, our understanding is – is that – (DME) can be separately billed. And if you need to – I can – you can send an e-mail to our mailbox and we will address that with you.

(Sharon Meister): Yes, OK. Thank you very much.

Cindy Massuda: Sure.

Operator: Your next question comes from the line of (Debbie Delilah) with (Hospice FTR), your line is open.

(Debbie Delilah): Yes, thank you so much. In your original proposal it said – in-home residence. But I think you said, you're in this presentation that was in a facility or in patient resident – is that right? Because we don't have in-home resident in hospices.

Cindy Massuda: OK, let me just see it clear. That in the Medicare hospice benefit – resident services can be provided if it's, if it fits the patient's need. And you know if safety – you know safety and everything else is in you know makes – meets that is criteria – can be provided in the patients at home.

And, so we – and some model – recognizing that these patients are still going about their life, still going about you know going to their office visit. Perhaps even still working, still going about their daily life – they're not as sick as you see them at the – when they've – in the hospices if – they've elected the Medicare Hospice Benefit.

These patients if they may be able to – if they seek respite – be able to be provided for it in the home. And we were just trying to channel that when we used the word in-home resident. We were trying to let it be clear that if these patients can be cared for in their home.

And you know you may be able to work it through with volunteers, neighbors – I mean, these are people who may not need the level of services you think about when you do in-patient resident in the Medicare Hospice Benefit.

That we wanted to channel that message. And that's what we meant when we used the word in-home resident – but, it is the in-patient resident service.

(Debbie Delilah): OK...

Cindy Massuda: Because of the care (fee)...

(Debbie Delilah): But – but about the part of the question would be – if that covered – to be covered in the \$400 – because I can see how that can get right costly. So, maybe...

Cindy Massuda: It's part of the \$400, yes.

(Debbie Delilah): Yes, OK, thank you.

Operator: Your next question comes from the line of (Christian Heart) with (BK Pierce and Associates), your line is open.

(Christian Heart): I'm – yes – hi, I was wondering, what special places service codes and modifiers – will Part B providers have to use for those curative services they are providing?

Cindy Massuda: Can you elaborate on what you mean by that?

(Christian Heart): So, a patient is in hospice and they are also seeing, let's say, an oncologist...

Cindy Massuda: OK, let's (see)...

(Christian Heart): That oncologist. Go ahead.

Cindy Massuda: I just want to be clear, these patients have not elected the Medicare Hospice Benefit – so, they're not in-hospice. They're getting services – wrap-around services provided by a (medic) – by hospice providers. But they are not – have elected the Medicare Hospice Benefits.

So, they are...

(Christian Heart): Oh, OK.

Cindy Massuda: So, they are still cure – these are patients who are still seeking curative services, they're still with their curative providers – nothing changes. And they are so – and so the services that are in this model are in addition to it. It's

like a wrap-around service to help support these patients who are hospice-eligible but has not elected the Medicare Hospice Benefit.

(Christian Heart): Thank you.

Cindy Massuda: So, does that help you with the coding issues that you're (braving)?

(Christian Heart): Yes, because that tells me that there are no special modifiers that they have to use.

Cindy Massuda: Correct.

(Christian Heart): I got it.

Cindy Massuda: Correct.

(Christian Heart): Yes.

Operator: Your next question comes from the line of (Janine Dennis) with (Visiting Nurse Service), your line is open.

(Janine Dennis): Thank you, I actually have two questions. The first – I would just like clarification on to what extent the inter – the model intervention needs to align with the hospice conditions of participation. I heard – I thought I heard that they are – you don't have to follow them. And then I heard that we did. So, that's my first question.

And, secondly, my assumption is that if someone enrolls in the model program – care coordination – they will understand that their wrap-around care coordination, added value services – are being delivered by a hospice program or not.

I mean, I think that's just something that I – just kind of – thinking about the consumers' perception of I don't want hospice even though I'm eligible, I

don't think I'm really that kind – you know – my condition is that advanced.
And I will take these services from a hospice program

It's just – there's a little bit of a oxymoron there for me anyway.

