PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D37

PROVIDER–
Seasons Hospice & Palliative Care of Southern Florida

HEARING DATE –
May 23, 2019

Provider No.: 10-1543

Hospice Cap Fiscal Year Ended –
October 31, 2012

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

CASE NO. – 16-1265

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ISSUE STATEMENT

Whether the Medicare Contractor incorrectly determined the cap year 2012 aggregate cap amount for Seasons Hospice & Palliative Care of Southern Florida ("Seasons" or "Hospice") when the Medicare Contractor used the patient-by-patient proportional method ("proportional method") instead of the streamlined method?[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor was correct in using the proportional methodology to calculate Seasons' aggregate cap for 2012 and all future years.

INTRODUCTION

Seasons is located in Miami, Florida. This Hospice is one of approximately thirty (30) hospice providers operating throughout the United States under the "Seasons" name.[2] Seasons appealed its revised 2012 aggregate cap determination to the Board because Palmetto GBA (the "Medicare Contractor"[3]) calculated Seasons' aggregate cap using the proportional method instead of the streamlined method.

Seasons met the jurisdictional requirements for a Board hearing.[4] Accordingly, the Board held a live hearing on May 23, 2019. Seasons was represented by Thomas M. Burnett, Esq. of Reinhart Boerner Van Deuren S.C. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

In 1982, Congress created the hospice benefit pursuant to § 122 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").[5] The hospice benefit is an election that certain terminally-ill Medicare beneficiaries can make "in lieu of" other Medicare benefits. Medicare pays hospice providers on a per diem basis, subject to an annual cap. For the period under appeal the cap year ran from November 1 to October 31.[6]

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[1] Hearing Transcript ("Tr.") at 5.
[2] *Id*. at 7:20-23.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] *See* Board Jurisdictional Decision (May 20, 2019).
[5] Pub. L. No. 97-248, § 122, 96 Stat. 324, 356 (1982). Initially, Congress made the hospice benefit a temporary benefit with a sunset in October 1986. But, in April 1986, Congress made this benefit permanent. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9123(a), 100 Stat. 82, 168 (1986).
[6] *See, e.g.*, 42 C.F.R. § 418.309(a) (2011). The aggregate cap year was changed beginning FY 2017 to run Oct 1 – Sep. 30. 80 Fed. Reg. 47142, 47184-85 (Aug. 6, 2015).

Total Medicare payments made to a hospice during the cap year are limited by a hospice-specific cap amount that is referred to as the "aggregate cap amount."[7] Each hospice's "aggregate cap amount" is calculated by multiplying the adjusted statutory per-beneficiary cap amount[8] for that cap year by the number of Medicare beneficiaries served by the hospice during that period.[9] Medicare payments made to a hospice during a cap year that exceed the aggregate cap amount are overpayments that the hospice must refund to the Medicare program.[10]

The statute provides that the number of Medicare beneficiaries in a hospice program in an accounting year "is equal to the number of individuals who have made an election [to receive hospice care] and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program."[11]

In 1983, HHS adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care.[12] This method, which is currently referred to as the "streamlined" method, calculates the number of hospice beneficiaries as follows:

> [T]hose 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 in accordance with § 418.24 during the period beginning on September 28 (34 days before the beginning of the cap year) and ending on September 27 (35 days before the end of the cap year)[.][13]

Under the streamlined method once a beneficiary is counted for a given hospice, the beneficiary is not counted toward the hospice's aggregate cap in subsequent years even if he/she continues to receive services from the hospice. Thus, under this methodology, a patient who receives services in multiple years is counted as 1.0 beneficiary in a single year, rather than as some fraction less than 1.0 in multiple years (with the fractions summing to 1.0).[14]

Some hospice providers filed appeals challenging this "streamlined" methodology, seeking to have hospice overpayment determinations using this methodology invalidated. Several federal district courts and two courts of appeals issued decisions concluding that this methodology is

