510.405 Beneficiary choice and beneficiary notification.

(a) Beneficiary choice. The CJR model does not restrict Medicare beneficiaries' ability to choose any Medicare enrolled provider or supplier, or any physician or practitioner who has opted out of Medicare.

(1) As part of discharge planning and referral, participant hospitals must provide a complete list of HHAs, SNFs, IRFs, or LTCHs that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient.

(i) This list must be presented to CJR beneficiaries for whom home health care, SNF, IRF, or LTCH services are medically necessary.

(ii) Participant hospitals must specify on the list those post-acute care providers on the list with whom they have a sharing arrangement.

(iii) Participant hospitals may recommend preferred providers and suppliers, consistent with applicable statutes and regulations.

(iv) Participant hospitals may not limit beneficiary choice to any list of providers or suppliers in any manner other than that permitted under applicable statutes and regulations.

(v) Participant hospitals must take into account patient and family preferences when they are expressed.

(2) Participant hospitals may not charge any CJR collaborator a fee to be included on any list of preferred providers or suppliers, nor may the participant hospital accept such payments.

(b) Required beneficiary notification - (1) Participant hospital detailed notification. Each participant hospital must provide written notification to any Medicare beneficiary that meets the criteria in § 510.205 of his or her inclusion in the CJR model. The notification must be provided upon admission to the participant hospital if the admission that initiates the CJR episode is not scheduled with the participant hospital in advance. If the admission is scheduled in advance, then the participant hospital must provide notice as soon as the admission is scheduled. In circumstances where, due to the patient's condition, it is not feasible to provide notification at such times, the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable but no later than discharge from the participant hospital accountable for the CJR episode. The participant hospital must be able to generate a list of all beneficiaries receiving such notification, including the date on which the notification was provided to the beneficiary, to

CMS or its designee upon request. The beneficiary notification must contain all of the following:

(i) A detailed explanation of the model and how it might be expected to affect the beneficiary's care.

(ii) Notification that the beneficiary retains freedom of choice to choose providers and services.

(iii) Explanation of how patients can access care records and claims data through an available patient portal, and how they can share access to their Blue Button® electronic health information with caregivers.

(iv) A statement that all existing Medicare beneficiary protections continue to be available to the beneficiary. These include the ability to report concerns of substandard care to Quality Improvement Organizations or the 1-800-MEDICARE helpline.

(v) A list of the providers, suppliers, and ACOs with whom the CJR participant hospital has a sharing arrangement. This requirement may be fulfilled by the participant hospital including in the detailed notification a Web address where beneficiaries may access the list.

(2) CJR collaborator notice. A participant hospital must require every CJR collaborator to provide written notice to applicable CJR beneficiaries of the structure of the CJR model and the existence of its sharing arrangement with the participant hospital.

(i) With the exception of ACOs, PGPs, NPPGPs, and TGPs, a CJR participant hospital must require every CJR collaborator that furnishes an item or service to a CJR beneficiary during a CJR episode to provide written notice to the beneficiary of the structure of the model and the existence of the individual's or entity's sharing arrangement. The notice must be provided no later than the time at which the beneficiary first receives an item or service from the CJR collaborator during a CJR episode. In circumstances where, due to the patient's condition, it is not feasible to provide notification at such time, the notification must be provided to the beneficiary or his or her representative as soon as is reasonably practicable. The CJR collaborator must be able to generate a list of all beneficiaries who received such a notice, including the date on which the notice was provided to the beneficiary, to CMS upon request.

(ii) A participant hospital must require every PGP, NPPGP, or TGP that is a CJR collaborator where a member of the PGP, member of the NPPGP, or member of the TGP furnishes an item or service to a CJR beneficiary during a CJR episode to provide written notice to the beneficiary of the structure of the model and the existence of the entity's sharing arrangement. The notice must be provided no later than the time at which the beneficiary first receives an item or service from any member of the PGP, member of the NPPGP, or member of the TGP, and the required PGP, NPPGP, or TGP notice may be provided by that member respectively. In circumstances where, due to the patient's condition, it is not feasible to provide notice at such times, the notice must be provided to the beneficiary or

his or her representative as soon as is reasonably practicable. The PGP, NPPGP, or TGP must be able to generate a list of all beneficiaries who received such a notice, including the date on which the notice was provided to the beneficiary, to CMS upon request.

(iii) A participant hospital must require every ACO that is a CJR collaborator where an ACO participant or ACO provider/supplier furnishes an item or service to a CJR beneficiary during a CJR episode to provide written notice to the beneficiary of the structure of the model and the existence of the entity's sharing arrangement. The notice must be provided no later than the time at which the beneficiary first receives an item or service from any ACO participant or ACO provider/supplier and the required ACO notice may be provided by that ACO participant or ACO provider/supplier respectively. In circumstances where, due to the patient's condition, it is not feasible to provide notice at such times, the notice must be provided to the beneficiary or his or her representative as soon as is reasonably practicable. The ACO must be able to generate a list of all beneficiaries who received such a notice, including the date on which the notice was provided to the beneficiary, to CMS upon request.

(3) Discharge planning notice. A participant hospital must provide the beneficiary with a written notice of any potential financial liability associated with non-covered services recommended or presented as an option as part of discharge planning, no later than the time that the beneficiary discusses a particular post-acute care option or at the time the beneficiary is discharged, whichever occurs earlier.

(i) If the participant hospital knows or should have known that the beneficiary is considering or has decided to receive a non-covered post-acute care service or other non-covered associated service or supply, the participant hospital must notify the beneficiary that the service would not be covered by Medicare.

(ii) If the participant hospital is discharging a beneficiary to a SNF prior to the occurrence of a 3-day hospital stay, and the beneficiary is being transferred to or is considering a SNF that would not qualify under the SNF 3-day waiver in § 510.610, the participant hospital must notify the beneficiary in accordance with paragraph (b)(3)(i) of this section that the beneficiary will be responsible for payment for the services furnished by the SNF during that stay, except those services that would be covered by Medicare Part B during a non-covered inpatient SNF stay.

(4) Access to records and retention. Lists of beneficiaries that receive notifications or notices must be retained, and access provided to CMS, or its designees, in accordance with § 510.110.