CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2482	Date: June 1, 2012
	Change Request 7838

SUBJECT: Updates to Caps and Limitations on Hospice Payments

I. SUMMARY OF CHANGES: To remove existing manual language on "Caps and Limitations on Hospice Payments", and replace with a pointer to Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 90.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/80/Caps and Limitations on Hospice Payments
D	11/80.1/Limitation on Payments for Inpatient Care
D	11/80.2/Cap on Overall Hospice Reimbursement
D	11/80.2.1/Services Counted
D	11/80.2.2/Counting Beneficiaries for Calculation
D	11/80.2.3/Adjustments to Cap Amount
D	11/80.3/Administrative Appeal

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

Pub. 100-04	Transmittal: 2482	Date: June 1, 2012	Change Request: 7838

SUBJECT: Updates to Caps and Limitations on Hospice Payments

**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

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: Section 80 and all its accompanying subsections have been revised, and moved from Pub. 100-04, Medicare Claims Processing Manual, chapter 11, to Pub. 100-02, Medicare Benefit Manual, chapter 9, section 90.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7838-04.1	Medicare contractors shall be aware that the former and current hospice caps and limitations on hospice payments policy has been updated and removed from Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 80 through 80.3 and is now located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 90 through 90.3.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7838-04.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ 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 localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

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 or Owen Osaghae, 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.

80 - Caps and Limitations on Hospice Payments

(Rev. 2482, 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)

For information regarding caps and limitations on hospice payments, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, section 90.