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[7] 42 C.F.R. § 418.308(a).
[8] The adjusted cap amount is determined for each cap year by adjusting $6,500 for inflation or deflation for cap years that end after October 1, 1984 by the percentage change in medical care expenditures category of the consumer price index for urban consumers. *See* 42 C.F.R. § 418.309(a).
[9] 42 C.F.R. § 418.309.
[10] 42 C.F.R. § 418.308(d).
[11] 42 U.S.C. § 1395f(i)(2)(C).
[12] 48 Fed. Reg. 56008, 56022 (Dec. 16, 1983).
[13] 42 C.F.R. § 418.309(b)(1) (2011).
[14] CMS Ruling 1355-R at 5 (Apr. 14, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1355R.pdf.

inconsistent with the plain language of the Medicare statute and have set aside these overpayment determinations.[15] As a result CMS issued CMS Ruling 1355-R, along with a proposed and final rule revising the methodology set out in § 418.309(b)(1). In the final rule published on August 4, 2011, CMS implemented a proportional methodology for cap years 2012 and beyond.[16] However, eligible hospices were allowed to make a *one-time* election to have their hospice cap calculated using the streamlined method. The *one-time* election had to be made no later than sixty (60) days after receipt of its 2012 cap determination. Once elected, the streamlined method would remain in effect until the hospice subsequently elected the proportional methodology or appealed the streamlined method.[17]

On December 5, 2013, the Medicare Contractor issued Seasons its 2012 cap determination. This determination was based on the proportional method and showed that based on claims paid through November 14, 2013, Seasons had not exceeded it aggregate cap.[18] This determination included notice to Seasons of its right to make the one-time election to have its hospice cap calculated using the streamlined method. However, Seasons claims it never received this determination.

Subsequently, the Medicare Contractor reopened Seasons' 2012 cap determination in order to make changes to the "Medicare beneficiary count and/or Change to Medicare Payments"[19] and issued a revised 2012 cap determination on September 22, 2015, determining an overpayment of $73,836.[20] The Hospice appealed the revised 2012 cap determination to the Board claiming it should be able to elect to use the streamlined method from the 2012 cap determination dated September 22, 2015.[21]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The question before the Board is whether the Medicare Contractor calculated Seasons' 2012 aggregate cap correctly when it used the proportional method rather than the streamlined method. Seasons argues that "[t]o the best of the Hospice's knowledge, it never received any information or instructions from [the Medicare Contractor] before or after September 25, 2015 [the date Seasons received the revised 2012 cap determination letter] regarding its right to elect the streamlined method for cap year 2012 and subsequent cap years."[22] Seasons believes the Medicare Contractor's failure to provide Seasons with notice of its right to elect the streamline method violates the regulations at 42 C.F.R. §418.309 and § 90 in Chapter 9 of the Medicare Benefit Policy Manual.[23] Seasons claims it had no mechanism to exercise its right to elect the

[15] *See id.* at 6.
[16] 76 Fed. Reg. 47301, 47308 (Aug. 4, 2011).
[17] 42 C.F.R. § 418.309(d)(2)(ii).
[18] Exhibit P-6.
[19] Exhibit C-2 at 6.
[20] Exhibit P-2.
[21] Exhibit P-3.
[22] Provider's Final Position Paper at 3.
[23] *Id.* at 5.

streamlined method except through an appeal of the September 22, 2015 revised 2012 cap determination.[24]

The Medicare Contractor disagrees and contends that it complied with CMS' notice requirements because Seasons' 2012 hospice cap determination, sent December 5, 2013, included a document titled "Your Grandfathering Rights."[25] The Medicare Contractor claims that it followed its normal practice of using the United States Postal Service when sending Seasons' December 5, 2013 notice of a hospice cap determination via regular U.S. Mail, because that determination did not result in an overpayment.[26] The Medicare Contractor's witness testified that hospice cap determinations were processed in batches and sent out via U.S. regular mail when there was no amount due and via Certified Mail when there was an overpayment.[27]

