August 17, 2017
1:00 – 2:30 pm

2017 HFS User Meeting

Hospice Critical Issues – Enrollment and CAP

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CAP – The Regulations

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- 42 CFR §418.308:
  - …"the total Medicare payment to a hospice for care furnished during a cap period is limited by the hospice cap amount specified in §418.309."
- 42 CFR §418.309:
  - "A hospice's aggregate cap is calculated by multiplying the adjusted cap amount (determined in paragraph (a) of this section) by the number of Medicare beneficiaries for a given cap year described in paragraphs (b) and (c) of this section.

How the CAP Really Works

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- The Medicare program sets the annual per-beneficiary CAP amount each year as level of care ("LOC") payments are updated.
  - The per-beneficiary CAP amount represents the lifetime financial benefit paid to the hospice(s) for hospice services provided.
  - The actual beneficiary count is calculated for each hospice based on one of two methods:
    - Proportional
    - Streamlined
  - The CAP (maximum annual payment) for each CAP Year is calculated in the aggregate (all patients) allowing short-term patients to offset excessive payments for long-term patients.

Calculating the CAP

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- Three Components:
  - Recognition of the CAP Year:
    - 2016 CAP Year – November 1, 2015 through October 31,2016
    - 2017 CAP Year (period) – November 1, 2016 through September 30, 2017
    - 2018 CAP Year – October 1, 2017 through September 30, 2018
  - Individual per-beneficiary CAP:
    - 2016 CAP Year - $27,820.75
    - 2017 CAP Year - $28,404.99
  - Determining beneficiary count:
    - Proportional Method
    - Streamlined Method

Counting Beneficiaries – Proportional Method

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- Each hospice serving the specific patient is entitled to a prorated portion of the individual beneficiary CAP based on the days that the hospice served the patient compared to the total days the patient was served. The proration is between hospices and between CAP Years.
- Medicare Learning Network (MLN Matters Number: MM7838) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7838.pdf.

Proportional Method – Example 1

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- Patient A receives 100 days of total hospice care from the same hospice. 60 days occurred in the 2016 CAP Year and 40 days occurred in the 2017 CAP Year. The beneficiary CAP proration would be as follows:
  - .6000 – 2016 CAP Year; resulting in CAP credit of $16,692.45 ($27,820.75*.6000)
  - .4000 – 2017 CAP Year; resulting in CAP credit of $11,362.00 ($28,404.99*.4000)

Proportional Method – Example 2

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- Patient A receives 120 days of care:
  - 60 by Hospice A in the 2016 CAP Year
  - 40 by Hospice B in the 2016 CAP Year
  - 20 by Hospice B in the 2017 CAP Year
- Hospice A receives .5000 in the 2016 CAP Year (60/120); $13,910.38
- Hospice B receives .3333 in the 2016 CAP Year (40/120); $ 9,272.66
- Hospice B receives .1667 in the 2017 CAP Year (20/120); $ 4,735.11

Counting Beneficiaries – Streamlined Method

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- When beneficiary receives care from only one hospice:
  - The hospice receives the entire beneficiary count (1.0000) based on the admission date:
    - September 28, 2015 through September 27, 2016 (included in the 2016 CAP Year count)
    - September 28, 2016 through September 30, 2017 (included in the 2017 CAP Year count)
    - October 1, 2017 through September 30, 2018 (included in the 2018 Cap Year count)
- When beneficiary receives care from multiple hospices the beneficiary count is based on the CAP Year and calculating on the Proportional Method.

Streamlined Method – Example 1

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- Patient admitted on October 4, 2015; served only by one hospice through February 4, 2017.
  - The Hospice receives the entire beneficiary count (1.000) in the 2016 CAP Year (November 1, 2015 through October 31, 2016). The Hospice receives no credit in the 2017 CAP Year even though the patient continued to be served in that year.

Streamlined Method – Example 2

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- In addition to the patient described in Example 1, the Hospice admitted a patient on October 4, 2015 who was previously served by another hospice for 100 days. The patient was served through January 11, 2016 (100 days). The Hospice is entitled to 100 days (.5000 of the total); 28 days in the 2015 CAP Year and 72 days in the 2016 CAP Year. The Hospice has the following beneficiary counts:
  - 2015 CAP Year (28/200); .1400 beneficiary count
  - 2016 Cap Year (72/200) plus the full beneficiary (1.3600)
- The other hospice is entitled to .5000 beneficiary count.

