Department of Health and Human Services
Office of Inspector General
Office of Audit Services

November 2024 | A-06-23-09003

CGS Administrators, LLC, Did Not Reopen and Recalculate Most Selected Hospices' Caps for Years Prior to 2020

REPORT HIGHLIGHTS

November 2024 | A-06-23-09003

CGS Administrators, LLC, Did Not Reopen and Recalculate Most Selected Hospices' Caps for Years Prior to 2020

Why OIG Did This Audit

- Payments made to hospices are limited by inpatient cap and aggregate cap amounts that represent the maximum amount of Medicare payments a hospice could have received for a cap year. The cap amounts are calculated annually, and any amount paid to a hospice above either cap amount is an overpayment and must be repaid to Medicare.
- Medicare administrative contractors (MACs) complete the hospice cap calculations for the inpatient and aggregate cap after the end of the cap year. Cap calculations are subject to CMS reopening regulations, which allow reopening for up to 3 years from the date of the cap calculation.
- Our audit determined whether CGS accurately calculated cap amounts and collected cap overpayments in accordance with CMS requirements.
- This audit is part of a series that reviewed MAC calculations and collections of hospice aggregate and inpatient cap overpayments.

What OIG Found

- CGS accurately calculated the initial 2020 cap amounts for all 805 hospices that operated in its jurisdiction and collected or attempted to collect the $9.1 million in cap overpayments it identified. However, for 45 selected hospices, CGS did not reopen and recalculate most hospice caps for prior cap years (i.e., 2017, 2018, and 2019), which limited CGS's overpayment identification and collection for those prior years.
- Because CGS missed cap reopening deadlines and failed to revisit prior years' cap calculations for hospices with Unified Program Integrity Contractor (UPIC) recoupments, it did not calculate and collect additional overpayments totaling $201,873 for prior cap years.

What OIG Recommends

We recommend that CGS:

1. discontinue its practices that limited the reopening of prior years' cap calculations and start reopening all prior years' cap calculations,
2. revise policies and procedures so that it meets the reopening deadlines established in the Federal requirements, and
3. conduct the prior years' hospice cap calculations for the five hospices with UPIC recoupments and collect any additional overpayments.

CGS concurred with our second and third recommendations and partially concurred with our first recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

The use of hospice care has grown steadily in recent years, with Medicare paying approximately $23 billion for hospice services to nearly 1.7 million hospice enrollees in 2021. To ensure that hospice care does not exceed the cost of conventional care at the end of life, there are two annual limits (called caps) to payments made to hospices. Hospices that receive claim payments exceeding the cap amounts must repay the difference (overpayment) to Medicare. The Centers for Medicare & Medicaid Services (CMS) contracts with three Medicare administrative contractors (MACs) to calculate cap amounts and recover overpayments. CGS Administrators, LLC (CGS), one of the MACs, processed hospice claims and oversaw the hospice cap calculation and overpayment collection processes for 805 hospices during our audit period of cap year 2020.[1] This audit is part of a series of audits regarding MACs' oversight of hospice cap calculations.[2]

OBJECTIVE

Our objective was to determine whether CGS accurately calculated cap amounts and collected cap overpayments in accordance with CMS requirements.

BACKGROUND

Medicare Part A Hospice Benefit

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part A, also known as hospital insurance, provides for the coverage of various types of services, including hospice services. The Medicare hospice benefit can provide great comfort to enrollees, families, and caregivers at the end of an enrollee's life. To be eligible for Medicare hospice care, an enrollee must be certified as terminally ill (i.e., having a medical prognosis that life expectancy is 6 months or less if the disease runs its normal course). The Medicare hospice benefit has four levels of care (routine home care, continuous home care, inpatient respite care, and general inpatient care), and Medicare provides an all-inclusive payment based on the level of care.

[1] For 2020, the cap year was from October 1, 2019, through September 30, 2020.

