# The Hospice Aggregate & Inpatient CAPS

*And How to Manage Them!*

CMS has two forms of capitation for Hospices: The **Inpatient CAP**, which does not allow total GIP Patient-Days to exceed 20% of total Medicare days. I have personally never witnessed a Hospice exceed the Inpatient CAP. The highest I have seen a Hospice run is about 19%. The other is the **Aggregate CAP**, which is the maximum amount of payments a Hospice can receive from Medicare during a period that runs from October 1st to September 30th. There are 2 flavors of the Aggregate CAP, the *Streamlined Method* and the *Proportional* or *Fully Prorated Method*.

**Streamlined Method** (Simpler and preferred method and MORE VALUABLE):

- Counts a full beneficiary only if they haven't received care from any hospice in the current or prior cap years.
- A one-time election, generally for newer agencies or those with very consistent patient populations, as it's difficult to switch back to.
- The Streamlined Method is calculated by multiplying the number of Medicare admissions by an annual rate set by CMS, currently $34,465.34. If a Hospice exceeds either of these CAPs, the "excess" monies must be returned to the MAC/FI. Usually, payment plans can be set up if you don't have the cash, but it is not pretty in any case. ALL Medicare payments to the Hospice are counted including Routine, General Inpatient, Respite, Continuous Care, Consulting Physician, Medical Director payments, etc.
- The Streamlined Method is the original Medicare method and is inherently more VALUABLE as it is easier to manage as it is based on the time period a patient is admitted multiplied by the Aggregate CAP rate ($34,465.34).

**Proportional Method** (Patient-by-Patient – MUCH more difficult to determine and goes back 3 years):

- Counts a fraction of each patient for the hospice based on the percentage of total days that patient spent in care at that agency.
- Used by most, as it accounts for patients moving between agencies or staying on service across years.
- Required for hospices on the cap calculation since October 1, 2011, and those that elected it previously.
- The Proportional or Fully Prorated Method is LESS VALUABLE as it spreads the Aggregate CAP amount over the life of the patient, meaning that each year or years the patient is on the program, a "proportional amount" of the CAP monies is allotted to those years. This makes the predictability less certain as a patient has to die or be discharged to know what amount to assign each year. Thus, it is LESS reliable and often Hospices get into trouble by going over CAP. All new Hospices must use the Proportional Method. Older programs are grandfathered into the Streamlined Method unless they opt out.

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Too many Hospices take pride in saying "we are far under CAP." Well, the truth of the matter is that this is not a good thing. It means that we are providing perhaps "brink of death" care and that we haven't gotten the message out that the best Hospice care is when we have patients for longer periods of time. **Hospices need to be managing "to CAP" and not away from it.** Whoever thought of the idea of an "Aggregate CAP" should be commended. While there are certain entities that want to complain about the CAP (usually folks who have gone over) and call it "unfair," it is, in the MVI mind, a good thing. However, it should be managed! Here are some questions to ask yourself:

- Is our Hospice uneasy about keeping long living patients?
- Do we understand that to make the fiscal model work, we must have long living patients to offset short living patients?
- Could our documentation education process be improved so that the documentation would support keeping more patients on service? (Think of Clinical Educators as revenue makers!)
- Are we training the medical community to refer late by the types of patients we admit or don't admit?

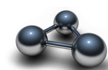
## An Increasing Number of Hospices are Exceeding the Aggregate CAP

With the introduction of the Proportional or Fully Prorated Method, with its inherent extreme difficulty to estimate or project exactly "when" a patient will die or be discharged, **PREDICTABLY more Hospices exceed the Aggregate CAP**. The number of Hospices exceeding Aggregate CAP has risen from 15-16% just a few years ago, to 18%, to 20% and is expected to be nearing 24% in 2025-26.

## When does CAP hit? Is it a version of Hospice Hell?

Hospices exceed the aggregate CAP when times are GOOD. The financial statements couldn't be better. Census is at an all-time high. Everybody is FEELING great! Then the LETTER arrives stating that your Hospice has exceeded the aggregate CAP and that you need to return $XXXXX to the FI. Not only do you owe for the last CAP year, you are already into the NEXT CAP year…and unless you take some immediate action, you will owe even more! Then, if the FI is in the mood and feels that their CAP calculation methodology was incorrect in prior years, they might even dig back into past years to see if you exceeded the aggregate CAP according to the new calculations. I would say that this definitely lends itself to a flavor of Hospice Hell.





