CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 246	**Date: September 14, 2018**
	Change Request 10517

SUBJECT: Manual Updates Related to Payment Policy Changes Affecting the Hospice Aggregate Cap Calculation and the Designation of Hospice Attending Physicians

I. SUMMARY OF CHANGES: This Change Request (CR) updates the Internet Only Manual (IOM) with policies related to section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123), which amended section 1861(dd)(3)(B) of the Social Security Act (the Act) such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. This CR also updates sections of the IOM with policies related to the calculation methodology for the cap amount for hospices required by section 1814(i)(2)(B)(i) and (ii) of the Act, as added by section 3(b) of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 (Pub. L. 113–185). In addition, this CR includes IOM updates to polices regarding timeframe and accounting procedures for the cap amount for hospices as discussed in the fiscal year (FY) 2016 Hospice Wage Index and Payment Rate Update final rule published on August 6, 2015.

EFFECTIVE DATE: December 17, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 17, 2018
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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/Table of Contents
R	9/10 - Requirements - General
R	9/20.1 - Timing and Content of Certification
R	9/20.2.1 – Hospice Election
R	9/20.2.1.1 - Hospice Notice of Election
R	9/40.1.3.1 - Attending Physician Services
R	9/40.1.3.2 - Nurse Practitioners as Attending Physicians
N	9/40.1.3.3 – Physician Assistants as Attending Physicians
R	9/90 - Caps and Limitations on Hospice Payments
R	9/90.1 - Limitation on Payments for Inpatient Care
R	9/90.2 - Aggregate Cap on Overall Reimbursement to Medicare-certified Hospices
R	9/90.2.1 – New Hospices
R	9/90.2.2 – Counting Beneficiaries for Calculation
R	9/90.2.3 – Changing Aggregate Cap Calculation Methods
R	9/90.2.4 – Other Issues
R	9/90.2.5 – Updates to the Cap Amount
D	9/90.2.6 - Updates to the Cap Amount
R	9/90.3 - Administrative Appeals

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-02	Transmittal: 246	Date: September 14, 2018	Change Request: 10517

SUBJECT: Manual Updates Related to Payment Policy Changes Affecting the Hospice Aggregate Cap Calculation and the Designation of Hospice Attending Physicians

EFFECTIVE DATE: December 17, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE December 17, 2018

I. GENERAL INFORMATION

A. Background: Section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) amended section 1861(dd)(3)(B) of the Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. Sections 1814(i)(2)(B)(i) and (ii) of the Act were amended by section 3(b) of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 (Pub. L. 113–185), which describes the calculation methodology for the aggregate cap amount for hospices. Additionally, in the fiscal year (FY) 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47141), CMS finalized policies related to the methodology used to calculate cap amounts for hospices as well as polices related to the timeframe and accounting procedures for cap amount for hospices.

B. Policy: Section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) requires that, effective January 1, 2019, physician assistants (PAs) be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. The Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been revised to reflect the inclusion of PAs as hospice attending physicians. Additionally, the Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been updated to reiterate that designated hospice attending physicians who are nurse practitioners or physician assistants may not certify a hospice patient as terminally ill in accordance with section 1814(a)(7) of the Social Security Act, which requires that no one other than a medical doctor or doctor of osteopathy can certify or re-certify terminal illness for the Medicare hospice benefit.

Section 3(b) of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 (Pub. L. 113–185) required that the hospice aggregate cap for accounting years ending after September 30, 2016 and before October 1, 2025, be updated by the hospice payment update percentage rather than using the consumer price index for urban consumers (CPI–U). This provision will sunset for cap years ending after September 30, 2025, at which time the annual update to the cap amount will revert back to the original methodology. These policies were finalized in the fiscal year (FY) 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47141). The Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been updated to reflect the revised hospice aggregate cap calculation methodology.

In the fiscal year (FY) 2016 Hospice Wage Index and Payment Rate Update final rule published on August 6, 2015 (80 FR 47141), we finalized the alignment of the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and later. The Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been revised to reflect the changes made to the hospice cap accounting year and to provide descriptive examples for cap calculations.

The timeframes in which beneficiaries and payments are counted for the purposes of determining each individual hospice's aggregate cap amount as well as the timeframes for determining whether a given hospice exceeded the cap for the transition year (2017 cap year) are outlined in the attached table "**Hospice Aggregate Cap Timeframes for Counting Beneficiaries and Payments for the Alignment of the Cap Year with the Federal Fiscal Year**." In addition, the timeframes for the 2018 cap year, which will remain consistent for all future cap years, are also included in the table.

