812. How to Master Hospice Aggregate CAP Reporting and Financial Management

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Hospice Aggregate Cap

- Aggregate cap: Designed to limit total aggregate payments a hospice can receive in a year; to protect Medicare from spending more for hospice care than conventional care at the end of life.

- First aggregate cap amount set at $6,500 per beneficiary (1983)– determined to be “well above the average cost of caring for a hospice patient”

- The aggregate payment amount a hospice may receive under Medicare for any given cap year is limited to the cap amount times the number of Medicare patients served.
Hospice Aggregate Cap

- Two methods for counting the number of Medicare patients:
  - The streamlined method
  - The proportional method

- Cap historically has been updated annually by the BLS medical expenditure category of the Consumer Price Index for all Urban Consumers (CPI-U)

- Beginning with accounting years starting on or after Sept. 30, 2016 (until Oct. 1, 2025) the aggregate cap will be updated by the net hospice market basket index (result of IMPACT Act of 2014)

Hospice Aggregate Cap

- MedPAC/CMS have tracked data on hospices that exceed aggregate cap. CMS found:
  - 2006 – 9.1%
  - 2009 – 12.8%
  - 2011 – 10.5%
  - 2012 – 11.6%

- Characteristics of over cap hospices:
  - Predominantly for-profit
  - VERY long length of stay
  - VERY high profit margin (before repayment)
Hospice Aggregate Cap

• Percent of over-cap hospices still a minority of hospices BUT are increasing in number; further, an increasing number of hospices are getting closer to hitting cap (CMS data)

• Historically MACs alert hospices of cap liability between 16-24 months after close of cap year

• Congressional, other concerns that overpayments are significantly delayed or go unrecovered

Hospice Aggregate Cap

• CMS FY2015 Hospice Wage Index/Payment Rule:
  o Effective for the 2014 and subsequent cap years, each hospice must calculate its aggregate cap
  o Calculation made NO SOONER than 3 months following close of cap year (Jan. 31)
  o Cap calculation must be provided NO LATER than 5 months following the close of the cap year (March 31)
  o Use pro forma spreadsheet supplied by CMS
CAP Reporting and Management Process

• (1) Monitoring CAP and any potential CAP liability throughout the year (no surprise at the end of the CAP year)
  o The frequency of this activity should be dependent on risk of exceeding the CAP
    • Historical CAP liability
    • Lack of spread between historical CAP and Medicare payments
    • Increasing average length of stay
  o Certain hospices should be monitoring on a monthly basis.

• (2) If apparent that the hospice will, or it is probable that the CAP will be exceeded, begin to make repayment arrangements
  o Payment is due when the CAP report is submitted

• If a Request for Extended Repayment Schedule (“ERS”) will be submitted, be prepared to submit the request for ERS with the CAP Report (due March 31st) – Request for ERS discussed later.
CAP Reporting and Management Process

• (3) Prepare CAP Report (using template to be provided) on or before February 25th (even though not due until March 31st)
  o You can submit as soon as completed, or
  o You now have until March 31st to provide any additional documentation, i.e. internal computations or Request for ERS

• Use PS&R information as of January 31st (earliest date possible) to minimize any interim liability.

• Review alternative computation (Proportional Method) if CAP still being computed on the Streamlined Method.

• (4) Estimate ultimate CAP liability (remember the CAP report submitted only reflects an interim liability)

• (5) Revisit prior year CAP computations for potential liability of increased liability.

• (5) Begin preparation for funding any ultimate liability

• (6) Begin estimation of subsequent year CAP and potential CAP liability (process begins again)
Anticipated MAC Activities

• Review CAP Report submitted on or before March 31st
  o Is the CAP Report a claim (False Claims Act or False Statement Laws)?
  o Will the MAC modify or update your report based on more current information?

• Make final CAP determinations and review prior year computations – issuance of Notice of CAP liability (expected one year after end of CAP Year)

CAP Computation

• (1) Identify method on which you CAP is computed:
  o Streamlined Method
  o Proportional Method
    • Once the Proportional Method is elected the Streamlined Method can never be used again.
  o Understand that if the hospice is still on the Streamlined Method – you can elect to switch to the Proportional Method.
  o If you switch computation will revert to Proportional Method back to the 2012 CAP Year (November 1, 2011 through October 31, 2012)
Access IACS

• Using User Name and Password access IACS
  https://applications.cms.hhs.gov/category.html?name=providers

• (2) Get Beneficiary Counts - Under Miscellaneous Reports select Beneficiary County (CAP Report)
  o Select Streamlined Method:
    • Beneficiary Period (September 28, 2013 – October 31, 2014) (September 28, 2013 through September 27, 2014)
    • Proportional Method (November 1, 2013 through October 31, 2014)
    • Payment dates through January 31, 2015 (earliest date available)
    • Run reports for the prior periods as well (2012 CAP Year and 2013 CAP Year)

Sample Beneficiary Count – Streamlined Method
Sample Beneficiary Count - Proportional

Secure Payments

• Using IACS, PSR – secure payment report. The report will automatically produce multiple year reports.

