Eli's Hospice Insider

Reimbursement: New Short Cap Repayment Timeline Will Prove Burdensome

CMS implements new aggregate cap procedures but leaves inpatient cap as-is.

If you fail to meet a new requirement finalized in Medicare's 2015 hospice payment final rule, your reimbursement will freeze in its tracks.

The **Centers for Medicare & Medicaid Services** has finalized its proposal to require hospices to "submit [their] aggregate cap determination 5 months after the end of the cap year and refund any overpayment with the filed cap determination," it says in the rule published in the Aug. 22 Federal Register. Hospices must calculate their own caps using the PS&R report they access electronically, CMS directs.

Consequence: "Hospices which fail to file their self-determined cap determination will have their payments suspended," CMS says in the rule.

CMS did drop its similar requirement for inpatient caps, due to the complexity of the inpatient cap calculation and the low incidence of hospices that exceed that cap. But CMS will "continue to monitor the inpatient cap and consider implementing in the future if needed," the agency warns in the rule.

Commenters on the proposed rule voiced concerns that hospices could "game" the system by calculating their cap too early immediately after the cap year ends. That would understate their cap liability for the year.

How it will work: So CMS put in place a new protection against gaming. "In order to allow a reasonable number of claims to be processed, the hospice shall wait at least 3 months after the end of the cap year, or January 31, 2016, before attempting to calculate the cap overpayment," CMS instructs in the rule. "Thus, the cap determination would be calculated after January 31, 2016 but before March 31, 2016 and the overpayment would be submitted at the same time as the cap determination."

Then, during the usual timeframe, the HHH Medicare Administrative Contractor will calculate the hospice's cap and reconcile any resulting overpayment amount.

Also, "we plan to continue to monitor hospices that may be 'gaming' the system, and CMS has the option of performing a cap review at any time after the end of the cap year, if needed," the agency says in the rule.

Despite the new three-month floor safeguard, "five months after the end of the year is too soon to 'settle' on the liability," says finance expert **Mark Sharp** with **BKD** in Springfield, Mo. "That cap year's liability can increase significantly after the five-month reporting/payment deadline and, therefore, they will have an additional liability to pay later," Sharp warns.

CMS insists that "most claims have been processed" by the three-month mark.

Don't Delay: Register For IACS

In general, the new requirement is "doable," allows consultant **Roseanne Berry** with **R&C Healthcare Solutions** in Phoenix.

"The new cap reporting requirement should not be too burdensome for agencies," Sharp agrees. The cap calculation itself is "pretty easy to do when using Medicare's PS&R data resources available in IACS," Sharp tells **Eli.**

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However, commenters on the proposed rule complained to CMS about the system, saying many agencies weren't registered in it and that hospices are routinely deactivated due to time limits.

"All hospices are required to register in Individuals Authorized Access to CMS Computer Services (IACS) and obtain their PS&R report from the PS&R system," CMS says. "Hospices experiencing difficulties can request a copy of their PS&R report from their MAC." The PS&R supports both the streamlined and patient-by-patient proportional methods for counting patients for the cap.

Even without technical difficulties, "the change from 16 to 24 months down to 5 months will be particularly difficult for those hospices that have not had time to prepare in advance," predicts attorney **Marie Berliner** with **Joy & Young** in Austin, Texas. Many hospices "are already repaying overpayments from the last few cap years, and thus may be hit with another overpayment at the same time," Berliner says.

Don't be surprised: More requests for extended repayment schedules are likely ahead, Berliner says.

CMS specifically addresses ERSs in the rule. The new cap requirement "is not changing the current ERS availability," the agency stresses. "Providers that have overpayments as a result of the self-determined cap calculation will follow the same overpayment processes that were in effect prior to this requirement."

And ERSs will get more complicated thanks to the early cap calculation deadline, Sharp forecasts. Many hospices use an extended repayment plan to repay the cap liability, he explains. "If you have the initial liability and then additional liabilities computed after the reporting deadline, agencies may need to request multiple extended repayment plans for the same cap year which can be problematic."

CMS shot down a number of other commenter suggestions, including that the MACs (instead of hospices) calculate the cap, that the cap requirement be phased in, and that the cap calculation be combined with the hospice cost report for administrative ease, according to the final rule.

Note: The rule is online at www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18506.pdf.

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