Also included in this update to chapter 9 are clarifications regarding retroactive Medicare entitlement and NOE exceptions. Section 418.24(a)(4) of the Code of Federal Regulations describes exceptions to the consequences of failure to submit a timely NOE. This CR provides clarification that retroactive Medicare entitlement qualifies as one of the exceptions to a timely-filed NOE as this would be a circumstance that is beyond the hospice's control.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10517.1	The contractors shall be aware of the revisions to Pub. 100-02, chapter 9 related to the policies discussed in this CR.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10517.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 chapter 6, section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10131	CR 10131 contains the related implementation and systems requirements.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Hillary Loeffler, 410-786-0456 or hillary.loeffler@cms.hhs.gov, Laura Ashbaugh, 410-786-1113 or laura.ashbaugh@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 2

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

Table of Contents
(Rev.246, Issued: 09-14-18)

10 - Requirements - General

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. Only care provided by (or under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit.

The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

(1) Diagnosis of the terminal condition of the patient.
(2) Other health conditions, whether related or unrelated to the terminal condition.
(3) Current clinically relevant information supporting all diagnoses.

Section 1814(a)(7) of the Social Security Act (the Act) specifies that certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician, if he/she has one, regarding the normal course of the individual's illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits. "Attending physician" is further defined in section 20.1 and 40.1.3.1.

An individual (or his authorized representative) must elect hospice care to receive it. The first election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods, and an unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice. Hospices obtain election statements from the individual and file a Notice of Election with the *Medicare contractor*, which transmits them to the Common Working File (CWF) in electronic format. Once the initial election is processed, CWF maintains the beneficiary in hospice status until a final claim indicates a discharge (alive or due to death) or until an election termination is received.

For the duration of the election of hospice care, an individual must waive all rights to Medicare payments for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and

- Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services provided by:

    1. The designated hospice (either directly or under arrangement);

    2. Another hospice under arrangements made by the designated hospice; or

    3. The individual's attending physician, who may be a nurse practitioner (NP) *or a physician assistant (PA)*, if that physician*, NP, or PA* is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care.

20.1 - Timing and Content of Certification

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

For the first 90-day period of hospice coverage, the hospice must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

The attending physician is a doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which he or she performs that function, a nurse practitioner, *or physician assistant,* and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. A nurse practitioner is defined as a registered nurse who performs such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets training, education, and experience requirements described in 42 CFR 410.75. *A PA is defined as a professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform (in the State in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets the training, education, and experience requirements as the Secretary may prescribe. The PA qualifications for eligibility for furnishing services under the Medicare program can be found in the regulations at 42 CFR 410.74 (c).*

Note that a rural health clinic or federally qualified healthcare clinic (FQHC) physician can be the patient's attending physician but may only bill for services as a physician under regular Part B rules. These services would not be considered rural health clinic or FQHC services or claims (e.g., the physicians do not bill under the rural health clinic provider number but they bill under their own provider number).

Initial certifications may be completed up to 15 days before hospice care is elected. Payment normally begins with the effective date of election, which is the same as the admission date. If the physician forgets to date the certification, a notarized statement or some other acceptable documentation can be obtained to verify when the certification was obtained.

For the subsequent periods, recertifications may be completed up to 15 days before the next benefit period begins. For subsequent periods, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's IDG. If the hospice cannot obtain written certification within 2 calendar days, it must obtain oral certification within 2 calendar days. When making an oral certification, the certifying physician(s) should state that the patient is terminally ill, with a prognosis of 6 months or less. Because oral certifications are an interim step sometimes needed while all the necessary documentation for the written certification is gathered, it is not necessary for the physician to sign the oral certification. Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.

The hospice must obtain written certification of terminal illness for each benefit period, even if a single election continues in effect.

A written certification must be on file in the hospice patient's record prior to submission of a claim to the *Medicare contractor*. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

A complete written certification must include:

1. the statement that the individual's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course;

2. specific clinical findings and other documentation supporting a life expectancy of 6 months or less;

3. the signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers (for more on signature requirements, see Pub. 100-08, Medicare Program Integrity Manual, chapter 3, section 3.3.2.4).

4. as of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms;

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.

- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.

- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.

