

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-02 Medicare Benefit Policy</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 156</b>	<b>Date: June 1, 2012</b>
	<b>Change Request 7838</b>

**SUBJECT: Updates to Caps and Limitations on Hospice Payments**

**I. SUMMARY OF CHANGES:** To add section 90, "Caps and Limitations on Hospice Payments", and to revise policy to allow the aggregate cap calculation using either the streamlined method or the proportional method, within certain limitations.

**EFFECTIVE DATE:** April 14, 2011 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years

**IMPLEMENTATION DATE:** July 2, 2012

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)  
R=REVISED, N=NEW, D=DELETED

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	9/Table of Contents
<b>N</b>	9/90/Caps and Limitations on Hospice Payments
<b>N</b>	9/90.1/Limitation on Payments for Inpatient Care
<b>N</b>	9/90.2/Aggregate Cap on Overall Reimbursement to Medicare-certified Hospices
<b>N</b>	9/90.2.1/Actual Medicare Payments Counted
<b>N</b>	9/90.2.2/New Hospices
<b>N</b>	9/90.2.3/Counting Beneficiaries for Calculation
<b>N</b>	9/90.2.4/Changing Aggregate Cap Calculation Methods
<b>N</b>	9/90.2.5/Other Issues

N	9/90.2.6/Updates to the Cap Amount
N	9/90.3/Administrative Appeals

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

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**SUBJECT: Updates to Caps and Limitations on Hospice Payments**

**Effective Date: April 14, 2011 for the 2011 Cap Year and Prior Cap Years;  
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**Implementation Date: July 2, 2012**

## **I. GENERAL INFORMATION**

**A. 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, 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, 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.

## **B. Policy:**

### **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 1<sup>st</sup> to October 31<sup>st</sup>. 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**

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate number of days of hospice care provided to all Medicare beneficiaries in that hospice during that same period. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 - October 31). The inpatient cap is calculated by the contractor as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.20.
2. If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.
3. If the total number of days of inpatient care exceeds the maximum allowable number, the limitation is determined by:
  - Calculating the ratio of the maximum allowable inpatient care days to total inpatient care days reported on the Provider Statistical and Reimbursement Report (PS&R). The calculated ratio is multiplied by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) paid to the provider.
  - Multiplying the excess inpatient care days by the routine home care (RHC) rate, wage adjusted for the location of the hospice.
  - Adding together the amounts calculated in the two bullets above to derive the total allowable payments for inpatient care.
  - Comparing the total allowable payments for inpatient care in bullet 3 above with actual payments made to the hospice for inpatient care during the "cap period" in order to determine the overpayments paid to the provider.

Any excess reimbursement must be refunded by the hospice.

**EXAMPLE:** Assume that:

40,000 total hospice days x 0.20 = 8,000 = the maximum allowable inpatient care days.

10,000 inpatient care days were reported and paid to the hospice.

The ratio of maximum allowable days to the number of actual days equals 8,000 to 10,000 or 0.80.

Assume the total reimbursement for inpatient care revenue codes 0655 and 0656 for services provided between November 1<sup>st</sup> and October 31<sup>st</sup> is \$4,000,000.

$\$4,000,000 \times 0.80 = \$3,200,000 =$  payments for allowable inpatient care days.

Excess inpatient days = (10,000 actual days) – (8,000 allowable days) = 2,000. Multiply the excess inpatient care days by the routine home care rate (wage adjusted for a hospice located in Redding, California, using the FY 2012 Wage Index value of 1.4631):  $2,000 \times \$199.09 = \$398,180 =$  allowable payments for the excess inpatient care days.

Add the allowable inpatient payments and the allowable payments for excess days to derive the inpatient cap:  $\$3,200,000 + \$398,180 = \$3,598,180 =$  inpatient cap.

Compare  $\$3,598,180$  inpatient cap with  $\$4,000,000$  actually paid for inpatient revenue codes.

The hospice must refund  $\$4,000,000 - \$3,598,180 = \$401,820$

### **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 1<sup>st</sup> of each year to October 31<sup>st</sup> of the next year. The aggregate cap is calculated by multiplying a Medicare beneficiary count during the period by a statutory “cap amount.” The Medicare beneficiary count is determined using either the proportional method or the streamlined method, as described in the section below entitled “Counting Beneficiaries for Calculation.” 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. The computation of the cap amount is explained in the section below entitled “Updates to the Cap Amount.”