Sample Calculation

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Medicare beneficiary count	45.8108
Statutory CAP per-beneficiary	$ 27,820.75
Allowable payments (CAP)	$ 1,274,490.81
Gross payments during CAP Year	$ 1,850,001.63
Gross CAP liability	$ 575,510.82
Sequestration add-back (2%)	$ 11,510.22
CAP liability	$ 564,000.60

CAP Reporting Process

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- Step 1: "A hospice must file its aggregate cap determination with its Medicare Administrative Contractor ("MAC") on or before five (5) months after the end of any CAP Year and remit any overpayment at that time." (CFR §418.308(c))
  - "Hospice shall file the aggregate CAP using data no earlier than 3 months after the end of the cap period."
- Step 2: The MAC will update the computation and issue a "Notice of Review of Hospice CAP" ("Original Notice")
- Step 3: Reopening is allowed for up-to three (3) years from the date of the cap determination notice. A revised cap determination letter issued as a result of a reopening may itself be reopened, subject to the three (3) year limitation on reopening.

What is Really Happening?

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- The self-reporting is due on or before five (5) months after the end of the CAP Year (February 28, 2018 for the 2017 Cap Year).
  - The self-reporting ("CAP Report") uses net payments (net of sequestration); accordingly, any liability is actually understated in the report.
    - Hospices should submit using net payments; however, gross payments should be used to assess the true liability that exists at the date of filing.
  - Data used to prepare the report (beneficiary counts and payments) must include data secured through PS&R System no earlier than 90 days after the end of the CAP Year.
    - If the Hospice has or expects to have a CAP liability, data should be secured at the earliest possible date (January 1, 2018 for 2017 CAP Year) to minimize the interim liability.

What is Really Happening?

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- The MACs are not really reviewing the CAP submission, except to validate the report was submitted. Information submitted is not being updated on submission.
  - Hospices have submitted using wrong methods
- Demands are being issued for CAP liabilities as reported; hospices have 15 days from the demand to liquidate the liability or arrange for an Extended Repayment Schedule ("ERS").
- If a request for ERS is submitted, the hospice will have additional time to accumulate all of the required documentation for the ERS.

What is Really Happening?

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- Typically, between September 1st and December 31st, MACs are recalculating the CAP liability based on current PS&R data and issuing Original Notice of CAP Liability ("Original Notice").
  - Using gross payments
  - Providing 15 days to liquidate or request ERS
  - Once ERS requested, provider generally has additional time to accumulate all of the sufficient information for the ERS

What is Really Happening?

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- CAP liability is recalculated each year (generally between September 1st and December 31st) based on current data (beneficiaries and payments).
  - Revised Notice is issued
  - Additional CAP liability is demanded
  - 15 days to liquidate or initiate the ERS request process
- Remember, the beneficiary count continues to decline as patients served during the CAP Year continue to be provided after the end of the CAP Year (proration of the beneficiary count)
- How long can the recalculation continue?

Real Example

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- 2013 CAP Original Notice (5/20/14) $ 0
- 2013 Revised Notice (5/20/15) $ 298,293
- 2013 Revised Notice (1/5/16) $ 42,692
- 2013 Revised Notice (7/14/16) $ 29,159
- 2013 Revised Notice (6/27/17) $ 76,962

- We estimate an additional liability of $32,560 (additional CAP erosion) will be demanded before the 2013 Cap Year is eventually closed.

CAP Management Process

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- If the hospice is substantially under CAP – annual CAP Reporting may be sufficient.
- If over or near CAP, at a minimum:
  - Assess prior and current year CAP (and liability) mid-year (end of July or early August is a good time)
  - Submit CAP Report (assess all completed years)
- If liabilities are significant – assessment may need to be completed on a more periodic basis.

Estimating CAP Erosion

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- Remember, your CAP liability based on payments and PS&R is not your ultimate CAP liability.
- The estimation of any CAP liability requires an estimation of the reduction (erosion) of the beneficiary count as patients continue to be served.
- The final CAP liability is only determined once all patients served during a CAP Year are deceased.

Beneficiary Count Reduction Example

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- 2015 Original CAP Notice 693.1535
- 2015 (8/8/17) 691.6427
- 2015 Estimated Ultimate 684.6020
- Many methods for estimating erosion:
  - Historical experience (numerous variations)
  - First time admissions only
- Length-of-stay:
  - Various methods – internal; discharged patients, on-census patients, others
    - Indicators, CAP length of stay drives CAP