- For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

5. face-to-face encounter. For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements specified in this section results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

The face to face encounter requirement is satisfied when the following criteria are met:

a. Timeframe of the encounter: The encounter must occur prior to the recertification for the third benefit period and each subsequent benefit period. The encounter must occur no more than 30 calendar days before the third benefit period recertification and each subsequent recertification. A

face-to-face encounter may occur on the first day of the benefit period and still be considered timely. (Refer to section 20.1.5.d below for an exception to this timeframe).

b. Attestation requirements: A hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a nurse practitioner or non-certifying hospice physician performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.

c. Practitioners who can perform the encounter: A hospice physician or a hospice nurse practitioner can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A hospice nurse practitioner must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice. If the hospice is a subdivision of an agency or organization, an employee of that agency or organization assigned to the hospice is also considered a hospice employee. Physician Assistants (PAs), clinical nurse specialists, and outside attending physicians are not authorized by section 1814(a)(7)(D)(i) of the Act to perform the face-to-face encounter for recertification.

d. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period: In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face to face encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a face to face encounter, a face to face encounter can be deemed as complete.

Recertifications that require a face-to-face encounter but which are missing the encounter are not complete. The statute requires a complete certification or recertification in order for Medicare to cover and pay for hospice services. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations.

The hospice must file written certification statements and retain them in the medical record. Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.

These requirements also apply to individuals who had been previously discharged during a benefit period and are being recertified for hospice care.

20.2.1 - Hospice Election

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Each hospice designs and prints its election statement. The election statement must include the following items of information:

Identification of the particular hospice that will provide care to the individual;

The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;

The individual's or representative's (as applicable) acknowledgment that the individual understands that certain Medicare services are waived by the election;

The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive;

The individual's designated attending physician (if any). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician, Nurse Practitioner (NP), *or Physician Assistant (PA)* was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician.

The individual's acknowledgment that the designated attending physician was the individual's or representative's choice.

The signature of the individual or representative.

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(1) Remains in the care of a hospice;
(2) Does not revoke the election; and
(3) Is not discharged from the hospice.

For Medicare payment purposes, an election for Medicare hospice care must be made on or after the date that the hospice provider is Medicare-certified. As with any election, the hospice must fulfill all other admission requirements, such as certification or recertification, any required face-to-face encounters, or Conditions of Participation (CoP) assessments. See also Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 20.1.1.

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election, but is a transfer. To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:

- the name of the hospice from which the individual has received care,
- the name of the hospice from which they plan to receive care, and
- the date the change is to be effective.

As described in Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 20.1.1, when a hospice patient transfers to a new hospice, the receiving hospice must file a new Notice of Election; however, the benefit period dates are unaffected. The receiving hospice must complete all assessments required by the hospice conditions of participation as described in 42 CFR 418.54. Because the benefit period does not change in a transfer situation, if the patient is in the third or later benefit period and transfers hospices, a face-to-face encounter is not required if the receiving hospice can verify that the originating hospice had the encounter.

A change of ownership of a hospice is not considered a change in the patient's designation of a hospice and requires no action on the patient's part.

Medicare beneficiaries enrolled in managed care plans may elect hospice benefits. Federal regulations require that the Medicare contractor assigned the hospice specialty workload maintain payment responsibility for hospice services and may pay for other claims if that *Medicare* contractor is the geographically assigned Medicare contractor for the managed care enrollees who elect hospice; for specifics, see regulations at 42 CFR 417, Subpart P, 417.585, Special Rules: Hospice Care (b), and 42 CFR 417.531 Hospice Care Services (b). Institutional claims for services not related to the terminal illness would otherwise be the responsibility of another geographically assigned Medicare contractor.

Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service *Medicare* contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked. As specified above, by regulation, the duration of payment responsibility by fee-for-service *Medicare* contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 2, "Admission and Registration" and Chapter 11, "Processing Hospice Claims," for requirements for hospice reporting to the Medicare contractor.

20.2.1.1 - Hospice Notice of Election

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Upon electing the Medicare hospice benefit, the beneficiary waives the right to Medicare payment for any Medicare services related to the terminal illness and related conditions (i.e., the patient's prognosis) during a hospice election, except when provided by, or under arrangement by, the designated hospice or individual's attending physician if he or she is not employed by the designated hospice (42 CFR 418.24 (d)). Prompt filing of the hospice Notice of Election (NOE) with the Medicare contractor is required to properly enforce this waiver and prevent inappropriate payments to non-hospice providers. The effective date of hospice election is the same as the hospice admission date.