[2] The previous two audits in the series were: *Palmetto GBA, LLC, Accurately Calculated Hospice Cap Amounts but Did Not Collect All Cap Overpayments* (A-06-19-08003) and *National Government Services, Inc., Accurately Calculated Hospice Cap Amounts but Did Not Collect All Cap Overpayments* (A-06-21-08004).

Hospice Aggregate Cap

Payments made to hospices are limited by inpatient cap and aggregate cap amounts (42 CFR §§ 418.302(f), 418.308(a), and 418.309).[3] The cap amounts are calculated annually, and any amount paid to a hospice above either cap amount is an overpayment and must be repaid to Medicare (42 CFR §§ 418.302(f)(4) and 418.308(d)). For calculating both types of caps, MACs use enrollee count[4] and claim payment information that is queried from CMS's Provider Statistical and Reimbursement System (PS&R) for each hospice. The PS&R is a web-based, centralized system that accumulates statistical and reimbursement data for Medicare Part A claims (e.g., hospice claims).

Hospices use one of two methods to count the enrollees they served within a given cap year for the aggregate cap: the streamlined method and the proportional method (42 CFR §§ 418.309 (b) and (c)). Hospices are not allowed to switch back and forth between cap calculation methods. Under the streamlined method, each enrollee is counted as one in the first year of services with a hospice and will not be counted and included in the hospice's cap calculations in any following years, regardless of the duration of care the same hospice provided. Under the proportional method, each hospice must include in its number of Medicare enrollees 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. The whole and fractional shares of Medicare enrollees' time in a given cap year are then summed to compute the total number of Medicare enrollees served by that hospice in that cap year. When a Medicare enrollee receives care from more than one Medicare-certified hospice during a cap year or years, the streamlined method cap calculation for this Medicare enrollee is identical to the proportional method.

The aggregate cap amount represents the maximum amount of Medicare payments a hospice could have received for a cap year. To calculate this amount for a hospice, CGS multiplies the number of Medicare enrollees a hospice served by the statutory cap amount.[5] The aggregate cap amount is not applied individually to the payments received for each enrollee, but rather to the total payments across all Medicare enrollees served by the hospice in the cap year. The statutory cap amount is adjusted every year; the intent of the cap is to ensure that payments for hospice care would not be higher than what Medicare would have paid for an enrollee if the enrollee had been treated in a conventional setting. An example of an aggregate cap calculation for one hospice is in Table 1 on the following page.

[3] CGS did not have any hospices with inpatient cap overpayments for cap year 2020; therefore, the inpatient cap calculation is not discussed in this report.

[4] The enrollee count represents the number of people who receive hospice care during the cap year.

[5] The statutory cap amount is a specified limit per Medicare enrollee for a cap year, adjusted annually based on the methodology outlined in the Act § 1814(i)(2)(B)(i) and (ii).

Table 1: Example of Aggregate Cap Calculation

Medicare Enrollee Count per the PS&R	50
Statutory Cap Amount for Cap Year 2020	$29,965
Aggregate Cap Amount for Cap Year 2020 (enrollee count multiplied by cap amount)	**$1,498,250**

In the above example, if payments made to the hospice were less than the aggregate cap amount, there is no overpayment. Conversely, if payments made to the hospice exceeded the aggregate cap amount, the difference is considered an overpayment and must be repaid to Medicare.

When an enrollee receives hospice services in more than 1 cap year, the enrollee count is allocated to each cap year based on the percentage of total hospice days that occurred in each cap year. For the second cap year, CGS must adjust the previous year's (i.e., the first cap year that hospice service was provided) cap calculation if the enrollee count has changed. If an enrollee continues to receive hospice care into a third cap year, CGS must adjust the cap calculations again for both previous cap years so that each enrollee is counted only one time for his or her total hospice days.