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Perhaps we should look at what leads to CAP issues, not as an admissions problem, but a discharge problem. Hospices need to admit patients that meet criteria, but determining "when their time will come" is far from an exact science. Therefore, it is better to err on the side of admitting the "grays," gaining a firsthand experience and history with the patient, and then discharging if necessary according to the facts that you know. If the discharge process or utilization review is flawed, then you could face a CAP problem.

## Dealing with the Medicare Aggregate CAP

If you've hit the Aggregate CAP, here are some suggestions:

- **Pump up Admissions**. The closer you get to September 30th the MORE valuable each admission becomes. Get an admission on September 30th and you redeem $34,465.34 in CAP money if you are over. Hire more marketers. If they get two admissions, they've almost paid for themselves. Goal: MAXIMIZE admissions!
- **Chances are you have a disproportionate percentage of patients who are not declining and may need to be discharged**. The closer you get to November 1st the LESS valuable it is to discharge patients. Earlier discharges are better. You must always do the right thing. Palliative Care is a good backdoor.
- **Open an IP Unit!** It would have to be a quick deal, but theoretically it would work. IP units draw short-living patients. Optionally, run more IP in qualified facilities. This would be your best bet in an excess CAP situation.

It is important that we recognize that CAP is calculated on "**cash**" payments from the Medicare System. It is NOT based on the accrual basis or on your Accounts Receivable.

What is the Cause and Fix for CAP problems?

1. Cause: Long-Living Patients
    a. The Residual – Sneak up Effect
    b. Happens when financial times are best
    c. If you have spent the CASH you may be out of business…then you have real problems
    d. Ineffective UR process
    e. Compute the Median LOS of Living Patients
    f. Divide Annual CAP amount by Routine Rate to get an approximation
2. Fix:
    a. Start to Manage the Patient Mix
    b. Discharge patients if inappropriate
    c. #1 Strategy – Staff up in Admissions and Marketing
        i. It only takes 2 admissions to pay a salary
    d. Run more inpatient on a contract basis

**"As far as CAP is concerned, all Medicare admissions are good. It doesn't matter if we are only able to serve the patient for 1 day, 1 hour or 1 minute! Each admission frees up about $20,000 of CAP headroom, plus it should be part of our mission."** ***AR***

Here is an illustration of the Medicare CAP calculations.

- Aggregate
  - MCR Admissions X CAP Rate
  - Example: 200 X 19,000 = $3,800,000

- Inpatient
  - Less than 20% of MCR Patient-Days can be at the GIP Level of Care
  - Example: If MCR Patient-Days total 20,000 in a year, then only 4,000 days can be at the GIP Level of Care

## The Aggregate CAP is Good, but there is a Flaw

I think that the Hospice CAPs are good. They help to protect the industry from abuse. To remove the CAP would be a mistake. If there is a flaw in the Aggregate CAP, it is that the CAP amount is not indexed by service area or CBSA. Therefore, with the 2023 rate of $34,465.34, a Hospice in California being paid a routine rate of $300 a day will use up its CAP more quickly than someone in Corn County, Iowa, who is getting $160 per day.

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## Monitoring Medicare CAPs

I rarely see a Hospice with an Inpatient CAP problem. But I have seen many Hospices have problems with the Aggregate CAP. The Aggregate CAP can creep up on an unsuspecting Hospice and turn “what appeared to be a great year” into a “nightmare year.” A healthy Hospice has a “residual” of long-living patients. They are needed to offset short-living patients. However, this residual “build-up” of patients is what catches Hospices off guard. And then one day, you exceed the CAP. The key is to deal with it early or even better, remedy the situation BEFORE you have an Aggregate CAP problem. Here is how to monitor the CAP:

- **An indication that you may be close to the Aggregate CAP is to calculate the <u>Median LOS on LIVING</u> patients…** NOT terminated patients. If your Hospice is close to 170 days, you’re very close to trouble or make be in DEEP trouble. ALOS based on terminated patients is of no value here because the patients driving the CAP are not included in the calculation! Think about it.