Cindy Massuda: And I really appreciate your questions.

If I can start with your second questions first – since you're talking about the oxymoron and that these are patients who really aren't interested in hospice, don't think of themselves as dying. And, so – how do they get their services from a hospice provider?

That's something that – what is – part of the reason – that's some of the reason why in our Request for Application, we purposely have named the model the Medicare Care Choices Model.

And on the first – in Table II – when you look at the application criteria and checklist under the models' design criteria – the provisions of services. The first bullet in there it said – the name of the model for the applicant service area, if you can give us a description of a name – of whatever you want to name the model that fits your service area.

And then, we go on to say – as the name of the model may influence a patient's willingness to participate in a model offering curative along with (hospice) services – CMS is open to applicants using a name other than Medicare Care Choices Model or Care Choices that the applicant determines to be appropriate for their service area.

If the applicant chooses to use a name other than the model name specified above – the applicant must provide that name along with the rationale for this alternative name. And so, we are open to using a name that fits your service area. Because we agree and – that was also one of the reasons we didn't think it was so palatable to provide the full Medicare Hospice Benefit for patients who weren't in one – who didn't want to be in hospice to start with.

So, we appreciate that.

(Janine Dennis): I – thank you and I did read that. But, just when I think about this operationally, the 24/7 access for people in care coordination – because of the \$400 per member per month – the at 24/7 access in my mind will have to come through the hospice program. So, when the phone rings at 2 am, the person that’s answering that phone is going to say you have reached – at least in my situation – (CNSMY) Hospice Care.

In order to have a different phone line and to put that kind of infrastructure in would just – would be prohibitive from a cost perspective.

So, that’s a – and if someone goes out and to see one of these patients at home and just going to be visits as well as telephonic. We were uniformed, we have ID cards, we have everything and it says – (CNSMY) Hospice Care.

So, it’s just that piece of it – to draw some kind of a distinct line – so, these folks are getting services that they are – that they believe that will benefit them. But, it somehow comes across to them as something not being delivered by hospice.

And that’s going to be difficult, I think for providers to work through it the limited reimbursement.

Cindy Massuda: Yes, I mean that’s up to the model. I mean, as soon as some point – I do think benefit then – I mean, people are not. You know people are smart people – some people have common sense. I think that it – people will understand that this is a program that a hospice provides and it’s being called you know that something supports services – if they don’t want to call it for the Care Choices model. Or, however they want to name it. And we’re – that’s totally fine.

But, I think – you know – the same way there’s hospices that we’re aware of that literally holds tailgate parties on their parking lot every Sunday. And I’m well aware that in Gainesville, Florida – and the community comes out and as

they are supporting – and it’s got nothing really to do with hospice although a lot of their former families come by along with others in the community.

I mean, that’s just – a function – people are well aware that they’re at a hospice. People are well aware that they are – you know – that they’re not necessarily getting hospice services at that moment. They are just participating in a community gathering that happens to be on the hospice premises.

So, it’s up to the model. Your other question – I want to make sure we – I answer it. You wanted to know if the pay – half this is need to be following the hospice pre-conditions of participation? And the answer is yes – as long as we are working with hospices, we are required to follow the condition to participation. And that is why, we purposely are paying significantly. And I mean tremendously more in this model for the – per beneficiary per month, than we do for our (palliative) care models that are also have – has these eligible patients in it.

Thank you very much...

(Male): So, search.

Cindy Massuda: For your question.

(Janine Dennis): Thank you. Thank you.

Operator: Your next question comes from the line of (Peggy Patrie) with (CAMC), your line is open.

(Peggy Patrie): Yes, I have a couple of questions. I work for a hospital and we handle and bill for the hospital list, who will be caring for these patients when they come in through the hospital.

And as my understanding that we will not be using modifiers on these particular patients that's going through this model. When we bill a (nine-nine), (two-three-two's) or whatever?