The following example and Tables 2 and 3 demonstrate how an enrollee count can change. An enrollee elected hospice on July 20, 2019 (cap year 2019), and received hospice care until January 16, 2020 (cap year 2020). The enrollee received hospice care for 180 total days, 72 days in cap year 2019 and 108 days in cap year 2020. Table 2 shows the initial 2019 cap year enrollee count for the 72 days of care provided during cap year 2019. Table 3 on the following page shows the enrollee count for the 2020 cap year and the adjusted count for the 2019 cap year.

Table 2: Enrollee Count for Cap Year 2019

Cap Year and Period of Hospice Care Provided	Number of Days	Total Days	Enrollee Count (number of cap year days divided by total days)
2019 Cap Year (July 20 – September 30, 2019)	72 days	72	1.00

Table 3: Enrollee Count for Cap Years 2019 and 2020

Cap Year and Period of Hospice Care Provided	Number of Days	Total Days	Enrollee Count (number of cap year days divided by total days)
2019 Cap Year (July 20 – September 30, 2019)	72 days	180	.4
2020 Cap Year (October 1 – January 16, 2020)	108 days	180	.6
Total	**180 days**		**1.00**

Past cap year determinations are subject to reopening and adjustment to account for updated data, which allow reopening for up to 3 years from the date of the cap calculation. The 3-year reopening period applies to reopening of a cap determination unless the determination was procured by fraud or similar fault (42 CFR §§ 405.1885(a)(1) & (b)(1), 405.1803(a)(3), and 418.309(b)(2) & (c)(2)).[6] The process of redetermining the cap calculations based on the change in enrollee counts for previous years is referred to as "reopening calculations." MACs should calculate each hospice's aggregate cap amount for a specific cap year a total of four times, consisting of the initial cap calculation year and 3 reopening years. For example, the initial cap calculation for 2017 was performed after the 2017 cap year had ended. For cap year 2018, MACs would perform a reopening calculation of 2017. For cap year 2019, MACs would perform reopening calculations of 2018 and 2017. For cap year 2020, MACs would perform reopening calculations of 2019, 2018, and 2017. After the third reopening calculation, MACs would not review the cap calculation for the initial cap year again. As a result, the 2020 cap calculation was the final reopening calculation of the 2017 cap year.

Extended Repayment Schedule Process

If a hospice cannot repay a cap overpayment immediately, it may submit an Extended Repayment Schedule (ERS) request to the MAC (42 CFR § 401.607(c)). CMS or its contractor can grant an ERS of 36 months and up to 60 months (42 CFR § 401.607(c)(2)(vi)).[7] If a hospice does not make ERS payments, the MAC classifies the debt as currently not collectible and refers the debt to the Department of the Treasury. According to CMS, debt that is currently not collectible is unlikely to be collected.[8]

[6] Past cap year determinations may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

[7] For the cap year 2020, MACs could approve ERS requests up to 36 months, but only CMS could approve ERS requests for 37 to 60 months. Effective October 2023, MACs may approve ERS requests up to 60 months.

[8] Chapter 5, section 400.20, of the CMS *Medicare Financial Management Manual,* Pub. No. 100-06, states that debt that is classified as currently not collectible is a debt that is at least 180 days delinquent.

Unified Program Integrity Contractors

The primary goal of a Unified Program Integrity Contractor (UPIC) is to identify cases of suspected fraud, waste, and abuse; develop these cases thoroughly and in a timely manner; and take immediate action when Medicare funds are inappropriately used. UPICs are required to coordinate with MACs in the hospice cap liability process.[9] A UPIC and MAC coordinate to avoid double recovery of the Medicare funds. As part of the process, the UPIC must finalize its review and issue the findings to the hospice and refer any overpayment to the MAC for collection. The MAC must take into account the hospice's cap liability and adjust it as appropriate.

