DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® — Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862(a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official. For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article SE1126, "Further Details on the Revalidation of Provider Enrollment Information."

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Related CR Transmittal #: R156BP and R2482CP

Implementation Date: July 2, 2012

Changes to the Hospice Aggregate Cap Calculation Method

Provider Types Affected

This MLN Matters® Article is intended for hospice providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment MACs or DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7838 which informs Medicare contractors about a new addition to the "Medicare Benefit Policy Manual," Chapter 9, Section 90. The new addition is titled, "Caps and Limitations on Hospice Payment." Some of the information in this new section was

originally found in the "Medicare Claims Processing Manual," Chapter 11, Section 80. Be sure your staffs are aware of the updates in the policy as a result of CR7838.

Background

Medicare pays hospice care providers on a per diem basis. The total payment to a hospice in an accounting year (November 1, to October 31, also known as the cap year) is limited, however, by a statutory cap. Payments made in excess of the statutory cap are considered overpayments and must be refunded by the hospice care provider. The statutory cap is calculated for each hospice care provider by multiplying the applicable "cap amount," which is updated annually, by the "number of Medicare beneficiaries in the hospice program in that year." The statute provides that the number of Medicare beneficiaries in a hospice program in an accounting year "is equal to the number of individuals who have made an election [to receive hospice care] and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program."

In 1983, the Department of Health and Human Services (HHS) adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. The original 1983 regulation calculates the number of hospice beneficiaries as follows:

> Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with § 418.24, from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

Since 1983, the vast majority of hospice providers have not objected to how Medicare beneficiaries are counted in the calculation of the aggregate cap. However, the original method of counting beneficiaries set forth in 42 CFR 418.309(b)(1) has been the subject of recent litigation. A small percentage of hospice providers have filed appeals challenging this methodology, seeking to have hospice overpayment determinations using this methodology invalidated. In April 2011, the Centers for Medicare & Medicaid Services (CMS) issued Ruling CMS 1355-R, which addresses cap years prior to the cap year ending October 31, 2012; CMS has also issued a proposed and final rule revising the previous regulation set forth at § 418.309(b)(1) to provide for application of a patient-by-patient proportional methodology for cap years 2012 and beyond, or, for qualifying providers, application of the streamlined methodology at the provider's election. CMS is also allowing certain hospice providers to elect to have that determination calculated pursuant to a patient-by-patient proportional methodology.

The key provisions of the new Chapter 9, Section 90 of the "Medicare Benefit Policy Manual" are summarized as follows:

Caps and Limitations on Hospice Payments

The statute requires that hospice payments be limited by an inpatient cap and by an aggregate cap. Medicare contractors make the cap calculations annually, after the end of the aggregate cap year, which runs from November 1st to October 31st. Contractors send each provider a cap determination letter, which serves as a notice of program reimbursement under 42 CFR §405.1803(a)(3), showing the results of those calculations. Any amounts in excess of either cap are considered to be overpayments, and must be repaid to Medicare. Contractors compute the inpatient cap and the aggregate cap in order to determine whether a provider has exceeded the allowable hospice cap amount. The contractor shall issue a demand for the overpayment from hospices that exceeded the allowable hospice cap amount.

Limitation on Payments for Inpatient Care

There were no policy changes to this section of the manual. Please see the "Medicare Benefit Policy Manual" (chapter 9, section 90.1) for details on the limitation on payments for inpatient care.

Aggregate Cap on Overall Reimbursement to Medicare-certified Hospices

Overall aggregate Medicare payments made to a Medicare-certified hospice are subject to an aggregate cap, calculated by the contractor at the end of the hospice cap period. The cap year is from November 1st of each year to October 31st of the next year. The aggregate cap is calculated by multiplying a Medicare beneficiary count during the period by a statutory "cap amount." The hospice cap amount for the cap year ending October 31, 2011, is $24,527.69. This amount is adjusted annually to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers. All Medicare-certified hospices are subject to the aggregate cap calculation. When a beneficiary receives hospice care from more than one hospice, only the care provided by the Medicare-certified hospice(s) is considered when computing the aggregate cap.