Timely-filed hospice NOEs shall be filed within 5 calendar days after the hospice admission date. A timely-filed NOE is one that is submitted to and accepted by the Medicare contractor within 5 calendar days after the hospice election. The practical meaning of 'submitted to and accepted by the Medicare contractor' is that the NOE was not returned to the provider for correction.

Example: The date of hospice election is October 1st. A timely-filed NOE would be submitted and accepted by the Medicare contractor on or before October 6th.

In instances where a NOE is not timely-filed, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days shall be provider liable, and the provider shall not bill the beneficiary for them.

Example: The date of hospice election is October 1st. The NOE was not submitted and accepted by the Medicare contractor until October 10th. Provider liable days would be October 1st through October 9th.

There may be some circumstances that may be beyond the control of the hospice where it may not be possible to timely-file the NOE within 5 calendar days after the effective date of election or timely-file the Notice of Termination or Revocation (NOTR) (see section 20.2.4 - Hospice Notice of Termination or Revocation) within 5 calendar days after the effective date of a beneficiary's discharge or revocation. Therefore, the regulations do allow for exceptions. There are four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than 5 calendar days after the effective date of election. These exceptional circumstances are as follows:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;

2. An event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice;

3. A newly Medicare-certified hospice that is notified of certification after the Medicare certification date, or is awaiting its user ID from its Medicare contractor; or,

4. Other circumstances determined by CMS to be beyond the control of the hospice.

If one of the four circumstances described above prevents a hospice from timely-filing its NOE, the hospice must document the circumstance to support a request for an exception, which would waive the consequences of filing the NOE late. Using that documentation, the hospice's Medicare contractor will determine if a circumstance encountered by a hospice qualifies for an exception to the consequences for filing an NOE more than 5 calendar days after the effective date of election. If the request for an exception is denied, the Medicare contractor will retain the decision of the denial. Hospices retain their usual appeal rights on the claim for payment.

A retroactive Medicare entitlement qualifies as one of the exceptions to a timely-filed NOE as this would be a circumstance that is beyond the hospice's control. An individual must be entitled to Medicare Part A in order to be eligible to receive services under the Medicare hospice benefit and an individual who receives retroactive Medicare entitlement is entitled to Medicare hospice services effective on the first day of that entitlement. In the event of retroactive Medicare entitlement, the hospice would submit a request for an exception, which would waive the consequences of filing the NOE late. To receive an exception, the individual must meet eligibility requirements under the Medicare hospice benefit and must have elected to receive services under the Medicare hospice benefit. Therefore, the hospice must be able to provide the following documentation to Medicare contractors and/or CMS, if requested:

(1) Proof of retroactive Medicare entitlement;
(2) The certification of terminal illness that meets the criteria set forth in section 20.1; and
(3) The hospice election statement that meets the criteria set forth in section 20.2.1.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 11, "Processing Hospice Claims" for requirements for NOE submission, reporting provider-liable days, and qualifying circumstances for a request for exception.

40.1.3.1 - Attending Physician Services

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

The attending physician is a doctor of medicine or osteopathy, a nurse practitioner, *or a physician assistant* and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

The election statement must include the patient's choice of attending physician. The information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician, NP*, or PA* was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician. Hospices have the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in 42 CFR 418.24(b) are met. The language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient's (or representative's) choice.

If a patient (or representative) wants to change his or her designated attending physician, he or she must follow a procedure similar to that which currently exists for changing the designated hospice. Specifically, the patient (or representative) must file a signed statement with the hospice that identifies the new attending physician in enough detail so that it is clear which physician, NP, *or PA* was designated as the new attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician. The statement must include the date the change is to be effective, the date that the statement is signed, and the patient's (or representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or representative's) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.

40.1.3.2 - Nurse Practitioners as Attending Physicians

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

A nurse practitioner is defined as a registered nurse who is permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets training, education and experience requirements described in 42 CFR 410.75.

If a beneficiary does not have an attending physician or a nurse practitioner who has provided primary care prior to or at the time of the terminal illness, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice. The beneficiary must be provided with a choice of a physician or a nurse practitioner.

Medicare pays for attending physician services provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and who have selected a nurse practitioner as their attending physician. This applies to nurse practitioners without regard to whether they are hospice employees.

Physician services provided by nurse practitioners may be billed to Medicare only if the:

- Nurse practitioner is the beneficiary's designated attending physician; and
- Services are medically reasonable and necessary; and
- Services are performed by a physician in the absence of the nurse practitioner; and
- Services are not related to the certification of terminal illness.

