DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-5512-N]

Medicare Program; Request for Applications for the Medicare Care Choices Model

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice informs interested parties of an opportunity to apply for participation in the Medicare Care Choices Model. The primary goal of the Medicare Care Choices Model is to test whether Medicare beneficiaries who meet Medicare hospice eligibility requirements would elect hospice if they could continue to seek curative services.

DATES: Applications will be considered timely if they are received on or before **[insert date 90 days after date of publication in the Federal Register**].

Applications received after this date will not be considered. Applicants must submit their application in a manner that provides proof of timely delivery, for example, FedEx, UPS, or USPS Express Mail. It is the applicant's responsibility to be able to prove delivery of the complete application by the due date.

ADDRESSES: Applications should be mailed to the following address:

Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Attention: Cindy Massuda

Mail Stop: WB-06-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850.

FOR FURTHER INFORMATION CONTACT:

Cindy Massuda at (410) 786-0652 or Georganne Kuberski at (410) 786-0799 or by e-mail at address: CareChoices@cms.hhs.gov.

The Innovation Center website at http://innovation.cms.gov/.

SUPPLEMENTARY INFORMATION:

General Information: In submitting application, refer to file code (CMS-5512-N).

Application requirements: Applications must be typed for clarity with a minimum font size of 12 using Microsoft Word and should not exceed 40 double-spaced pages, exclusive of cover letter, the executive summary, resumes, and letters of engagement from referring providers. Follow guidance in this Request for Application for elements to include in the application, specifically those elements outlined in the selection criteria.

Submission of Application: Applicants must submit a total of 10 hard copies printed single-sided with page numbers in the bottom right-hand corner to ensure that each reviewer receives an application in the manner intended by the applicant (for example, collated, tabulated, or color copies). Applicants must designate 1 copy as the official proposal. Applicants must provide 10 hard copies and 1 electronic copy saved onto a USB flash drive of the full application as the basic requirement of what constitutes submission of an application. Hard copies and electronic copies must be identical.

Note: We will not accept applications by any other means such as facsimile (FAX) transmission or by e-mail.

Eligible Organizations: Eligible providers for this Model are Medicare certified and enrolled hospice programs based on their Medicare provider number, in good standing

and of all sizes, located in a mix of rural and urban areas that are experienced in care coordination with their referring network of providers.

I. Background

The Center for Medicare and Medicaid Innovation (Innovation Center), within the Centers for Medicare & Medicaid Services (CMS), was created to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries.

We are interested in identifying models designed to improve care for specific populations. One such population is terminally ill Medicare beneficiaries who qualify for, but do not elect to use the hospice benefit until late in their disease process. There is evidence that providing hospice care to terminally ill Medicare beneficiaries can reduce program expenditures while improving beneficiary satisfaction. Despite this evidence, only 44 percent of Medicare beneficiaries reach the end of life while using the hospice benefit, and most use the benefit for only a short period of time. While the average length of stay on Medicare hospice has grown over time, the median length of stay has remained stable at about 17 days. The hospice industry and other stakeholders often cite the requirement to forgo curative treatment as a primary reason patients do not elect hospice until the final days of their lives.

The Medicare Care Choices Model design is based on established relationships hospices have with their referring network of providers. Many hospices already have care coordination programs in place to coordinate hospice support services with the

curative care services. This Model leverages those established relationships to allow Medicare to test and evaluate this care coordination concept.

The Medicare Care Choices Model seeks to test whether traditional Medicare beneficiaries with certain types of advanced cancers, congestive heart failure (CHF), human immunodeficiency virus (HIV), and chronic obstructive pulmonary disease (COPD) who meet Medicare hospice eligibility requirements under either the Medicare or Medicaid Hospice Benefit would elect to receive hospice supportive services earlier in their disease trajectories if they could continue to seek curative services. The Model will evaluate whether there are associated improvements in patient care, patient and family or caregiver satisfaction with care, and quality of life at the end-of-life.

II. Provisions of this Notice

The Medicare Care Choices Model participating hospices will use care coordination services both within the hospice and between the hospice and other providers and suppliers to effectively manage hospice-eligible Medicare beneficiaries and report process and outcome measures on their results. The Medicare Care Choices Model participating hospices will be paid a $400 per beneficiary per month fee for certain hospice support services furnished to traditional fee-for-service Medicare beneficiaries who are hospice eligible and meet the criteria stated in the Request for Application (RFA).

In selecting hospices to participate in the program, CMS seeks eligible beneficiaries from a mix of rural and urban areas representing Medicare hospices of all sizes. These hospice providers must demonstrate experience with care coordination

between providers including physicians, hospitals, pharmacies, DME suppliers, other suppliers, and skilled nursing facilities.

We expect to select at least 30 Medicare certified and enrolled hospices based on their Medicare provider number to participate in the Medicare Care Choices Model. The Medicare Care Choices Model period of performance will be 3 years. Applicants must present evidence that their network of referring providers is capable of successfully identifying beneficiaries who meet the Medicare Care Choice Model eligibility requirements. Applicants are required to provide a detailed narrative with supporting documentation describing the beneficiary population they intend to serve, how services will be provided, the quality measures in place and planned, and the number of beneficiaries expected for each year of the 3-year Medicare Care Choices Model period.

CMS will use a competitive process to select eligible organizations to participate in the Medicare Care Choices Model. We will accept timely applications in the standard format outlined in the Medicare Care Choices Model RFA in order to be considered for review by an internal technical panel. Applications that are not received in this format will not be considered for review.

For more specific details regarding the Medicare Care Choices Model (including the RFA), we refer applicants to the informational materials on the Innovation Center website at: http://innovation.cms.gov/. Applicants are responsible for monitoring the website to obtain the most current information available.

III. Collection of Information Requirements

Section 1115A(d)(3) of the Act, as added by section 3021 of the Affordable Care Act, states that chapter 35 of title 44, United States Code (the Paperwork Reduction Act

of 1995), shall not apply to the testing and evaluation of models or expansion of such models under this section. Consequently, this document need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

CMS-5512-N

Dated: November 14, 2013

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Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

BILLING CODE 4120-01-P

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