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CMS Interpretation of Window for Revised Cap Demands Has Providers Worried

Hospice care providers participating in Medicare and Medicaid have, in recent weeks, been in receipt of notices from the Centers for Medicare & Medicaid Services (CMS) that have likely been disconcerting. The CMS has been sending revised cap demands: nothing new in and of themselves—it's the timetable of the demands that has caused concern…they are for fiscal years 2012 and earlier.

And the main point of contention is that the initial demands in the cases in question were issued more than three years prior—but CMS is saying it has the authority to reopen cap demands for as much as three years from the most recent demand, rather than from the initial demand…a distinction that makes all the difference.

And under this interpretation, what this ultimately means is that CMS could, if it chooses, reopen each and every year, into perpetuity.

You can imagine how hospice providers, wanting to close the books on a certain calendar period, feel about this.

Revised cap rule took effect in 2011; questions about reopening window emerging now

The CMS cap was developed in order to create a ceiling for Medicare payments that a hospice healthcare provider would be eligible to receive within a fiscal year. The cap is determined by multiplying the number of Medicare beneficiaries a hospice facility or provider are caring for by the fiscal year's cap amount, a figure that the CMS adjusts each year.

CMS implemented the revised cap rule in 2011. During the comment period at that time, the agency was asked about the timeframe for reopening cap demands since hospice care organizations need to know when they are past the period of potentially shifting allowances. In response at the time, CMS clarified that the proposal would be revised to "make it clear that there is a 3-year time frame for reopening."

Said the CMS in 42 C.F.R. § 405.1885: "reopening is timely only if the notice of intent to reopen…is mailed no later than 3 years after the date of the determination or decision that is the subject of the reopening."

It's true that the regulation does not directly state that the reopening clock starts ticking at the time of the initial demand, but the Provider Reimbursement Review Board (PRRB), courts, and providers themselves have, until now, seen it through the initial—and not the most recent—lens. (According to the CMS website, the PRRB is "an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination by its Medicare contractor or by the Centers for Medicare & Medicaid Services.")

Of course, the CMS is the one that retains the authority to reopen. This doesn't mean that providers shouldn't challenge the broad interpretation of it in court if that's the avenue they choose, but if they're looking for expediency in resolution, it likely won't be found in that avenue.

Potentially major impact for care facilities serving large number of patients

Looking at the long-term impact of this, though, one can't help but consider that many patients under the umbrella of hospice care do not survive beyond three years from the first medical service date involving palliative care. In the case of those patients that do, however, the probability of their CMS allowances being scattered across a period of many years is high, which means allowance adjustments in any one fiscal year will most likely be on the smaller side. But for large care facilities, the impact of the CMS's interpretation of their reopening authority could be substantial.

For more information/questions regarding any legal matters, please email info@nelsonhardiman.com or call 310.203.2800.