Actual Medicare Payments Counted

"Total actual Medicare payments made for services furnished to Medicare beneficiaries during the cap year" refers to Medicare payments for services rendered beginning November 1 and ending October 31, regardless of when payment is actually made. All payments made to hospices on behalf of all Medicare hospice beneficiaries receiving services during the cap year are counted, regardless of which year(s) the beneficiary is counted in determining the cap, using the best data available at the time of the calculation. For example payments made to a hospice for an individual initially electing hospice care on October 5, 2011, and dying on October 25, 2011, pertain to services rendered in the cap year beginning November 1, 2010, and ending October 31, 2011, and are counted as payments made during the 2011 cap year (November 1, 2010 - October 31, 2011), even though the beneficiary would be counted in the 2012 cap year if that hospice used the streamlined method (the period for counting beneficiaries using the streamlined method is September 28, 2011, to September 27, 2012).

New Hospices

The hospice aggregate cap is calculated in a different manner for new hospices entering the Medicare program if the hospice has not participated in the program for an entire cap year. In this situation, the

initial cap calculations for newly certified hospices must cover a period of at least 12 months but less than 24 months. For example, the first cap period for a hospice entering the program on October 1, 2010, is from October 1, 2010, through October 31, 2011. Similarly, the first cap period for hospice providers entering the program after November 1, 2009, but before November 1, 2010, ends October 31, 2011.

Counting Beneficiaries for Calculation

From the inception of the hospice benefit in 1983 until April 14, 2011, the original method for counting beneficiaries for use in the aggregate cap calculation remained unchanged. That method is described below, and is now also known as the streamlined method:

Each hospice's cap amount is calculated by the contractor multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes—

(1) Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care from the hospice during the period beginning on September 28 (34 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

(2) In the case in which a beneficiary has elected to receive care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that hospice.

Two Methods for Counting Beneficiaries

The procedures for counting beneficiaries used in the hospice cap calculation were described in CMS Ruling 1355-R (published in the **Federal Register** as CMS-1355-NR (76 FR 26731, May 9, 2011, found at http://www.gpo.gov/fdsys/pkg/FR-2011-05-09/pdf/2011-10694.pdf#page=1) and in the Fiscal Year (FY) 2012 Hospice Wage Index Final Rule. The two methods for counting beneficiaries are the streamlined method and the proportional method.

Proportional Method: Under the proportional method, for each hospice, the contractor shall include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year (November 1st to October 31st), using the best data available at the time of the calculation (subject to revision at a later time based on updated data). The whole and fractional shares of Medicare beneficiaries' time in a given cap year are then summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year.

When a hospice's cap is calculated using the proportional method, and a beneficiary included in that calculation survives into another cap year, the contractor may need to make adjustments to prior cap determinations. Reopening is allowed for up to 3 years from the date of the cap determination notice, except in the case of fraud, where reopening is unlimited. A revised cap determination letter issued as a result of a reopening may itself be reopened, subject to the 3 year limitation on reopening.

Streamlined Method:

When a beneficiary receives care from only one hospice: The hospice includes in its number of Medicare beneficiaries those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care during the period beginning on September 28 (34 days before the beginning of the cap year) and ending on September 27 (35 days before the end of the cap year), using the best data available at the time of the calculation.

Once a beneficiary has been included in the calculation of a hospice cap, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent cap year exceeds that of the period where the beneficiary was included (this could occur when the beneficiary has breaks between periods of election).

When a beneficiary receives care from more than one Medicare-certified hospice during a cap year or years: Each Medicare-certified hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all Medicare-certified hospices and all years that was spent in that hospice in that cap year (November 1st to October 31st), using the best data available at the time of the calculation. Cap determinations are subject to reopening/adjustment to account for updated data. The streamlined method cap calculation for a Medicare beneficiary who has been in more than one Medicare-certified hospice is identical to the proportional method.