Cindy Massuda: And these – these are for the services that the hospital is going to be providing for these patients separate from services in the (mod-care) choices models. And, that is correct. We – there are – these patients are still under curative care. They have not – they have the full Medicare Parts A, B and D available to them – they have not elected the Medicare Hospice Benefits.

(Peggy Patrie): OK. Now, I'm relatively new to the hospice area. So, I have a question – can you answer any questions regarding the (palliative) (hospice)?

Cindy Massuda: You can ask the question if I'm unable to answer it – I will ask you to send it to our mailbox and we will make sure we get you an appropriate response.

(Peggy Patrie): OK, when a patient comes in and they happen to be in the (palliative) hospice, do we as a provider, even if we are not the elected provider – we're just a hospital caring for a patient – do we send that bill to the hospice or do we mail it to Medicare?

Cindy Massuda: Can you explain what (palliative) hospices – so that I can help you?

(Peggy Patrie): These are patients who are enrolled into the regular hospice not your model but the regular hospice care. And they come in, the hospice person actually comes in, does the evaluation, (funds) them up and from that point forward they are a hospice patient.

Who do we – do we bill Part B for the patient – the physician's portion or do we send the bill to the hospice and they pay us out of the – like a \$140 a day they receive? Can anyone answer this question?

Cindy Massuda: OK, I think here – the question you're asking refers to Medicare Hospice Beneficiary.

(Peggy Patrie): Yes, correct.

Cindy Massuda: And for that – that is unrelated to our model. But, if you would like to ask – you send that question to me, I will send it to the appropriate people within the agency to assist you. But, that is unrelated to this model. And I'm doing that as a – because I care about the people working – the providers in our Medicare program.

So, you can send it to me – cindy.massuda – M A S S U D A – @cms.hhs.gov and I will get that question for you.

(Peggy Patrie): OK. OK thank you very much.

Cindy Massuda: Sure.

Operator: Your next question comes from the line of (Jackie Everett), with (Wellmont Hospice), your line is open.

(Jackie Everett): Thank you. I have a couple of questions like everyone else. We're dual licensed in two States because our program actually sits on the State line. So, if we wanted to provide an application, would we have to send an application for both provider numbers. And then, what's the potential that one would be chosen and not the other?

Cindy Massuda: OK. The model is being done by provider numbers – what is the size of your hospices? Are your average daily census?

(Jackie Everett): Ninety.

Cindy Massuda: Ninety in the facility?

(Jackie Everett): Our – we only – we have an eight-bed, free-standing facility. So, our home program that combined total is 90 to 100 of the two programs together.

Cindy Massuda: Oh, between the two? OK. The reason I'm asking is because there are hospices, the smaller hospices, and these are hospices that are around 50 – 50 average daily census. So, it sounds like you may fall in that category.

But, if they – want to – that we're looking at as putting out as FAQ for our smaller hospices that may want to work together for this model. That our (use) are already are working together and so – so but are independent in every other way.

So, if you could – we're going to be addressing that issue but as a general statement – we are – the hospices are providing the service. Are applying by their provider numbers.

(Jackie Everett): OK. Then, two other questions, one is the requirement for two admissions within the last twelve months, two hospitalizations – does that apply to like the 23 hour observation bed? Or does it have to be a full acute care admission?

Cindy Massuda: We're looking at the acute care admissions.

(Jackie Everett): All right, and then, my last question has to do with the diagnoses of these – this patient that you're wanting to set the model up for. If these patients are like the congestive heart failure or pulmonary diagnosis and they're involved in a rehab program – does that eliminate them from being able to be involved in this model?

Cindy Massuda: Can you just if – can you describe the rehab program a little please?

(Jackie Everett): Well, we have a can – our system has a congestive heart failure program where they have regular support from the pulmonologist and – or the cardiologist and calls from a nurse that helped them with medication adjustments and symptom management. And diet and you know encouraged them to exercise, those type of things.