The total actual Medicare payments made for services furnished to Medicare beneficiaries during the cap year (November 1<sup>st</sup> to October 31<sup>st</sup>) are compared to the aggregate cap for this period. Any actual Medicare payments in excess of the aggregate cap must be refunded by the hospice.

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.

Contractors shall use the proportional method when calculating the aggregate cap for all hospices which are Medicare-certified on or after October 1, 2011.

### **Counting Beneficiaries for Calculation**

From the inception of the 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:

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.

The following descriptions of CMS policies outlining procedures for counting beneficiaries used in the hospice cap calculation were described in CMS Ruling 1355-R and in the FY 2012 Hospice Wage Index Final Rule. The policies differ by timeframe, so note carefully the timeframe and cap years mentioned. The two methods for counting beneficiaries are the streamlined method and the proportional method, and are explained below.

#### **A. 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. This ruling provided for application of a proportional method to hospices that have challenged the original method of counting beneficiaries (shown at the beginning of the section entitled “Counting Beneficiaries for Calculation”) for the aggregate cap calculation. Specifically, 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. The proportional method is described in subsection C. below.

#### **B. 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, as opposed to the original method described at the beginning of this section. The proportional method is defined below in subsection C. below.

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. The streamlined method is defined in subsection C. below.

### **C. 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, as described later in this section. Contractors shall provide hospices with details on how to make that one-time election.

**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 1<sup>st</sup> to October 31<sup>st</sup>), 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:** Eligible hospices can exercise a one-time election to have its cap determination for cap years 2012 and beyond 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.

- **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 1<sup>st</sup> to October 31<sup>st</sup>), 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.

#### **D. Beneficiary Counting Examples**

The following examples are for illustrative purposes only. As the examples indicate, if a hospice transitions from the streamlined method to the proportional method during the 2012 cap year, the transition might result in particular beneficiaries being counted a total of less or more than 1.0. As the examples illustrate, if the proportional method is applied for a given year, then every beneficiary who receives services in that year is counted based on the number of days of care furnished to the beneficiary in that year, relative to the total days of care for the beneficiary for all years.

**Example 1.** Jane Smith, a Medicare beneficiary, initially elected hospice care from Hospice A beginning on June 1, 2011. Her condition improved, and she was discharged from Hospice A on August 15, 2011, as she was no longer terminally ill. However, in January 2012 Ms. Smith's condition worsened; she re-elected hospice at Hospice A on January 15, 2012, and subsequently died on February 26, 2012.

Streamlined Method: Hospice A would count Ms. Smith as 1 in its 2011 cap year, but would not count Ms. Smith again in its 2012 cap year. Medicare payments for hospice care provided would be counted in the cap year in which those services were provided, regardless of when payments were actually made, using the best data available at the time of the calculation.

Proportional Method: Ms. Smith would be counted as follows:

2011 cap year (June 1 <sup>st</sup> – August 15 <sup>th</sup> ):	76 days =	76/119 =	0.64
2012 cap year (Jan 15 <sup>th</sup> – Feb 26 <sup>th</sup> ):	43 days =	43/119 =	0.36
Total days:	119 days =		1.00

The contractor uses the best data available at the time the cap is calculated to determine the proportional allocation of Ms. Smith's time. Because the contractor calculates the cap after allowing time for claims and adjustments to flow through the claims processing system, and assuming Hospice A files its claims without delay, by the time the 2011 cap is calculated the contractor would have information about Ms. Smith's complete hospice stay. Therefore, the contractor is able to correctly count Ms. Smith's stay for the 2011 and 2012 cap determinations, without having to make prior year adjustments to her proportional shares.

Had Ms. Smith lived until August 25, 2012, the contractor would consider the information it has at the time it makes the cap calculation when determining proportional shares. For example, if the contractor calculated the 2011 cap on June 30, 2012, using claims for dates of service through April 30, 2012, Ms. Smith's total stay would have been 183 days, and the 2011 proportional share would be  $76 / 183 = 0.42$ . When calculating the 2012 cap determination, the contractor would be able to re-open the 2011 cap determination and correct the proportional allocation made in the previous cap year, to reflect a final allocation of  $76/300 = 0.25$  for the 2011 cap determination and  $224/300 = 0.75$  in the 2012 cap determination.

**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 28<sup>th</sup> – September 27<sup>th</sup> to November 1<sup>st</sup> – October 31<sup>st</sup>. As a result, there is a 34 day period from September 28<sup>th</sup> to October 31<sup>st</sup>, 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.