Which Method Applies, and When

1. Hospice Appeals for Review of an Overpayment Determination (Ruling CMS-1355-R):

Effective April 14, 2011, a CMS Ruling entitled "Medicare Program; Hospice Appeals for Review of an Overpayment Determination" (CMS-1355-R), and also published in the Federal Register as CMS-1355-NR (76 FR 26731, May 9, 2011, found at http://www.gpo.gov/fdsys/pkg/FR-2011-05-09/pdf/2011-10694.pdf#page=1), was issued related to the aggregate cap calculation for hospices. The Ruling provides that, for any hospice which has a timely-filed administrative appeal of the method used to determine the number of Medicare beneficiaries used in the aggregate cap calculation for a cap year ending on or before October 31, 2011, the Medicare contractors shall recalculate that year's cap determination using the proportional method.

2. Cap year ending October 31, 2011 (the 2011 cap year) and all prior cap years:

Ruling CMS-1355-R applies only to the 2011 cap year and any prior cap year(s) for which a hospice received an overpayment determination and filed a timely qualifying appeal. For any hospice that received relief through Ruling CMS-1355-R in the form of a recalculation of one or more of its cap determinations, or for any hospice that receives relief from a court after challenging the validity of the cap regulation, the hospice's cap determination for any subsequent cap year is also calculated using a proportional method.

Additionally, there are hospices that have not filed an appeal of an overpayment determination challenging the validity of the original method for counting beneficiaries and which are waiting for CMS to make a cap determination for cap years ending on or before October 31, 2011. Any such hospice

provider, as of October 1, 2011, may elect to have its final cap determination for such cap year(s), and all subsequent cap years, calculated using the proportional method.

Finally, those hospices which would like to continue to have the original method (hereafter called the streamlined method) used to determine the number of beneficiaries in a given cap year would not need to take any action, and would have their cap calculated using the streamlined method for cap years ending on or before October 31, 2011.

3. Cap year ending October 31, 2012 (the 2012 cap year) and subsequent cap years:

For cap years ending on or after October 31, 2012, and all subsequent cap years, the hospice aggregate cap is calculated using the proportional method, except that eligible hospices can make a one-time election up to 60 days after receiving their 2012 cap determination to have their aggregate cap calculated using the streamlined method. The option to elect the continued use of the streamlined method for cap years 2012 and beyond is available only to hospices that have had their cap determinations calculated using the streamlined method for all cap years prior to cap year 2012. Contractors shall provide hospices with details on how to make that one-time election.

Transitioning from the Streamlined Method to the Proportional Method: There are advantages and disadvantages for hospices transitioning from the streamlined method to the proportional method. When a transition to the proportional method occurs for the 2012 cap year, contractors shall not re-open the cap determination for prior cap years to pro-rate beneficiaries calculated under the streamlined method, who are included in beneficiary count for the 2012 cap year, unless those beneficiaries were in more than one hospice. Contractors shall consider all days of hospice care for these beneficiaries, including those in the previous cap year(s), when computing the proportional share of a beneficiary headcount using the proportional method. Therefore, some beneficiaries that were previously counted as 1 may be counted as more than 1 as a result of the transition.

When a hospice that elects to continue to have the streamlined method used for its cap calculation in 2012, later elects to change to the proportional method for the 2013 cap year or a later cap year, contractors can reopen cap determinations for the 2012 and later cap years. Reopening is allowed for up to 3 years from the date of the applicable cap determination, except in the case of fraud, where reopening is unlimited.

Additionally, when a transition to the proportional method is made, the timeframe for counting beneficiaries changes from September 28th – September 27th to November 1st – October 31st. As a result, there is a 34 day period from September 28th to October 31st, 2011 in the transition year where beneficiaries who elect hospice and die within that period are not counted in the total number of beneficiaries for either the 2011 or the 2012 cap year. However, the payments associated with those beneficiaries are counted in the 2011 cap year.

When a hospice transitions from the streamlined method to the proportional method, the beneficiaries' days of care from September 28 – October 31, 2011 (34 days) would not be included in the numerator for the beneficiary count calculation. However, that 34-day period would be included in the denominator because the proportional method includes in the denominator all days of hospice care provided to a beneficiary in order to prorate the beneficiary correctly. As such, any beneficiary that elected hospice care during the 34-day period would be counted as less than 1, since the numerator

only includes days of service in the new cap year, but the denominator includes all days of care, including the days in the 34-day transition period. The counting of these beneficiaries as less than 1 could be offset (in whole or in part) by other beneficiaries that will be carried over from years prior to the 2012 cap year that would be counted as more than 1 (one) beneficiary.