• Parameters:
  o Service Dates (initial period)
    • November 1, 2011 – October 31, 2012

• You will now get multiple year payments
Medicare Payments

Computation

<table>
<thead>
<tr>
<th>CAP ON OVERALL MEDICARE REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE BENEFICIARIES PER IACS PAID THROUGH</td>
</tr>
<tr>
<td>Note: These beneficiaries are counted using the Patient by Patient Proportional Methodology.</td>
</tr>
<tr>
<td>2. STATUTORY CAP AMOUNT FOR THE CAP YEAR ENDED</td>
</tr>
<tr>
<td>3. ALLOWABLE MEDICARE PAYMENTS</td>
</tr>
<tr>
<td>4. ACTUAL PAYMENTS PER THE PS&amp;R PAID THROUGH</td>
</tr>
<tr>
<td>5. PAYMENTS IN EXCESS OF THE CAP AMOUNT</td>
</tr>
</tbody>
</table>

Payments reflects are net patients, after sequestered Amounts – further discussion.
Check Prior Year

- **Streamlined Method**
  - Having access to IACS, check prior year computations back to the 2012 CAP Year (Medicare can revise CAP for three years)
  - Compute any CAP liability under the Proportional Method back to 2012 (2012, 2013, 2014) - Medicare cannot go back to years earlier than the 2012 CAP year if you convert
  - Should you convert?

Conversion to Proportional

- If it is determined in the Hospice’s best interest, make your election prior to or with the submission of the report for the 2014 CAP Year.
- Any conversion after the Notice of CAP Liability is issued requires PRRB Appeal to be filed. The PRRB then instructs the MAC to recompute.
- (Remember – review any potential liability associated with the 2013 and 2012 CAP Years under the Proportional Method).
Over CAP (Liability)

- Must be remitted with CAP report (on or before March 31, 2015), or
- Submission of Request for ERS (Extended Repayment Schedule):
  - Unknown:
    - Will they give you 15 days to respond to overpayment as in the past
    - If potentially near or in excess of CAP – recommend making computations in February allowing time to prepare Request for ERS and submitting with CAP Report.

Extended Repayment Schedules

- A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" (10% of annual payments) on the provider, a request for an ERS should be submitted immediately. However, the provider may request an ERS at any time the overpayment is outstanding, and the contractor shall review that request. Instructions on how to apply for an ERS shall be available on the contractor's website for provider reference.
- If a complete ERS request is received within 15 days of the date of the demand letter and first payment is included, contractors shall not begin 100% recoupment of payments, unless payments are being suspended or withheld for another outstanding overpayment or investigation. During review, the contractor may reduce recoupment to 30% of payments until a decision is made.
- If a complete ERS request is received after 15 days of the date of the demand letter and first payment is included, during the review, the contractor may reduce recoupment to 30% of payments until a decision is made.
Request for ERS

• Up to 60 months:
  o Information Needed:
    • Signed amortization schedule
    • Balance sheets, income statements, cash flow statements, projected cash flow statements, and sources and uses of funds. (prior year, current year, projections may vary)
    • Restricted cash funds
    • Investments
    • Notes and mortgages payable
    • Related party transactions and balances
    • Loan application and denial letter from bank
    • Occupancy
    • First installment payments

Projecting Final Liability

• Using historical experience to project final liability due to Medicare program:
  o Use last three years distributions of patients based on information secure through IACS.
  o Give consideration to changes in historical patient utilization (distributions)
  o Update total patients for projected admissions through end of CAP period (September 27th or October 31st - depending on method)
### Estimating Beneficiaries

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<td>3 years prior</td>
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<td>2 years prior</td>
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<td>1.28%</td>
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### Estimating Interim CAP

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<th>At June 30, 2014</th>
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<td>June 1 through October 31 estimated</td>
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Settlement Process

- CAP Report to be submitted on or before March 31st.
- MAC review of CAP Report submitted (?)
- MAC revision and update of CAP Report submitted (?)
- MAC review of final CAP (expected sometime around 10-12 months after end of CAP Year)
- MAC ongoing review of CAP for three (3) years.

Management Summary

- If your hospice is substantially under the CAP, the management process may be as easy as being alert and filing the annual CAP Report.
- If your hospice is over the CAP or approaching the CAP, the management process becomes a periodic event addressing estimates, overpayments, and prior year CAP modifications.
- If ERS is currently used or planned to be used, financial records must be adequate, possibly updated to include accrual-basis financial statements for ongoing reporting to the MAC.