- **How to Guage Where You are in Relation to the Aggregate CAP.**

    1. Get the current Hospice Aggregate CAP amount from the CMS website.
    2. **Find Your MLOS for Living Patients** - Run out of the EMR an Excell compatible report listing all LIVING Patients subtracting the SOC date (Start of Care) with TODAY. Export to Excel and run a MEDIAN formula on it. This will give you your MLOS for Living Patients.
    3. **Determine your Routine Rate** - The simple thing to do is to take your Tier 1 Routine and call it good. It is inherently a conservative number as it is higher than Tier 2. If you want to get more precise, do a Weighted Average by taking 60% of your Tier 1 Routine Home Care Rate and then 40% of your Tier 2 Routine Home Care Rate (a “Weighted Average).
    4. **To Find Out Where You Are** - MULTIPLY your Routine Hospice Home Care Rate by your MLOS for Living Patients. THEN compare your result with the current Hospice Aggregate CAP amount. This will give you a great approximation of where you are in relation to the Hospice Medicare Aggregate Cap.
    5. **To Find Your Aggregate CAP Target** - DIVIDE the Hospice Medicare Aggregate CAP amount by your Weighted Average Routine Home Care Rate. This with tell you approximately the MAXIMUM Median Length of Stay for Living Patients you can have without going over the Aggregate CAP.
    6. As a conservative measure, we advise that you MULTIPLY the MAXIMUM Median LOS for Living Patients by .8 or .7. This lowers it and we would use this number to manage to. We call this the “Screw Up Factor.” It is good to have a “buffer” or “screw-up” factor of 20-30% included when you compare with your current Median Length of Stay for Living Patients with this amount. This is conservative because you must remember that you also have GIP, Respite and Continuous Care revenue to factor in!

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# Example: $33,494.01 divided by $155 = 216 Days

(This is the MAXIMUM Days for Median LOS for Living Patients)

Tier 1 Tier 2
(($165 x 60%) + ($140 x 40%)) = $155 (Weighted Average)

In this example: You have "Printed to File" a current list of "Living" patients with their SOC (Start of Care) date in an Excel readable format. Subtract today's date from the SOC Date. Then, do a Median function on this subtraction of the column. For example, if this result is 230, you're probably over CAP. If it is 200, you are close, but are probably under. If you are trying to manage the CAP, it is again best to multiply the MAXIMUM Days for Median LOS for Living Patients by a factor of 8. or .7 making your goal or target 172.8 (.8) or 151.2 (.7). This is conservative because you must remember that you also have GIP, Respite and Continuous Care revenue to factor in!

## *The MVI CAP Calculator in the MA (Management Application)*

- Calculate and forecast your CAP amount. Multiply the number of Medicare admissions by the rate. You can also prorate the rate when doing an interim calculation. This is the "earn as you go" method. It works. It is simple and effective. NOTE: To be conservative in your estimate, EXCLUDE all patients that have previously elected the Hospice Medicare benefit. Even if you are going to receive a pro rata share of the CAP amount for a patient, it is better to err on the side of conservatism.
- In your patient management system, look for a CAP report. Misys used to have one as well as other major systems.

Below is a screenshot of the CAP tool that MVI provides.

**Revenue Tests and Medicare CAP Tests**

**Inpatient CAP Test**
*(Medicare IP days can not exceed 20% of routine days)*

IP Percent: 0.5%

The Inpatient CAP is calculated for the same time periods as the aggregate CAP. However, for estimation purposes, this model uses YTD or Monthly amounts.

**Aggregate CAP Test**
*(Total Medicare payments can not exceed the number of annual admissions multiplied by the rate set by CMS)*

| | |
|---|---|
| CMS Amount per Admission >>>>>>>>>>>>>>>>>>>> | 18,963.47 |
| Number of Admissions from 9-28-Year 1 to 9-27 Year 2 | 522 |
| Maximum Medicare Revenue >>>>>>>>>>>>>>>>>>>> | 9,898,931.34 |
| Estimated Medicare Payments *(revenue aproximates payments)* | 9,649,495.15 |
| Difference >>>> | 249,436.19 |

*For estimation purposes, accrued revenue is used rather than payments.*

| | Nov 2004 | Dec 2004 | Jan 2005 | Feb 2005 | Mar 2005 | Apr 2005 |
|---|---|---|---|---|---|---|
| Medicare | 757,042 | 810,090 | 747,878 | 703,273 | 762,000 | 720,725 |
| *Pass-Throughs* | | | | | | |
| IP | 17,224 | 3,937 | 13,287 | 6,890 | 1,968 | 17,716 |
| Respite | 1,976 | 1,976 | 2,558 | 116 | 2,325 | 4,301 |
| Physician | - | - | - | - | - | - |



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