# NEWS AND ALERTS

## HOSPICE CAP SELF-REPORTING

On 8/6/2015, CMS issued the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. The Final Rule finalized the proposals to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the FFY starting in FY 2017 and to align the timeframe for counting the number of beneficiaries with the FFY. This alignment eliminates timeframe complexities associated with counting payments and beneficiaries differently from the FFY and will help hospices avoid mistakes in calculating their aggregate cap determinations. Additionally, shifting the cap accounting year timeframes to coincide with the hospice rate update year (the FFY) better aligns with the intent of the new cap calculation methodology required by the IMPACT Act of 2014 (P.L. 113–185).

### *2017 Cap Year (10/1/2016–9/30/2017)*

The per beneficiary cap amount for calculating the hospice aggregate cap for the 2017 transition year will not be prorated for the shorter time frame. Instead, hospices and the HHH MACs are to count payments, count beneficiaries, and determine the percentage of inpatient days as follows for the 2017 cap year:

- The beneficiary count period for the aggregate cap determination for hospices using the patient-by-patient method is from 11/1/2016 to 9/30/2017.
- The beneficiary count period for the aggregate cap determination for hospices using the streamlined method is from 9/28/2016 to 9/30/2017, which is 12 months plus three days.
- The payment period for the cap calculation for both the streamlined and patient-by-patient methods is 11/1/2016 to 9/30/2017. This is 11 months of payments.
- For the inpatient cap, HHH MACs are to calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care and respite care) from 11/1/2016 through 9/30/2017 (11 months).

### *2018 Cap Year (10/12017–9/30/2018)*

- Hospices and HH MACs are to count both beneficiaries and payments for hospices using the streamlined or the patient-by-patient proportional methods from 10/1/2017 to 9/30/2018.
- HHH MACs are to calculate the percentage of all hospice days of care that were provided as inpatient days (GIP or respite care) from 10/1/2017 to 9/30/2018.

Any hospice that does not report its self-determined cap by February 28th will be subject to a payment suspension.

Once hospice providers have self-reported, we will send a confirmation letter within 45 days of receipt. When applicable the confirmation letter will also serve as a demand letter for the provider with an amount due the Medicare Program. We will also perform a cursory review of the submitted self-determination within 60 days of receipt.

### *Completing the Pro-Forma*

Before completing the CMS issued pro-forma, please review the "Instructions for completing the Pro-Forma for Provider Self-Determination of Aggregate Cap Limitation" tab of the pro-forma. Providers should download and use the CMS issued pro-forma calculation form. The pro-forma and instructions can be found on the HH+H page of our website. If you are having issues with accessing this link above, from our website, select HH+H and your state, click on "Next" and accept the attestation. Then, select **Provider Resources > Forms > Other > Hospice Cap**. The PS&R data used in filing the self-reported cap cannot be earlier than 12/31 of the applicable cap year. The statutory cap amount to be used for the 2017 self-reported hospice cap calculation is $28,404.99.

**Submitting the Pro-Forma**

Hospice providers should submit the pro-forma calculation along with supporting documentation and a copy of submitted check (if applicable) to NGS no later than March 31st. Providers are able to submit their determinations via email, mail or fax. Please submit the self-reported hospice cap pro-forma calculation and support to one of the following via:

1. Email: selfreportedhospicecap@anthem.com
2. NGSConnex
3. U.S Mail to:
   National Government Services
   Attn: Reimbursement Department
   8115 Knue Rd.
   Indianapolis, IN 46250
4. Fax: 414-459-5081, ATTN: Mario Berkec

### *Repaying an Overpayment*

If the self-reported cap calculation indicates an amount due to Medicare, please make a check payable to National Government Services and submit it in a separate envelope to one of the following locations:

- **J6 Wisconsin Providers (WI, MI, MN, NJ, NY, Puerto Rico, Virgin Islands)**
  National Government Services
  00450 WI Part A Non-MSP
  P.O. Box 809199
  Chicago, IL 60680-9199

- **J6 California Providers (AK, AZ, CA, HI, ID, NV, OR, WA, American Samoa, Guam, North Mariana Islands)**
  National Government Services
  00454 CA Part A Non-MSP
  P.O. Box 809311
  Chicago, IL 60680-9311

- **JK RHHI Providers (CT, MA, ME, NH, RI, VT)**
  National Government Services
  14011 ME MA RI Part A
  P.O. Box 809086
  Chicago, IL 60680-9086

### *Requesting an Extended Repayment Plan*

If a provider is unable to repay the self-determined overpayment within 30 days, they can submit a request for an ERS by faxing the following three items to 414-459-6007 or emailing them; J6 providers: J6A.ERS.requests@anthem.com and for JK providers: jkextendedrepaymentsschedules@anthem.com, ATTN: ERS REQUESTS:

- Written request for extended repayment
- Proposed amortization schedule
- A check copy of the first payment

Depending on the length of the requested repayment term additional documentation may be required. Additional information, including a checklist of documentation requirements for an ERS request, is available on our website.

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