HOW WE CONDUCTED THIS AUDIT

Our audit covered the cap calculation process for all 805 hospices that operated in CGS's jurisdiction, 61 of which had net cap overpayments totaling $9.1 million for cap year 2020. CGS's calculation process for cap year 2020 did not identify any inpatient cap overpayments. We reviewed the templates that CGS and hospices used to calculate aggregate cap amounts to determine whether they were functioning appropriately. We also selected a non-statistical sample of 45 hospices to determine whether CGS followed its processes and whether the calculations in the templates were accurate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

CGS accurately calculated the initial 2020 cap amounts for all 805 hospices and collected or attempted to collect the $9.1 million in cap overpayments in accordance with CMS requirements.[10, 11] However, for the 45 selected hospices, CGS did not reopen and recalculate most hospice caps for prior cap years (i.e., 2017, 2018, and 2019), which limited CGS's

[9] The hospice cap liability process involves identifying any overpayments exceeding the statutory cap and managing the collection of these excess amounts.

[10] The exact net reopening overpayments were $9,070,834.

[11] The cap overpayments that CGS attempted to collect but was unable to totaled approximately $400,000 (i.e., 4 percent of the $9.1 million in cap overpayments for cap year 2020) and were classified as currently not collectible. See the "Other Matters" section on page 9 for details.

overpayment identification and collection for those prior years. CGS did not perform those recalculations because it (1) used practices that limited when it reopened prior cap years for certain hospices, (2) missed the deadline for reopening hospice cap year 2017, and (3) failed to revisit prior years' cap calculations for hospices with UPIC recoupments as CGS intended. Table 4 provides the recalculations CGS did not perform by issue and year for the 45 selected hospices.

Table 4: Recalculations CGS Administrators Did Not Perform by Issue and Year

Cap Year	2019	2018	2017
Reviewed Hospices*	44	42	39
Less Reopening Limitations	19	27	24
Less 2017 Cap Reopening Deadline Missed	0	0	10
Less Providers With UPIC Recoupments	5	5	5
Total Calculations Completed	**20**	**10**	**0**

*Of the 45 selected hospices, there were 1, 3, and 6 hospices for 2019, 2018, and 2017, respectively, that did not participate in the hospice program for the entire cap year. CGS did not need to perform the reopening for these hospices because the initial cap calculations for newly certified hospices must cover a period of at least 12 months but less than 24 months (*Medicare Benefit Policy Manual*, chapter 9, § 90.2.1).

Because CGS missed the 2017 cap reopening deadline and failed to revisit prior years' cap calculations for hospices with UPIC recoupments, it did not calculate and collect additional overpayments totaling $201,873 for prior cap years for the 45 selected hospices. When CGS did not perform recalculations because of its reopening limitation practices, CGS did not generate enrollee count and claim payment information needed to perform the prior years' cap calculations, so we could not determine the hospice cap overpayments CGS did not calculate and collect.

CGS ADMINISTRATORS LIMITED THE REOPENING OF PRIOR CAP YEARS FOR CERTAIN HOSPICES

CMS's *Medicare Benefit Policy Manual*, chapter 9, section 90.2.2, indicates that cap calculations are subject to reopening and adjustments to account for updated data, and section 90.2.4 indicates that the Medicare contractor must continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. Cap calculations are subject to the existing CMS reopening regulations, which allow reopening for up to 3 years from the date of the cap determination letter (42 CFR §§ 405.1885(a)(1) & (b)(1) and 405.1803(a)(3)). The streamlined method cap calculation for a Medicare enrollee who has been in more than one Medicare-certified hospice is identical to the proportional method cap calculation (42 CFR § 418.309(b)(2)).

For the 45 selected hospices, CGS implemented practices that limited the reopening of prior years' cap calculations for hospices (1) with total Medicare reimbursement that was less than

95 percent of the cap limit during the initial cap calculation for the cap year to be reopened and (2) that used the streamlined method for enrollee count. Those reopening practices were not specified or documented in CGS's written policies and procedures for conducting cap calculations. Because of the 95-percent limit, CGS did not reopen and recalculate hospice caps for 16 selected hospices for cap year 2019, 24 selected hospices for cap year 2018, and 21 selected hospices for cap year 2017.