CAP Length of Stay and Critical Elements

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	2012	2013	2014	2015	2016	2017
Current Beneficiaries (Proportional)	440.7388	512.6619	564.3927	696.6111	475.0052	313.8185
Current Patient Days	90,697	95,909	114,451	128,596	113,193	58,439
Reimbursement	$ 13,321,270	$ 14,248,649	$ 17,087,415	$ 19,464,471	$ 16,167,360	$ 8,289,146
Projected Final Beneficiaries	439.5674	510.1494	555.022	663.4697	427.673	311.1501
Reimbursement Per-Day	$ 146.88	$ 148.56	$ 149.30	$ 151.36	$ 142.83	$ 141.84
Per-Beneficiary CAP	$ 25,377.01	$ 26,157.50	$ 26,725.79	$ 27,382.63	$ 27,820.75	$ 28,404.99
Days to CAP	172.78	176.07	179.01	180.91	194.78	200.26
Current CAP Length-of-Stay	205.78	187.08	202.79	184.60	238.30	186.22
Projected CAP Length-of-Stay	206.33	188.00	206.21	193.82	264.67	258.25
Days in Excess of CAP	33.55	11.93	27.20	12.91	69.89	57.99

Correcting Misconceptions

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- Your CAP calculation and liability computed based on current data is not your CAP or the ultimate liability!
- When the MAC issues its “Final Review of CAP Liability”; it is not a Final Review of CAP liability!
- Geography makes huge difference (CAP determined on a national basis – no variance).
- The impact of consolidations and other strategic moves can be significant, i.e. transfer of patients to Proportional hospice from Streamlined hospice.

Medicare Enrollment

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- CMS 855A is institutional enrollment form:
  - Community Mental Health Center
  - CORF
  - CAH
  - End-Stage Renal
  - FQHC
  - Hospital
  - HHA
  - Hospice
  - RHC
  - SNF
  - Others

Enrollment Information

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- Provider
- Practice Location
- Service Areas (some providers)
- Medical records storage
- Ownership – organizations and individuals
  - Direct and indirect
- Other Control - lenders
- Chain operations
- Billing agencies
- Authorized officials

Other Enrollment Forms

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- 855B – Clinics, Group Practices
- 855I – Physicians and non-Physician Practitioners
- 855R – Reassignment of Medicare Benefits
- 855O – Ordering and Referring Physicians

Reporting Changes

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- PECOS or paper –
  - Change in ownership – 30 days
  - Adverse legal action – 30 days
  - Change in practice location – 30 days or 90 days (provider determined)
  - Other changes – 90 days
  - Revalidation – 60 day notice provided, extension available

  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1617.pdf
  - https://data.cms.gov/revalidation

Failure to Report

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- Failure to report changes and to report changes on a timely basis could result in the revocation of Medicare billing privileges.

Fees

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- Initial Enrollment
- Revalidation
- Addition of Practice Location
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf
- 2017 Fee is $560.

Common Reporting Errors

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- Ownership
- Tax-Exempt Provider Boards – Board Members
- Failure to Report Timely Changes

Company A is Indirect Owner, Company B is Direct Owner

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Look Further at Ownership

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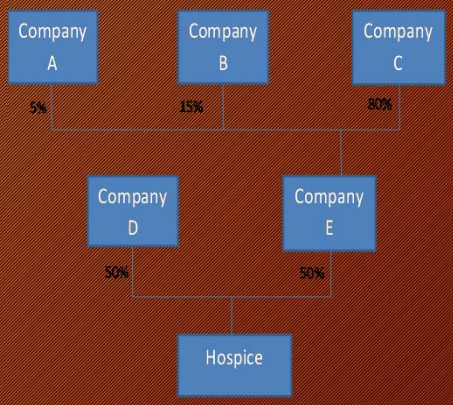

Company A:
2.5% indirect
Company B:
7.5% Indirect
Company C:
40% Indirect
Company D:
50% Direct
Company E:
50% Direct

Be Aware

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- Proposed rules never finalized to comply with Affordable Care Act regarding debt provisions and disclosures (will they be issued)
- However, Medicare enrollment can be denied for various reasons, including:
  - The enrolling provider, supplier, or owner has an existing Medicare debt that existed when the previous enrollment was voluntarily terminated, involuntarily terminated, or revoked and other criteria exist (subject to CMS determination of risk)
  - 42 CFR §424.530

Final Thoughts

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- Update NPI data (consistent with 855A) as necessary
- Contact MAC regarding contact persons:
  - MAC slow to update
  - Mailings lost as a result of out-of-date contact information
- Transfers of access to all systems with acquisitions, mergers, etc.
- Contact person should be identified in all 855A submissions
- 855A is the quickest way for Medicare to cause billing and collection problems for the provider

Critical

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- Periodic review of information on file (855, Pecos) against current information.
- Submission of updates as needed on a timely basis.
  - Recommend all changes be submitted
  - Most important – ownership, practice locations, key personnel, and authorized officials.