If the nurse practitioner is employed by the hospice, the hospice can bill Part A for physician services meeting the above criteria on a hospice claim. If the nurse practitioner is not employed by the hospice, the nurse practitioner can bill Part B for physician services meeting the above criteria.

Payment for nurse practitioner services is made at 85 percent of the physician fee schedule amount. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Nurse practitioners cannot certify *or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.* In the event that a beneficiary's attending physician is a nurse practitioner *or a physician assistant*, the hospice medical director *or the physician member of the hospice IDG certifies the individual as terminally ill.*

Hospice nurse practitioners may conduct face-to-face encounters as described in §20.1(5) as part of the certification process, but are still prohibited by statute from certifying the terminal illness.

40.1.3.3 – Physician Assistants as Attending Physicians

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by physician assistants (PAs) to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician. PAs are paid 85 percent of the fee schedule amount for their services as designated attending physicians.

A physician assistant is defined as a professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform (in the State in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets the training, education, and experience requirements as the Secretary may prescribe. The physician assistant qualifications for eligibility for furnishing services under the Medicare program can be found in the regulations at 42 CFR 410.74 (c).

If a beneficiary does not have an attending physician, a nurse practitioner, or physician assistant who has provided primary care prior to or at the time of the terminal illness, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice. The beneficiary must be provided with a choice of a physician or a nurse practitioner.

Medicare pays for attending physician services provided by physician assistants to Medicare beneficiaries who have elected the hospice benefit and who have selected a physician assistant as their attending physician. This applies to physician assistants without regard to whether they are hospice employees.

Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by PAs to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician. PAs are paid 85 percent of the fee schedule amount for their services as designated attending physicians.

Attending physician services provided by PAs may be separately billed to Medicare only if:

- *The PA is the beneficiary's designated attending physician; and*
- *Services are medically reasonable and necessary; and*
- *Services would normally be performed by a physician in the absence of the PA, whether or not the PA is directly employed by the hospice; and*
- *Services are not related to the certification of terminal illness.*

If the physician assistant is employed by the hospice, the hospice can bill Part A for physician services meeting the above criteria on a hospice claim. If the physician assistant is not employed by the hospice, the physician assistant can bill Part B for physician services meeting the above criteria. PAs are authorized to furnish physician services under their State scope of practice, under the general supervision of a physician; therefore the regulations at 42 CFR 410.150(a)(15) require that payment for PA services may be made to the employer or contractor of a PA.

Payment for physician assistant services is made at 85 percent of the physician fee schedule amount. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Since PAs are not physicians, as defined in 1861(r)(1) of the Act, they may not act as medical directors or physicians of the hospice or certify the beneficiary's terminal illness and hospices may not contract with a PA for their attending physician services as described in section 1861(dd)(2)(B)(i)(III) of the Act, which outlines the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the agency or organization. All of these provisions apply to PAs without regard to whether they are hospice employees.

Physician assistants cannot certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

The hospice face-to-face encounter must be performed by a hospice physician or hospice nurse practitioner. PAs may not perform the face-to-face encounter.

90 – Caps and Limitations on Hospice Payments

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

To ensure that hospice care does not exceed the cost of conventional care, there are two annual limits to hospice payments. The statute requires that hospice payments be limited by an inpatient cap and by an aggregate cap in any given cap year. The cap determinations are calculated on an annual basis. Any amounts in excess of either cap are considered to be overpayments, and must be repaid to Medicare. *The hospice inpatient cap limits the total number of Medicare inpatient days to no more than 20 percent of a hospice's total Medicare hospice days. The hospice aggregate cap limits the total aggregate payments any individual hospice can receive in a cap year to an allowable amount, based on an annual per beneficiary cap amount & the number of beneficiaries served.*

Medicare contractors complete the hospice cap determinations for the inpatient cap after the end of the cap year. Hospices must file their self-determined aggregate cap determination notice with their Medicare contractor no later than 5 months after the end of the cap year and remit any overpayment due at that time. The Medicare contractor then reconciles all payments at the final cap determination. If a provider fails to file its aggregate cap determination 5 months after the end of the cap year, payments to the provider are suspended in whole or in part until the self-determined cap is filed with the Medicare contractor.

For the 2016 cap year and earlier, the cap year for the inpatient and aggregate cap runs from November 1st to October 31st. For the 2018 cap year and later, the cap year for both the inpatient and aggregate cap, as well as the timeframes in which beneficiaries and payments are counted for the purposes of determining each individual hospice's aggregate cap aligns with the federal fiscal year (i.e., October 1st to September 30th).