Additionally, CGS did not reopen prior years' cap calculations for three selected hospices that used the streamlined method. CGS did not generate the enrollee count and claim payment information needed to perform the prior years' cap calculations for years it did not reopen for the hospices subject to the 95-percent limit or that used the streamlined method. Without enrollee count and claim payment information needed to perform the prior years' cap calculations, we could not determine the hospice cap overpayments CGS did not calculate and collect.

CGS ADMINISTRATORS MISSED REOPENING DEADLINES FOR HOSPICE CAP YEAR 2017

CMS's *Medicare Benefit Policy Manual*, chapter 9, section 90.2.2, indicates that cap calculations are subject to reopening and adjustments to account for updated data, and section 90.2.4 indicates that the Medicare contractor must continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. Cap calculations are subject to CMS reopening regulations, which allow reopening for up to 3 years from the date of the cap determination letter.

For the 45 selected hospices, CGS did not complete its 2020 reopening cap calculations within 3 years from the date of the cap determination letter for 10 of our selected hospices. CGS's policies and procedures did not specify timing for completing hospice cap calculations in accordance with the reopening deadlines established in Federal requirements. As a result, CGS did not calculate and collect additional overpayments totaling $42,610 for cap year 2017.

CGS ADMINISTRATORS FAILED TO REVISIT PRIOR YEARS' CAP CALCULATIONS FOR HOSPICES WITH UNIFIED PROGRAM INTEGRITY CONTRACTOR RECOUPMENTS

CMS's *Medicare Program Integrity Manual*, chapter 4, section 4.7.6, "UPIC Hospice Cap Liability Process – Coordination with the MAC," specifies the communication and coordination between the UPICs and MACs to minimize the occurrence of double recoveries. CGS is required to reconcile its cap calculation results with UPIC recoveries of overpayments to avoid any double recovery from hospice providers.

When CGS conducted the 2020 cap calculations, the UPIC informed CGS that it had recouped payments from five hospices.[12] CGS intended to complete the cap calculations for those five

[12] The five hospices with UPIC-identified overpayments are part of the 45 selected hospices.

hospices after it identified the cap years impacted by the UPIC recoupments; however, before it could do that, CGS redirected hospice cap resources to other activities it considered more pressing. After completing the other activities, CGS failed to revisit and conduct those five hospices' prior years' cap calculations as it had intended. As a result, CGS did not calculate and collect additional overpayments, totaling $159,263, spanning cap years 2017 through 2019.[13]

RECOMMENDATIONS

We recommend that CGS Administrators, LLC:

- discontinue its practices that limit the reopening of prior years' cap calculations and start reopening all prior years' cap calculations,

- revise its policies and procedures so that it meets the reopening deadlines established in Federal requirements, and

- conduct the prior years' hospice cap calculations for the five hospices with UPIC recoupments and collect any additional overpayments.

CGS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CGS concurred with our second and third recommendations and partially concurred with our first recommendation. Regarding our second and third recommendations, CGS said that it will include instruction in the hospice cap determination procedures to meet reopening deadlines and that it would complete prior years' hospice cap calculations for the hospices with UPIC recoupments and collect any additional overpayments identified.

Regarding our first recommendation, CGS agreed that the look back should apply to both the streamline and proportional methods to count the enrollees a hospice served within a given cap year. However, CGS believed it was appropriate to limit reopening of prior years' cap calculations for hospices under the 95-percent limit because it believed reopening regulations and CMS guidance strongly indicate the MAC has discretion in which cap determinations to reopen. CGS stated that the 95-percent limit allowed it to focus on reopenings that presented a material risk to the Medicare trust fund.

CGS's comments are included in their entirety as Appendix B.