That's considered a duplication of services.

Cindy Massuda: I think that the kind – your question – I was – if you could send that question to our Care Choices mailbox, so I think this may be one that we need to look at a little more closely – just looking at your particular situation.

(Jackie Everett): All right, thank you.

Cindy Massuda: So, I appreciate it.

Operator: Your next question comes from the line of (Janine Peak), with (Homestead Hospice), your line is open.

(Janine Peak) with (Homestead Hospice), your line is open.

(Janine Peak): I'm sorry I was on mute. I wondered if you could classify please regarding discharge and revocation? Because if we are being held to the standards as though – of a couple of callers ago asked – of the COPs for hospice. We are going to be looking at these patients at (IDP), we're going to be looking at interventions to take care of the problems that are identified.

And, as they become more and more hospice intensive, what can we do to help them choose the right program? What are our parameters? Because we can't discharge them but they can revoke. But can we educate them well enough so that they have an educated decision to revoke and choose hospice instead?

Cindy Massuda: OK, we – in this model – we're (stay) – we're really are looking for patient education. We are not looking for the patients to be revoked out of our model. This is – that's – so, we are really looking for patient education. Because that's what we are looking – that's part of what – that's why a lot of this focus on – that's part of what the focus is, is the care, case management, the patient-centered goals and working with these families.

So, it would really against to have revocation in this model. So, that's not what we're expecting.

(Janine Peak): But, as they are brought to (IDP) and decline we're going to have to provide more traditional hospice services if we're being held to hospice COPs, correct?

Cindy Massuda: That's true but what we are purposely are not providing continuous home care or the (GIP) levels of care in this model – because these patients – because that's part of a discussion that can be had with these patients.

So, that if they want something that is much smoother than what would occur if they were in this model – continued in this model – they would want – and if – they would want to consider making the transition and elect the Medicare Hospice Benefits.

But, we do realize that there's some patients who will just never elect an – I mean – that it gets balanced with other patients who require very minimal care. So, it's – it's part of – I think that's just part of how – you know – work with provider – what happens in any good business.

(Janine Peak): OK, so just so that I am clear. Once they choose this model – regardless of whether they become more like a traditional hospice patient which I can see happening, because this is a three-year program.

We – as the Medicare Care Choices applicant – would have to provide hospice-like services to meet the COPs and try to balance that with a \$400 reimbursement for other patients?

Cindy Massuda: I mean, the real focus of this model is for – to be having patient education, the person having the care – there's care coordinator providing case management – letting, giving patients and their families information.

Letting them know about their options and I mean, if the research that this is based off of – and the reason why there is a lot of interest for this model holds true in fee-for-service Medicare. Is it holds true in other insurance industries

is that once these patients are receiving pain symptom management, and there's good care case management along with patient-centered goals.

And the patient knows there's 24/7 access for them – the mental awareness of all of that, along with their pain symptoms managed – typically has the patient and their family thinking about whether or not they want to continue in actual curative care.

In fact curative care has side effects that is making the patient so sick and so on. I mean, these are very personal decisions and the ultimate decision is the patient. And, which is why this model is a patient-driven model.

But, and that's part of – that is what we're looking at. Whether or not the services is in it of themselves and the model benefit these patients – or if these patients – as the patients otherwise considering electing hospice. And if they do so – do they do it any earlier than this – these patients currently are doing in Medicare.

(Janine Peak): OK. I may just send an e-mail afterwards and we can discuss more later, I don't want to hold up the other callers.

Cindy Massuda: OK. I'd be happy to see that, thank you.

(Janine Peak): OK.

Jill Darling: And (Stephanie), that's all we have time now for the Q&A session. I just want to thank everyone for joining us and to those who asked questions, again you can – any questions for Cindy you can send e-mail to her. And thanks again everyone for joining, have a great day.

Operator: Thank you for participating in today's Introduction to the Medicare Care Choices Model Special Open Door Forum. This concludes today's conference call. You may now disconnect.

END