In the year of transition (2017 cap year), for the inpatient cap, the Medicare contractors will calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care and respite care) from November 1, 2016 through September 30, 2017 (11 months). For the 2017 cap year, hospices using the patient-by-patient proportional method for their aggregate cap determinations should count beneficiaries from November 1, 2016 to September 30, 2017. For those hospices using the streamlined method for their aggregate cap determinations, hospices should count beneficiaries from September 28, 2016 to September 30, 2017, which is 12 months plus 3 days, in that cap year's calculation. For the counting of hospice payments, hospices using either the streamlined method or the patient-by-patient proportional method, hospices should count 11 months of payments from November 1, 2016 to September 30, 2017 for the 2017 cap year. For the 2018 cap year and later, hospices should count both beneficiaries and payments, regardless of whether the streamlined or the patient-by-patient proportional methods are used, from October 1 to September 30.

Hospice Aggregate Cap Timeframes for Counting Beneficiaries and Payments for the Alignment of the Cap Year with the Federal Fiscal Year

Cap year	***Beneficiaries***		***Payments***	
	Streamlined method	*Patient-by-patient proportional method*	*Streamlined method*	*Patient-by-patient proportional method*
2016	*9/28/15-9/27/16*	*11/1/15-10/31/16*	*11/1/15-10/31/16*	*11/1/15-10/31/16*

2017 (Transition Year)	*9/28/16-9/30/17 (12 months & 3 days)*	*11/1/16-9/30/17 (11 months)*	*11/1/16-9/30/17 (11 months)*	*11/1/16-9/30/17 (11 months)*
2018 and later	*10/1-9/30*	*10/1-9/30*	*10/1-9/30*	*10/1-9/30*

90.1 – Limitation on Payments for Inpatient Care

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. *The total inpatient days reported for both general inpatient and inpatient respite care may not exceed 20% of the total Medicare days reported by the hospice for a cap year.* This limitation is applied once each year, at the end of the hospice*'*s **"**cap *year.*" The inpatient cap is calculated by the *Medicare 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:

   - *Divide the maximum allowable inpatient days by total inpatient days reported on the Provider Statistical and Reimbursement Report (PS&R). Multiply the resulting ratio against total inpatient care reimbursement reported on the PS&R.*

   - Multiply the excess inpatient care days by the routine home care (RHC) rate, wage adjusted for the location of the hospice.

   - Add together the amounts calculated in the two bullets above to derive the total allowable payments for inpatient care.

   - Compar*e* 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" *(i.e., the cap year)* 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 *(representing Inpatient Respite Care and General Inpatient Care, respectively)* for services provided between October *1st and September 30th* 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 *of $192.78,* wage adjusted for a hospice located in Redding, California, using the FY 201*8* Wage Index value of *1.4968, leading to a wage-adjusted rate of $288.55*:

2,000 x $*288.55*= $*577,100*= 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 + $*577,100*= $*3,777,100*= inpatient cap.

Compare $*3,777,100* inpatient cap with $4,000,000 actually paid for inpatient revenue codes.

The hospice must refund $4,000,000 - $*3,777,100*= $*222,900*

If a provider's covered days of hospice care or Medicare payments are adjusted through an audit or other review, the *Medicare contractor* may recalculate the inpatient cap if the amount is material.

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

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Overall aggregate Medicare payments made to a Medicare-certified hospice are subject to an aggregate cap *for each cap year.* The aggregate cap is calculated by multiplying a Medicare beneficiary count during the period by a statutory "cap amount." *The cap amount is adjusted annually.* The Medicare beneficiary count is determined using either the proportional method or the streamlined method, as described in section 90.2.*2* below.

The total actual Medicare payments made for services furnished to Medicare beneficiaries during the cap year are compared to the aggregate cap for this period. *"Total actual Medicare payments made for services furnished to Medicare beneficiaries during the cap year" refers to Medicare payments for services rendered during the cap year, regardless of when payment is actually made. 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* – New Hospices

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

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.

Hospices and Medicare contractors shall use the proportional method when calculating the aggregate cap for all hospices which are Medicare-certified on or after October 1, 2011 *(as described in Section 90.2.2 below).*

90.2.*2* – Counting Beneficiaries for Calculation

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

Each hospice's cap amount is calculated by multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period.