After reviewing CGS's comments, we maintain that our findings and recommendations are valid. CMS's *Medicare Benefit Policy Manual*, chapter 9, section 90.2.2, indicates that cap

[13] Some of this effect might have been offset by the UPIC recoveries; however, because CGS did not complete its research related to the amount of the UPIC recoveries to apply, we could not determine how much the amount would have been affected.

calculations are subject to reopening and adjustments to account for updated data, and section 90.2.4 indicates that the Medicare contractor must continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. By applying limitations on reopenings, such as the 95-percent limit, CGS did not obtain updated data needed to determine additional hospice cap overpayment amounts, which CGS is required to continue to demand hospices repay.

OTHER MATTERS

SOME HOSPICE CAP OVERPAYMENTS CLASSIFIED AS CURRENTLY NOT COLLECTIBLE

Chapter 4 of the CMS *Medicare Financial Management Manual* outlines various collection requirements that MACs must follow for Medicare provider overpayments. These requirements include a timeline for sending an initial demand letter, contacting the providers, processing ERS requests, and suspending payments, among other requirements.

CGS followed CMS debt collection requirements. Almost $400,000 of the $9.1 million (4 percent) in total cap overpayments for cap years 2019 and 2020 was deemed currently not collectible. Debt that is classified as currently not collectible is a debt that is at least 180 days old. According to CMS, any debt that is determined to be currently not collectible is unlikely to be collected. CGS could not collect a portion of Medicare provider cap overpayments for cap years 2019 and 2020.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the cap calculation processes for all 805 hospices that operated in CGS's jurisdiction for cap year 2020. For the 2020 cap calculation, CGS calculated aggregate cap overpayments totaling $7,623,431 for 34 hospice providers. For the reopening calculations of the 3 prior cap years, CGS calculated additional net reopening aggregate overpayments totaling $1,220,846 for 30 hospice providers in 2019 and $226,557 for 16 hospices in 2018. CGS did not reopen calculations for 2017. In total for cap year 2020, NGS calculated overpayments totaling $9,070,834. We selected a non-statistical sample of 45 hospices to determine whether CGS followed its processes and whether its calculations were accurate.

We assessed the design, implementation, and operating effectiveness of CGS's internal controls over its hospice cap calculation and overpayment collection processes and tested cap and overpayment calculations for accuracy.

We conducted our audit from March 2023 through June 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and CMS guidance;
- gained an understanding of the hospice cap calculation and debt collection requirements;
- met with CGS officials to gain an understanding of, and obtain its policies and procedures on, the hospice cap calculation and debt collection process;
- requested a hospice list from CMS and reconciled it with CGS's list of hospices in its jurisdictions to ensure the completeness of the hospice population for cap year 2020;
- selected a non-statistical sample of 45 hospices (34 with aggregate cap overpayments, 6 without overpayments, and all 5 hospices with outstanding UPIC overpayments), requested the financial documentation associated with the 2020 cap calculation process of the 45 hospices, and analyzed their cap calculations and overpayments, if any, to determine whether CGS followed its processes and the calculations were accurate;
- reviewed electronic templates CGS and hospices use to calculate cap amounts to ensure the formulas were functioning appropriately and resulted in complete and accurate calculations;

- reviewed spreadsheets CGS used to calculate cap amounts and overpayments to determine whether the information used for the inpatient and aggregate cap calculations flowed similarly to our non-statistical sample work and whether the cap calculations and overpayments were accurate;

- requested and reviewed financial documentation for the 45 sampled hospices discussed above to determine whether overpayment balances were correct and documented appropriately;

- requested and reviewed the overpayment balances and collection statuses of all hospices with overpayments calculated during the 2020 cap calculation process; and

- discussed the results of our audit with CGS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: CGS COMMENTS

Steve Smith
President & COO
CGS Administrators, LLC

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September 12, 2024

Miquel Darcey
Assistant Regional Inspector General
DHHS-OIG-OAS
200 NW. 4th Street, Suite 4040
Oklahoma City, OK 73102

RE: CGS Response to Draft OIG Report entitled *CGS Administrators, LLC, Did Not Reopen and Recalculate Most Selected Hospices' Caps for Years Prior to 2020* (Report Number A-06-23-09003).