**Example 2.** Hospice A's cap was calculated using the streamlined method for the 2011 cap year, but Hospice A changed to the proportional method for the 2012 cap year. Ms. Jones is a beneficiary who elected Hospice A on September 1, 2011, and who died November 15, 2011. Ms. Jones was counted as 1 in the 2011 cap determination, using the streamlined method. When computing the 2012 cap determination using the proportional method, the contractor does not re-open the 2011 cap determination to adjust Ms. Jones' count. Ms. Jones was in hospice care for a total of 76 days. In the 2012 cap year calculation using the proportional method, the contractor would count Ms. Jones as  $15 / 76 = 0.20$ . In this case, Ms. Jones was counted as 1.20 beneficiaries.

**Example 3.** Jason Smith, a Medicare beneficiary, initially elected hospice care from Hospice A in June 2012. He received hospice care for 30 days, but revoked the benefit to try a new treatment. The treatment put his disease into remission until 2016. Mr. Smith elected hospice at Hospice B in January 2016, and died 30 days later. The cap determination letter for the 2012 cap year was issued on December 29, 2013, and December 1, 2017 for the 2016 cap year. Mr. Smith received a total of 60 days of hospice care, with 30 days in the 2012 cap year and 30 days in the 2016 cap year. The contractor counted Mr. Smith in Hospice A's 2012 cap determination as 1. That 2012 cap determination is subject to reopening limitations because the 3 year reopening timeframe from the date of the cap determination letter has passed. The contractor for Hospice B counted Mr. Smith as 0.50, because Hospice B provided 30 days of care out of a total of 60 days of care. In this case, Mr. Smith was counted as 1.5 beneficiaries.

Had Mr. Smith re-elected the hospice benefit for 30 days in 2014 instead of 2016, and then died, then the contractor would reopen Hospice A's 2012 cap determination and re-compute the cap after reducing the total beneficiary count by 0.5, to account for the adjustment to Mr. Smith's time. Hospice B's contractor would also count Mr. Smith as 0.5 in its 2014 cap calculation. Between the 2 hospices and the different years, Mr. Smith is counted as 1 in total.

**Example 4.** Mark Williams, a Medicare beneficiary, initially elected hospice care from Hospice A in June 2012. He received hospice care for 30 days, but revoked the benefit to try a new treatment, which put his disease into remission until 2014. Mr. Williams again elected hospice at Hospice A in January 2014, and died 30 days later. Hospice A has its contractor use the streamlined method. The contractor counted Mr. Williams

in Hospice A's 2012 cap determination as 1. When computing the 2014 cap, the contractor would count Mr. Williams as 0, because the streamlined method requires that a beneficiary who receives care from a single hospice be counted in the initial year of election only.

**Example 5.** Marla Jackson, a Medicare beneficiary, initially elects hospice care from Hospice A on September 2, 2011. Ms. Jackson stays in Hospice A until October 1, 2011, (30 days) at which time she changes her election and transfers to Hospice B. Ms. Jackson stays in Hospice B for 70 days until her death on December 9, 2011. Each hospice can count the day of transfer in its total days of care. The contractor determines that the total length of hospice stay for Ms. Jackson is 100 days (30 days in Hospice A and 70 days in Hospice B).

Since Ms. Jackson was in more than one hospice, it doesn't matter which calculation method hospice A or B uses; the calculation is identical and is proportional. The timeframe for counting beneficiaries using the proportional method follows that of the cap year: November 1<sup>st</sup> to October 31<sup>st</sup>. Therefore, Ms. Jackson's hospice stay not only occurred in 2 hospices, but also in 2 cap years.

Since Ms. Jackson was in Hospice A for 30 days in the 2011 cap year only, hospice A counts 0.3 of a Medicare beneficiary for her in its hospice cap calculation (30 days/100 days). Hospice B counts 0.7 of a Medicare beneficiary in its cap calculation (70 days/100 days), but Ms. Jackson's stay in Hospice B must also be allocated to the appropriate cap year:

	<b>Hospice A</b>	<b>Hospice B</b>
Total stay: 9/2/2011 – 12/9/2011	9/2/2011 – 10/1/2011	10/1/2011 – 12/9/2011
Total days: 100	30 days	70 days
2011 Cap year (11/1/2010 – 10/31/2011)	30/100= 0.30	31/100= 0.31
2012 Cap year (11/1/2011 – 10/31/2012)	<u>----</u>	39/100= <u>0.39</u>
<b>Total</b>	<b>0.30</b>	<b>0.70</b>

If Hospice A was not Medicare certified, then the contractor would only consider Ms. Jackson's time in Hospice B.