The two methods for counting beneficiaries are the streamlined method and the proportional method, and are explained below.

Proportional Method: Under the proportional method, each hospice 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, 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.

The fractional share for any given beneficiary counted using the proportional method shall be calculated as follows:

Proportion = Beneficiary's Hospice Days in Cap Year in a Distinct Hospice / Beneficiary's Total Hospice Days for all Years

When a hospice's cap is calculated using the proportional method, and a beneficiary included in that calculation survives into another cap year, the *Medicare 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: *This method is used by e*ligible hospices *that had their cap determinations calculated using the streamlined method for all cap years prior to cap year 2012 and elected to have their cap determination for cap years 2012 and beyond calculated using the streamlined method. The method that these hospices must use is described below.*

- **When a beneficiary receives care from only one hospice:** *Each beneficiary is counted as 1 in the first year of services with that hospice facility and will not be counted in any following years.* 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 *timeframe for counting beneficiaries associated with 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, 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.

Beneficiary Counting Examples

The following examples are for illustrative purposes only.

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. ***(One Hospice).***

Jane Smith, a Medicare beneficiary, initially elected hospice care from Hospice A beginning on June 1, 201*8*. Her condition improved, and she was discharged from Hospice A on August 15, 201*8*, as she was no longer terminally ill. However, in *November* 201*8* Ms. Smith's condition worsened; she re-elected hospice at Hospice A on *November* 15, 201*8*, and subsequently died on *December* 2*7*, 201*8*.

Streamlined Method: Hospice A would count Ms. Smith as 1 in its 201*8* cap year, but would not count Ms. Smith again in its 201*9* 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. *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.*

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

201*8* cap year (June 1st – August 15th):	76 days	=	76/119 =	0.64
201*9* cap year (*Nov* 15th – *Dec* 2*7*th):	43 days	=	43/119 =	0.36
Total days:	119 days	=		1.00

Hospices and Medicare contractors use the best data available at the time the cap is calculated to determine the proportional allocation of Ms. Smith's time. Because the *Medicare 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 201*8* cap is calculated the *Medicare contractor* would have information about Ms. Smith's complete hospice stay. Therefore, the *Medicare contractor* is able to correctly count Ms. Smith's stay for the 201*8* and 201*9* cap determinations, without having to make prior year adjustments to her proportional shares.

Example 2. ***(Reopening/Adjustment).***

*Continuing with the proportional method scenario from Example 1 above, h*ad Ms. Smith lived until August 25, 201*9*, the *hospice and the Medicare contractor* would consider the information *available* at the time *of* the cap calculation when determining proportional shares.

For example, if the *hospice* calculated the 201*8* cap on *February 15*, 201*9*, using claims for dates of service through *December* 3*1*, 201*8*, Ms. Smith's total stay would have been *1*2*3* days, and the 201*8* proportional share would be 76 / *1*2*3* = 0.*6*2.

Cap Accounting with Claims through December 31, 2018:				
2018 cap year (June 1st – August 15th):	*76 days*	=	*76/123 =*	*0.62*
2019 cap year (Nov 15th – Dec 31st):	*47 days*	=	*47/123 =*	*0.38*
Total days:	*123 days*	=		*1.00*

When calculating the 201*9* cap determination *using claims for dates of service through December 31, 2019*, the *Medicare contractor* would be able to re-open the 201*8* cap determination and correct the proportional allocation made in the previous cap year, to reflect a final allocation of 76/3*6*0 = 0.2*1* for the 201*8* cap determination and 2*8*4/3*6*0 = 0.7*9* in the 201*9* cap determination*, reflecting the final date of August 25, 2019*.

Cap Accounting with Claims through December 31, 2019:

2018 cap year (June 1st – Aug 15th):	*76 days*	*= 76/360 =*	*0.21*
2019 cap year (Nov 15th – Aug 25th):	*284 days*	*= 284/360 =*	*0.79*
Total days:	*360 days*	*=*	*1.00*

Example 3. ***(Two Different Hospices)***.