These methods and procedures are explained in more detail in Chapter 9, Section 90.2.3 of the "Medicare Benefit Policy Manual"; that entire chapter is attached to one of the transmittals of CR7838, which you will find at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156BP.pdf on the CMS website. There are a number of illustrative examples of counting beneficiaries and on transitioning from the streamlined method to the proportional method of counting beneficiaries in the same section of that attachment to CR7838.

Changing Aggregate Cap Calculation Methods

Hospices are not allowed to switch back and forth between cap calculation methods, as doing so would greatly complicate the cap determination calculation, would be difficult to administer, and could lead to inappropriate switching by hospices seeking merely to maximize Medicare payments. Additionally, in the year of a change in the calculation method or when a previous cap determination cannot be re-opened, there is a potential for over-counting some beneficiaries. Allowing hospices to switch back and forth between methods would perpetuate the risk of over-counting beneficiaries. Therefore:

1) Those hospices that have their cap determination calculated using the proportional method for any cap year prior to the 2012 cap year will continue to have their cap calculated using the proportional method for the 2012 cap year and all subsequent cap years; and,
2) All other hospices would have their cap determinations for the 2012 cap year and all subsequent cap years calculated using the proportional method unless they make a one-time election to have their cap determinations for cap year 2012 and beyond calculated using the streamlined method. Contractors do not reopen cap determinations for the 2011 cap year and prior cap years as a result of a hospice transition from the streamlined to the proportional method for the 2012 cap year. Note: this does not apply to hospices that appealed their cap determination.
3) A hospice would be able to elect the streamlined method no later than 60 days following the receipt of its 2012 cap determination.
4) Hospices which elected to have their cap determination calculated using the streamlined method may later elect to have their cap determinations calculated using the proportional method by either:
    a) electing to change to the proportional method (if the election is made prior to receipt of the cap determination associated with the cap year where the change is desired); or
    b) appealing a cap determination calculated using the streamlined method to determine the number of Medicare beneficiaries.

5) If a hospice elected the streamlined method, and changed to the proportional method for a subsequent cap year, the hospice's aggregate cap determination for that cap year (i.e., the cap year of the change) and all subsequent cap years would be calculated using the proportional method. Past cap year determinations for the 2012 cap year and later cap years are subject to reopening; existing re-opening rules allow reopening for up to 3 years from the date of the cap determination, except in cases of fraud, where reopening is unlimited. A revised cap determination letter issued as a result of reopening may itself be reopened, subject to the 3 year limitation on reopening.

Other Issues

The computation and application of the aggregate cap is made by the contractor after the cap year ends. The updated Provider Statistical & Reimbursement (PS&R) system enables each hospice's contractor to correctly determine proportional allocations. For all cap years through the 2011 cap year, hospices are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the contractor. This must be done within 30 days after the end of the cap period. For the 2012 cap year and beyond, hospices no longer need to report the number of Medicare beneficiaries to be counted in the aggregate cap calculation due to the updated PS&R system.

Hospices can obtain instructions regarding the cap determination method election process from their contractors. Regardless of which method is used, the contractor shall continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. Cap determinations are subject to the existing CMS reopening regulations, which allow reopening for up to 3 years from the date of the cap determination letter, except in cases of fraud, where reopening is not limited.

There were no policy changes related to updating to the cap amount or to administrative appeals. Information about these two topics is included in Chapter 9, of the "Medicare Benefit Policy Manual" in section 90.2.6 ("Updates to the Cap Amount") and section 90.3 ("Administrative Appeals"). Chapter 9 is attached to one of the transmittals of CR7838, which you will find at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156BP.pdf on the CMS website.

Additional Information

The official instruction, CR7838 was issued to your contractor via two transmittals. The first removes the hospice policy discussion from the "Medicare Claims Processing Manual" and it is at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2482CP.pdf on the CMS website. The second adds the Chapter 9, Section 90 to the "Medicare Benefit Policy Manual" at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156BP.pdf on the same site.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.