**Example 6.** Hospice A decided that it would like its contractor to calculate its cap using the proportional method beginning with the 2012 cap year. Hospice A admitted Susan Brown on October 1, 2011, and she passed away on October 20, 2011. In computing Hospice A's cap for the 2011 cap year, the contractor uses the streamlined method, which counts beneficiaries for the aggregate cap based on the date of initial election. Since Ms. Brown initially elected the Medicare hospice benefit on October 1<sup>st</sup>, she would not be included in Hospice A's beneficiary count for 2011, but the payments associated with her would be included in the total payments for the 2011 cap calculation. When the contractor calculates the 2012 cap using the proportional method, beneficiaries are counted based on the cap year timeframe (November 1, 2011 to October 31, 2012). As such, Ms. Brown is not included in the 2012 beneficiary count.

In the 2012 cap year, the transition from the streamlined method to the proportional method, beneficiaries who initially elect hospice and pass away during the 34 day period between September 28<sup>th</sup> and October 31<sup>st</sup> 2011, would not be included in either the count of beneficiaries for the prior year's streamlined cap calculation or in the approaching year's proportional cap calculation. However, the Medicare payments to the hospice associated with those beneficiaries are included in the total actual payments used in the 2011 cap calculation.

Had Ms. Brown lived until November 15, 2011, she would have been included in Hospice A's cap calculation for the 2012 cap year. Her total hospice stay would then have been 46 days, with 15 of those days occurring during the 2012 cap year. Ms. Brown would be counted in the 2012 cap determination as 15/46=0.33.

## **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 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.

## Updates to the Cap Amount

The original cap amount of \$6,500 per year is increased or decreased for accounting years that end after October 1, 1984, by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (CPI-U, United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. The hospice cap is calculated on the basis of a cap year beginning November 1 and ending the following October 31.

For example, for the cap amount for the cap year ending October 31, 2011, calculate using the March 2011 CPI-U in the medical care expenditures category of 397.726 and divide by the March 1984 CPI-U in the medical care expenditures category of 105.4 to yield an index of 3.773491 (rounded). The new hospice cap amount is the product of \$6,500 (base year cap) multiplied by 3.773491. Therefore, the cap amount for the period ending October 31, 2011, is \$24,527.69.

In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is accomplished.

### EXAMPLE

10/01/10 - Hospice A is Medicare certified.

10/01/10 to 10/31/11 - First cap period (13 months) for hospice A.

Statutory cap amount for first Medicare cap year (11/01/09 - 10/31/10) = \$23,874.98

Statutory cap amount for second Medicare cap year (11/01/10 - 10/31/11) = \$24,527.69

Weighted average cap amount calculation for hospice A:

One month (10/01/10 - 10/31/10) at \$23,874.98 = \$ 23,874.98

12 months (11/01/10 - 10/31/11) at \$24,527.69 = \$294,332.28

13 month period \$318,207.26 divided by 13 = \$24,477.48 (rounded)

In this example, \$24,477.48 is the weighted average cap amount used in the initial cap calculation for Hospice A for the period October 1, 2010, through October 31, 2011

**NOTE:** If Hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.

### Administrative Appeals

The applicable contractor shall issue a letter to notify hospice providers of the results of the contractor's cap calculations and to serve as the provider's determination of program reimbursement. If there is a cap overpayment, there shall be an accompanying demand for repayment. As indicated in 42 CFR 418.311, a hospice that believes that its payments have not been properly determined may request a review from the applicable contractor or the Provider Reimbursement Review Board (PRRB). Each determination of program reimbursement shall include language describing the provider's appeal rights.

The above described letter, serving as the provider's determination of program reimbursement, shall include the following language:

“This notice is the contractor’s final determination for purposes of appeal rights. If you disagree with this determination, you may file an appeal, in accordance with 42 CFR 418.311 and 42 CFR, part 405, subpart R. The appeal should be filed with either the applicable contractor (FI, RHHI, or A/B MAC) or the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Appeal requests must be in writing and be filed within 180 days from the date of this determination.”