Jane Smith, a Medicare beneficiary, initially elected hospice care from Hospice A *beginning on* June *1,* 201*8*. *Her condition improved, and she was discharged from Hospice A on August 15, 2018, as she was no longer terminally ill. However, in January 2019, Ms. Smith's condition worsened; she re-elected hospice at Hospice B on January 15, 2019, and subsequently died on February 26, 2019.*

Streamlined Method:

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 (as described below). Therefore, Hospice A would count Ms. Smith as a fraction (0.64) in its 2018 cap year and would not count Ms. Smith again in its 2019 cap year. Hospice B would count Ms. Smith as a fraction (0.36) in its 2019 cap year and would not count Ms. Smith in its 2018 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:

Under the proportional method, Ms. Smith would be counted as follows:

Hospice A:

2018 cap year (June 1st – August 15th):	*76 days*	*= 76/119 =*	*0.64*

Hospice B

2019 cap year (Jan 15th - Feb 26th):	*43 days*	*= 43/119 =*	*0.36*
Total days:	*119 days*	*=*	*1.00*

The Medicare 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 Medicare 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 2018 cap is calculated the Medicare contractor would have information about Ms. Smith's complete hospice stay. Therefore, the Medicare contractor is able to correctly count Ms. Smith's stay for the 2018 and 2019 cap determinations, without having to make prior year adjustments to her proportional shares.

90.2.*3* – Changing Aggregate Cap Calculation Methods

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

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) *H*ospices 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. A/B MACs (HHH) 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.*4* – Other Issues

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

The computation of the aggregate cap is made by the *hospice* after the cap year ends*, which now is in alignment with the federal fiscal year*.

Hospices can obtain instructions regarding the cap determination method election process from their *Medicare contractor*. Regardless of which method is used, the *Medicare 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.

If a provider's covered days of hospice care or Medicare payments are adjusted through an audit or other review, the *Medicare contractor* may recalculate the aggregate cap if the amount is material.

90.2.*5* – Updates to the Cap Amount

(Rev. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

*T*he aggregate cap *amount was set at $6,500 per beneficiary when first enacted in 1983. Since 1983, the $6,500 amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI–U, United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the cap year, as required by section 1814(i)(2)(B) of the Act.*

Section 1814(i)(2)(B)(i) and (ii) of the Act, as added by section 3(b) of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 (Pub. L. 113–185) requires, effective for the 2016 cap year

(November 1, 2015 through October 31, 2016), that the cap amount for the previous year to be updated by the hospice payment update percentage, rather than the original $6,500 being annually adjusted by the change in the CPI–U for medical care expenditures since 1984. This provision will sunset for cap years ending after September 30, 2025, at which time the annual update to the cap amount will revert back to the original methodology.

In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year, 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 *(Cap amounts utilized in this example are for illustrative purposes only and do not reflect actual cap amounts.)*

09/01/1*8* - Hospice A is Medicare certified.

*09/*01/1*8 to* 10/31/1*9* - First cap period (13 months) for hospice A.

Statutory cap amount for first Medicare cap year *(09/*01*/18 - 09/*3*0/18) = $*2*8,000.00*

Statutory cap amount for second Medicare cap year
*(*1*0/*01*/18 - 09/*3*0/*1*9) = $28,*5*00.00*

Weighted average cap amount calculation for hospice A:

One month (*09/*01*/18 – 09/*3*0/18*) at $2*8*,000.00* = $2*8*,000.00*

12 months (1*0/*01/1*8 - 09/*3*0/19*) at $2*8*,500.00* = $*342*,000.00*

13 month period $3*70,000.00* divided by 13 = $2*8,*4*61.54* (rounded)

In this example, $*28,*4*61.54* is the weighted average cap amount used in the initial cap calculation for Hospice A for the period *September* 1, 201*8*, through *September* 3*0*, 201*9*.

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. 246, Issued: 09-14-18, Effective: 12-17- 18, Implementation: 12-17-18)

The applicable *Medicare contractor* shall issue a *Cap Determination L*etter to notify hospice providers of the results of the *Medicare contractor*'s cap calculations and to serve as the provider's *Notice* of *P*rogram *R*eimbursement *(NPR)*. 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 *Medicare 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 *Medicare 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 *Medicare contractor* 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."

Hospice Aggregate Cap Timeframes for Counting Beneficiaries and Payments for the Alignment of the Cap Accounting Year with the Federal Fiscal Year

Cap year	Beneficiaries		Payments	
	Streamlined method	Patient-by-patient proportional method	Streamlined method	Patient-by-patient proportional method
2016	9/28/15-9/27/16	11/1/15-10/31/16	11/1/15-10/31/16	11/1/15-10/31/16
2017 (Transition Year)	9/28/16-9/30/17	11/1/16-9/30/17	11/1/16-9/30/17	11/1/16-9/30/17
2018 and later	10/1-9/30	10/1-9/30	10/1-9/30	10/1-9/30