Dear Miquel Darcey,

Thank you for the opportunity to review the OIG draft report dated August 12, 2024, report number A-06-23-09003. As requested, we are responding to the recommendations listed in the report.

OIG Recommendation #1 - Discontinue its practices that limit the reopening of prior years' cap calculations and start reopening all prior years' cap calculations.

CGS Response:
As stated in the draft report, the OIG's position is that cap calculations are subject to reopening and adjustments to account for updated data, and the Medicare Contractor (MAC) shall continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. The OIG believes that CGS limits reopenings of prior years' cap by applying a 95 percent threshold and only conducting look backs for proportional method Providers. The OIG also believes MACs should calculate each hospice's aggregate cap amount for a specific cap year a total of four times, consisting of the initial cap calculation year and 3 reopening years. As a result of CGS' limiting of reopenings, the OIG states there were additional overpayments that were not recovered for the hospices selected in the OIG audit.
CMS instructions to the MACs for reopenings of cap determinations are in 42 CFR, Section 418.309(b)(2) & (c)(2), the Provider Reimbursement Manual (PRM) 15-1, Section 2931.2 and Internet Only Manual (IOM) 100-02, Chapter 9. Per 42 CFR, Section 418.309(b)(2) & (c)(2), "the aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data" (Attachment 2, 42 CFR, Section 418.309). CMS reopening instructions in the PRM 15-1, Section 2931.2 state "Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, ..." (Attachment 1, PRM 15-1, Section 2931.2). Additionally, Internet Only Manual (IOM) 100-02, Chapter 9, Section 90.2.4 states "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" (Attachment 3, IOM 100-02, Chapter 9, Section 90.2.4). CGS' interpretation of CMS requirements is based on the words "may be adjusted" from the CFR, "depend upon" and "material evidence" from the PRM, and "which allow reopening" from the IOM. These words strongly indicate the MAC has discretion in which cap determinations to reopen. Missing from these regulations and instructions are the words "must" and "shall" and specifics to the number of times a reopening should be done.
Based on CFR, PRM, and IOM guidance, CGS' practice is to reopen hospice cap determinations at our discretion. CGS' practice includes using a predetermined materiality threshold in determining whether a reopening will be completed. CGS only performs look back reopenings on proportional method Providers when the hospice's reimbursement is 95 percent or greater than the hospice cap amount in a cap year. Using this materiality threshold, CGS' efforts are focused on reopenings that present a material risk to the Medicare trust fund. CMS has exceeded contractual requirements in the prior two contract periods. Any increase in reopenings would result in additional funding needed, not currently supported by CMS guidance and instruction.

In summary, we do not agree that CMS reopening instructions require unlimited reopening of prior years' cap calculations. We do agree that the look back should apply to both the Streamline and Proportional methods as indicated in IOM 100-02, Chapter 9.

OIG Recommendation #2 - Revise its policies and procedures so that it meets the reopening deadlines established in the Federal requirements.

CGS Response: CGS concurs with this recommendation. While our current reopening procedures provide instructions to ensure that a reopening is completed timely, CGS will include instruction in the hospice cap determination procedures to meet reopening deadlines.

OIG Recommendation #3 - Conduct the prior years' hospice cap calculations for the five hospices with UPIC recoupments and collect any additional overpayments.

CGS Response: CGS concurs with this recommendation. Prior years' hospice cap calculations will be completed for the five hospices with UPIC recoupments and CGS will collect any additional overpayments identified.

Sincerely,

Steve Smith,

Steve Smith,
President & COO

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