**II. BUSINESS REQUIREMENTS TABLE**

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility									
		A / B  M A C	D M E  M A C	F I  I E R	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
7838-02.1	Medicare contractors shall be aware that the hospice policies originally located in Pub. 100-04, Medicare Claims Processing Manual, chapter 11, sections 80 through 80.3, have been updated and relocated to Pub. 100-02, Medicare Benefit Policy manual, chapter 9, sections 90 through 90.3.	X		X		X					

**III. PROVIDER EDUCATION TABLE**

Number	Requirement	Responsibility									
		A / B  M A C	D M E  M A C	F I  I E R	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
7838-02.2	A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with	X		X		X					

Number	Requirement	Responsibility									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

**IV. SUPPORTING INFORMATION**

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space: N/A**

**V. CONTACTS**

**Pre-Implementation Contact(s):** Katie Lucas, [katherine.lucas@cms.hhs.gov](mailto:katherine.lucas@cms.hhs.gov) or Owen Osaghae, [owen.osaghae@cms.hhs.gov](mailto:owen.osaghae@cms.hhs.gov).

**Post-Implementation Contact(s):** Contact your Contracting Officer’s Representative (COR) or Contractor Manager, as applicable.

**VI. FUNDING**

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers, use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: For Medicare Administrative Contractors (MACs), include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

# **Medicare Benefit Policy Manual**

## **Chapter 9 - Coverage of Hospice Services Under Hospital Insurance**

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## **90 – Caps and Limitations on Hospice Payments**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*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 1<sup>st</sup> to October 31<sup>st</sup>. 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.*

### **90.1 – Limitation on Payments for Inpatient Care**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate number of days of hospice care provided to all Medicare beneficiaries in that hospice during that same period. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 - October 31). The inpatient cap is calculated by the contractor as follows:*

- 1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.20.*
- 2. If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.*
- 3. If the total number of days of inpatient care exceeds the maximum allowable number, the limitation is determined by:*
  - Calculating the ratio of the maximum allowable inpatient care days to total inpatient care days reported on the Provider Statistical and Reimbursement Report (PS&R). The calculated ratio is multiplied by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) paid to the provider.*



- *Multiplying the excess inpatient care days by the routine home care (RHC) rate, wage adjusted for the location of the hospice.*
- *Adding together the amounts calculated in the two bullets above to derive the total allowable payments for inpatient care.*
- *Comparing the total allowable payments for inpatient care in bullet 3 above with actual payments made to the hospice for inpatient care during the “cap period” in order to determine the overpayments paid to the provider.*

*Any excess reimbursement must be refunded by the hospice.*

**EXAMPLE:** *Assume that:*

*40,000 total hospice days x 0.20 = 8,000 = the maximum allowable inpatient care days.*

*10,000 inpatient care days were reported and paid to the hospice.*

*The ratio of maximum allowable days to the number of actual days equals 8,000 to 10,000 or 0.80.*

*Assume the total reimbursement for inpatient care revenue codes 0655 and 0656 for services provided between November 1<sup>st</sup> and October 31<sup>st</sup> is \$4,000,000.*

*\$4,000,000 x 0.80 = \$3,200,000 = payments for allowable inpatient care days.*

*Excess inpatient days = (10,000 actual days) – (8,000 allowable days) = 2,000. Multiply the excess inpatient care days by the routine home care rate (wage adjusted for a hospice located in Redding, California, using the FY 2012 Wage Index value of 1.4631): 2,000 x \$199.09 = \$398,180 = allowable payments for the excess inpatient care days.*

*Add the allowable inpatient payments and the allowable payments for excess days to derive the inpatient cap: \$3,200,000 + \$398,180 = \$3,598,180 = inpatient cap.*

*Compare \$3,598,180 inpatient cap with \$4,000,000 actually paid for inpatient revenue codes.*

*The hospice must refund \$4,000,000 - \$3,598,180 = \$401,820*

## **90.2 – Aggregate Cap on Overall Reimbursement to Medicare-certified Hospices**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

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 1<sup>st</sup> of each year to October 31<sup>st</sup> of the next year. The aggregate cap is calculated by multiplying a Medicare beneficiary count during the period by a statutory “cap amount.” The Medicare beneficiary count is determined using either the proportional method or the streamlined method, as described in section 90.2.3 below. 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. The computation of the cap amount is explained in section 90.2.6 below.

The total actual Medicare payments made for services furnished to Medicare beneficiaries during the cap year (November 1<sup>st</sup> to October 31<sup>st</sup>) are compared to the aggregate cap for this period. Any actual Medicare payments in excess of the aggregate cap must be refunded by the hospice.

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.

### **90.2.1 – Actual Medicare Payments Counted**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

“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).

