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# Hospice Aggregate CAP
# Frequently Asked Questions

## What is Hospice Aggregate CAP?

Hospice aggregate cap is an amount set by the Centers for Medicare and Medicaid Services (CMS) each year. It is used to calculate the maximum amount a hospice will be reimbursed for Medicare hospice services. The purpose is to limit total aggregate payments a hospice can receive in a year, protecting Medicare from spending more for hospice care than conventional care at the end of life.

## Are there penalties for exceeding Hospice Aggregate CAP?

Yes, there are penalties for exceeding hospice aggregate cap. Any Medicare payments in excess of the aggregate cap are considered overpayments and must be returned to Medicare by the hospice. Payment is due at self-determination or can be paid over time with an Extended Repayment Schedule (ERS).

## How is Hospice Aggregate CAP calculated?

Hospice aggregate cap is calculated by multiplying the statutory cap amount by the number of beneficiaries in the cap period and comparing this to payments received. The statutory cap amount is updated and published each year.

The number of beneficiaries is determined by either the Proportional Method or the Streamlined Method:

- **Proportional Method:** For each hospice, the count of the number of Medicare beneficiaries counted is the fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in this hospice in this cap year (October 1 to September 30).

- **Streamlined Method:** The count includes those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care from the hospice during the period beginning on October 1st and ending on September 30th. Under the Streamlined Method, when a beneficiary has received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in this hospice in this cap year. Note that the Streamlined method is only available to hospices that previously elected this method back in 2012.

Example: All reports from Provider Statistical & Reimbursement System

| **YE 09/30/2022** | |
|---|---|
| Hospice Cap Report for Beneficiary Count | 50 |
| Hospice Statutory Cap Amt for YE 09/30/2022 | $31,297.61 |
| Allowable Payments (Beneficiary Count x Statutory Cap) | $1,564,881 |
| PS&R Summary Report for Gross Reimbursement | $1,600,000 |
| Overpayment (Underpayment) = Gross Reimbursement – Allowable Payments | $32,120 |
| **The amount due to Medicare for an overpayment is $32,120** | |

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## What happens if a hospice does not return the overpayments?

If a hospice does not return overpayments to Medicare, it is considered a debt owed to the federal government. The Centers for Medicare and Medicaid Services (CMS) initiates the overpayment recovery process by sending a demand letter requiring repayment. If the overpayment is not fully repaid within 30 days, interest will accrue. The MAC can also withhold from agency remittances to collect payment.

If the hospice does not pay in full, CMS will send an Intent to Refer (ITR) letter 61–90 days after the initial demand letter. The ITR letter advises the hospice to refund the overpayment or establish an Extended Repayment Schedule (ERS). If the hospice still does not comply, the Medicare Administrative Contractor (MAC) refers the case to the Department of Treasury for collection.

## How can a hospice avoid exceeding the aggregate cap?

Hospices can take several steps to avoid exceeding the aggregate cap:

- Careful Management of Resources: Hospices should be proactive in monitoring their operations and resources to have a better understanding of their position relative to reaching the cap. There should be a regular assessment and evaluation of the beneficiary count and patient care days.

- Increasing Mix of Shorter Length of Stay Patients: Increasing the mix of shorter length of stay patients is a viable solution to address cap challenges. For example, if a patient is admitted and stays on service for 30 days before passing away, the hospice will receive the full cap credit.

- Monitoring Cap and Potential Cap Liability: Hospices should monitor the cap and any potential cap liability throughout the year. The frequency of this activity should be dependent on the risk of exceeding the cap. Certain hospices should monitor potential liability monthly if CAP overpayment is imminent.

- Repayment Arrangements: If it appears that the hospice will, or it is probable that the cap will be exceeded, hospices should begin to make repayment arrangements. Payment is due when the self-determination cap report is submitted.

## What is “reopening” and why does an agency receive multiple years of determination letters?

"Reopening" refers to the process of revisiting and adjusting previously calculated cap determinations. Example: When filing a self-determination report for year ending 09/30/2022, your agency will receive determination letters for year ended 09/30/2022 **plus three (3) previous CAP years** including years ended 09/30/2021, 09/30/2019, and 09/30/2018 with **up-to-date** Hospice Cap Reports and PS&R Summary Reports reflecting currently calculated beneficiary counts and payments. Contractors reopen these earlier determinations to assess **changes in beneficiary count and payments** and adjust the amount due to Medicare. *If an agency had cap liability in previous years, it is likely the liability will grow over time as beneficiary counts change.*