### **90.2.2 – New Hospices**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*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.*

*Contractors shall use the proportional method when calculating the aggregate cap for all hospices which are Medicare-certified on or after October 1, 2011.*

### **90.2.3 – Counting Beneficiaries for Calculation**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*From the inception of the 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:*

*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.*

*The following descriptions of CMS policies outlining procedures for counting beneficiaries used in the hospice cap calculation were described in CMS Ruling 1355-R and in the FY 2012 Hospice Wage Index Final Rule. The policies differ by timeframe, so note carefully the timeframe and cap years mentioned. The two methods for counting*

*beneficiaries are the streamlined method and the proportional method, and are explained below.*

***A. 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. This ruling provided for application of a proportional method to hospices that have challenged the original method of counting beneficiaries (shown at the beginning of section 90.2.3) for the aggregate cap calculation. Specifically, 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. The proportional method is described in section 90.2.3.C below.*

***B. 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, as opposed to the original method described at the beginning of this section. The proportional method is defined below in section 90.2.3.C.*

*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. The streamlined method is defined in section 90.2.3.C below.*

**C. 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, as described later in this section. Contractors shall provide hospices with details on how to make that one-time election.

**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 1<sup>st</sup> to October 31<sup>st</sup>), 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:** Eligible hospices can exercise a one-time election to have its cap determination for cap years 2012 and beyond 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.

- **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 1<sup>st</sup> to October 31<sup>st</sup>), 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.

#### **D. Beneficiary Counting Examples**

The following examples are for illustrative purposes only. As the examples indicate, if a hospice transitions from the streamlined method to the proportional method during the 2012 cap year, the transition might result in particular beneficiaries being counted a total of less or more than 1.0. As the examples illustrate, if the proportional method is applied for a given year, then every beneficiary who receives services in that year is counted based on the number of days of care furnished to the beneficiary in that year, relative to the total days of care for the beneficiary for all years.

**Example 1.** Jane Smith, a Medicare beneficiary, initially elected hospice care from Hospice A beginning on June 1, 2011. Her condition improved, and she was discharged from Hospice A on August 15, 2011, as she was no longer terminally ill. However, in January 2012 Ms. Smith's condition worsened; she re-elected hospice at Hospice A on January 15, 2012, and subsequently died on February 26, 2012.

Streamlined Method: Hospice A would count Ms. Smith as 1 in its 2011 cap year, but would not count Ms. Smith again in its 2012 cap year. Medicare payments for hospice care provided would be counted in the cap year in which those services were provided, regardless of when payments were actually made, using the best data available at the time of the calculation.

Proportional Method: Ms. Smith would be counted as follows:

2011 cap year (June 1 <sup>st</sup> – August 15 <sup>th</sup> ):	76 days =	76/119 =	0.64
2012 cap year (Jan 15 <sup>th</sup> – Feb 26 <sup>th</sup> ):	43 days =	43/119 =	<u>0.36</u>
Total days:	119 days =		1.00

The contractor uses the best data available at the time the cap is calculated to determine the proportional allocation of Ms. Smith's time. Because the contractor calculates the cap after allowing time for claims and adjustments to flow through the claims processing system, and assuming Hospice A files its claims without delay, by the time the 2011 cap is calculated the contractor would have information about Ms. Smith's complete hospice stay. Therefore, the contractor is able to correctly count Ms. Smith's stay for the 2011

*and 2012 cap determinations, without having to make prior year adjustments to her proportional shares.*

*Had Ms. Smith lived until August 25, 2012, the contractor would consider the information it has at the time it makes the cap calculation when determining proportional shares. For example, if the contractor calculated the 2011 cap on June 30, 2012, using claims for dates of service through April 30, 2012, Ms. Smith's total stay would have been 183 days, and the 2011 proportional share would be  $76 / 183 = 0.42$ . When calculating the 2012 cap determination, the contractor would be able to re-open the 2011 cap determination and correct the proportional allocation made in the previous cap year, to reflect a final allocation of  $76/300 = 0.25$  for the 2011 cap determination and  $224/300 = 0.75$  in the 2012 cap determination.*

**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 28<sup>th</sup> – September 27<sup>th</sup> to November 1<sup>st</sup> – October 31<sup>st</sup>. As a result, there is a 34 day period from September 28<sup>th</sup> to October 31<sup>st</sup>, 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.

**Example 2.** Hospice A's cap was calculated using the streamlined method for the 2011 cap year, but Hospice A changed to the proportional method for the 2012 cap year. Ms. Jones is a beneficiary who elected Hospice A on September 1, 2011, and who died November 15, 2011. Ms. Jones was counted as 1 in the 2011 cap determination, using the streamlined method. When computing the 2012 cap determination using the proportional method, the contractor does not re-open the 2011 cap determination to adjust Ms. Jones' count. Ms. Jones was in hospice care for a total of 76 days. In the 2012 cap year calculation using the proportional method, the contractor would count Ms. Jones as  $15 / 76 = 0.20$ . In this case, Ms. Jones was counted as 1.20 beneficiaries.

**Example 3.** Jason Smith, a Medicare beneficiary, initially elected hospice care from Hospice A in June 2012. He received hospice care for 30 days, but revoked the benefit to try a new treatment. The treatment put his disease into remission until 2016. Mr. Smith elected hospice at Hospice B in January 2016, and died 30 days later. The cap determination letter for the 2012 cap year was issued on December 29, 2013, and December 1, 2017 for the 2016 cap year. Mr. Smith received a total of 60 days of hospice care, with 30 days in the 2012 cap year and 30 days in the 2016 cap year. The contractor counted Mr. Smith in Hospice A's 2012 cap determination as 1. That 2012 cap determination is subject to reopening limitations because the 3 year reopening timeframe from the date of the cap determination letter has passed. The contractor for Hospice B counted Mr. Smith as 0.50, because Hospice B provided 30 days of care out of a total of 60 days of care. In this case, Mr. Smith was counted as 1.5 beneficiaries.

Had Mr. Smith re-elected the hospice benefit for 30 days in 2014 instead of 2016, and then died, then the contractor would reopen Hospice A's 2012 cap determination and re-compute the cap after reducing the total beneficiary count by 0.5, to account for the adjustment to Mr. Smith's time. Hospice B's contractor would also count Mr. Smith as 0.5 in its 2014 cap calculation. Between the 2 hospices and the different years, Mr. Smith is counted as 1 in total.

**Example 4.** Mark Williams, a Medicare beneficiary, initially elected hospice care from Hospice A in June 2012. He received hospice care for 30 days, but revoked the benefit to try a new treatment, which put his disease into remission until 2014. Mr. Williams again elected hospice at Hospice A in January 2014, and died 30 days later. Hospice A has its contractor use the streamlined method. The contractor counted Mr. Williams in Hospice A's 2012 cap determination as 1. When computing the 2014 cap, the contractor would count Mr. Williams as 0, because the streamlined method requires that a beneficiary who receives care from a single hospice be counted in the initial year of election only.

**Example 5.** Marla Jackson, a Medicare beneficiary, initially elects hospice care from Hospice A on September 2, 2011. Ms. Jackson stays in Hospice A until October 1, 2011, (30 days) at which time she changes her election and transfers to Hospice B. Ms.



*Jackson stays in Hospice B for 70 days until her death on December 9, 2011. Each hospice can count the day of transfer in its total days of care. The contractor determines that the total length of hospice stay for Ms. Jackson is 100 days (30 days in Hospice A and 70 days in Hospice B).*

*Since Ms. Jackson was in more than one hospice, it doesn't matter which calculation method Hospice A or B uses; the calculation is identical and is proportional. The timeframe for counting beneficiaries using the proportional method follows that of the cap year: November 1<sup>st</sup> to October 31<sup>st</sup>. Therefore, Ms. Jackson's hospice stay not only occurred in 2 hospices, but also in 2 cap years.*

*Since Ms. Jackson was in Hospice A for 30 days in the 2011 cap year only, Hospice A counts 0.3 of a Medicare beneficiary for her in its hospice cap calculation (30 days/100 days). Hospice B counts 0.7 of a Medicare beneficiary in its cap calculation (70 days/100 days), but Ms. Jackson's stay in Hospice B must also be allocated to the appropriate cap year:*

	<b>Hospice A</b>	<b>Hospice B</b>
Total stay: 9/2/2011 – 12/9/2011	9/2/2011 – 10/1/2011	10/1/2011 – 12/9/2011
Total days: 100	30 days	70 days
2011 Cap year (11/1/2010 – 10/31/2011)	30/100= 0.30	31/100= 0.31
2012 Cap year (11/1/2011 – 10/31/2012)	----	39/100= <u>0.39</u>
<b>Total</b>	<b>0.30</b>	<b>0.70</b>

*If Hospice A was not Medicare certified, then the contractor would only consider Ms. Jackson's time in Hospice B.*

**Example 6.** *Hospice A decided that it would like its contractor to calculate its cap using the proportional method beginning with the 2012 cap year. Hospice A admitted Susan Brown on October 1, 2011, and she passed away on October 20, 2011. In computing Hospice A's cap for the 2011 cap year, the contractor uses the streamlined method, which counts beneficiaries for the aggregate cap based on the date of initial election. Since Ms. Brown initially elected the Medicare hospice benefit on October 1<sup>st</sup>, she would not be included in Hospice A's beneficiary count for 2011, but the payments associated with her would be included in the total payments for the 2011 cap calculation. When the contractor calculates the 2012 cap using the proportional method, beneficiaries are counted based on the cap year timeframe (November 1, 2011 to October 31, 2012). As such, Ms. Brown is not included in the 2012 beneficiary count.*

*In the 2012 cap year, the transition from the streamlined method to the proportional method, beneficiaries who initially elect hospice and pass away during the 34 day period between September 28<sup>th</sup> and October 31<sup>st</sup> 2011, would not be included in either the count of beneficiaries for the prior year's streamlined cap calculation or in the approaching year's proportional cap calculation. However, the Medicare payments to the hospice*

*associated with those beneficiaries are included in the total actual payments used in the 2011 cap calculation.*

*Had Ms. Brown lived until November 15, 2011, she would have been included in Hospice A's cap calculation for the 2012 cap year. Her total hospice stay would then have been 46 days, with 15 of those days occurring during the 2012 cap year. Ms. Brown would be counted in the 2012 cap determination as  $15/46=0.33$ .*

#### ***90.2.4 – Changing Aggregate Cap Calculation Methods***

***(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)***

*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.*

### **90.2.5 – Other Issues**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*The computation and application of the aggregate cap is made by the contractor after the cap year ends. The updated 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.*

### **90.2.6 – Updates to the Cap Amount**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*The original cap amount of \$6,500 per year is increased or decreased for accounting years that end after October 1, 1984, by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (CPI-U, United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. The hospice cap is calculated on the basis of a cap year beginning November 1 and ending the following October 31.*

*For example, for the cap amount for the cap year ending October 31, 2011, calculate using the March 2011 CPI-U in the medical care expenditures category of 397.726 and divide by the March 1984 CPI-U in the medical care expenditures category of 105.4 to yield an index of 3.773491 (rounded). The new hospice cap amount is the product of \$6,500 (base year cap) multiplied by 3.773491. Therefore, the cap amount for the period ending October 31, 2011, is \$24,527.69.*

*In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is accomplished.*

### **EXAMPLE**

*10/01/10 - Hospice A is Medicare certified.*

*10/01/10 to 10/31/11 - First cap period (13 months) for hospice A.*

*Statutory cap amount for first Medicare cap year (11/01/09 - 10/31/10) = \$23,874.98*

*Statutory cap amount for second Medicare cap year (11/01/10 - 10/31/11) = \$24,527.69*

*Weighted average cap amount calculation for hospice A:*

*One month (10/01/10 - 10/31/10) at \$23,874.98 = \$23,874.98*

*12 months (11/01/10 - 10/31/11) at \$24,527.69 = \$294,332.28*

*13 month period \$318,207.26 divided by 13 = \$24,477.48 (rounded)*

*In this example, \$24,477.48 is the weighted average cap amount used in the initial cap calculation for Hospice A for the period October 1, 2010, through October 31, 2011.*

**NOTE:** *If Hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.*

### **90.3 – Administrative Appeals**

**(Rev. 156, Issued: 06-01-12, Effective: 04-14-11 for the 2011 Cap Year and Prior Cap Years; October 1, 2011 for the 2012 Cap Year and Subsequent Cap Years; Implementation Date: 07-02-12)**

*The applicable contractor shall issue a letter to notify hospice providers of the results of the contractor's cap calculations and to serve as the provider's determination of program reimbursement. If there is a cap overpayment, there shall be an accompanying demand for repayment. As indicated in 42 CFR 418.311, a hospice that believes that its*

*payments have not been properly determined may request a review from the applicable contractor or the Provider Reimbursement Review Board (PRRB). Each determination of program reimbursement shall include language describing the provider's appeal rights.*

*The above described letter, serving as the provider's determination of program reimbursement, shall include the following language:*

*“This notice is the contractor’s final determination for purposes of appeal rights. If you disagree with this determination, you may file an appeal, in accordance with 42 CFR 418.311 and 42 CFR, part 405, subpart R. The appeal should be filed with either the applicable contractor (FI, RHHI, or A/B MAC) or the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Appeal requests must be in writing and be filed within 180 days from the date of this determination.”*