The Board disagrees that Seasons had no mechanism to exercise its right to elect the streamlined method except through an appeal of the revised 2012 cap determination. CMS regulations are clear that, "for cap years ending on or after October 31, 2012, hospices would have their aggregate caps calculated using the patient-by-patient proportional methodology, unless a hospice exercises a one-time election to have its aggregate cap for cap years 2012 and beyond calculated using the streamlined methodology."[28] The time frame for electing the streamlined methodology was set out in a duly promulgated regulation, which "requires that the election be made no later than 60 days after receipt of the 2012 cap determination."[29]

CMS initiated significant efforts to ensure that hospices were aware of, and were given the opportunity, to elect the streamlined methodology. The 2011 Federal Register explained that

> Contractors will provide hospices with instructions on how to elect a methodology in the coming months. In addition, we will revise the cap section of the hospice claims processing manual (Internet-only manual (IOM) 100-04, chapter 11, section 80) to reflect the policies implemented in this final rule. . . . There will also be a MedLearn Matters article, discussion on Open Door forums, and information on the hospice center webpage (http://www.cms.gov/center/hospice.asp) to further educate the industry. Additional education will come from industry associations and from contractor Web sites, reminding hospices of the procedures for electing a methodology. In case a provider misses these educational efforts, we will also ask contractors to include language on the 2012 cap determinations

[24] *Id.* at 4-5.
[25] Exhibit C-4.
[26] MAC Final Position Paper at 4 & n.2.
[27] Tr. at 168-171.
[28] 76 Fed. Reg. at 47311; 42 C.F.R. § 418.309(d)(2)(ii).
[29] *Id.* CMS explained that "We allow this 60 days *after* receipt of the 2012 cap determination because we are concerned that a hospice that intended to continue to use the streamlined methodology might fail to elect it due to an oversight, and we do not want any provider to be forced to change methodologies due to such an error." 76 Fed. Reg. at 47311 (Emphasis in original.).

> which explains that the provider has up to 60 days from the date of receipt of the determination to elect to continue using the streamlined methodology.[30]

Notably, Seasons did not have to wait until it received its 2012 cap determination but could have elected the streamlined method beginning October 1, 2011.[31]

While Seasons argues that it never received the 2012 notice, the Board notes that it is the Hospice's burden to prove this contention. Based on the long-standing common law mailbox rule, there is a presumption that, if a letter or document is properly addressed and delivered to the post office or a postman via a mailbox, it was received by the person to whom is was addressed.[32] In this case, the evidence overwhelmingly establishes that the Medicare Contractor sent Seasons its 2012 cap determination letter on December 5, 2013 via regular U.S. mail, and that this letter included a document titled "Your Grandfathering Rights."[33]

The Hospice has failed to rebut the presumption that the December 5, 2013 letter with the grandfathering notice regarding Seasons' right to elect the streamlined method was properly sent by the Medicare Contractor. Rather, the evidence adduced at hearing showed potential issues with Seasons' mail handling processes. The evidence shows that mail for Seasons is delivered to the Miami Jewish Health mailroom,[34] and subsequently delivered to the Seasons office by Miami Jewish mailroom personnel.[35] Seasons did not provide evidence of formal mail room procedures related to how Miami Jewish or its staff handled the incoming mail. Additionally, Seasons' witness testified that mail addressed to Mr. Stern (the cap determination letters are addressed to Mr. Stern) was scanned and sent to four specific individuals at the "National Office" within a day.[36] However, the record does not reflect this process as there are inconsistencies in when letters are date stamped, when the scanned mail is sent, and who receives the scanned mail.[37] At the hearing, Seasons acknowledged that it is possible that the December 5, 2013 letter was received by Miami Jewish, but just never forwarded to Seasons by the Miami Jewish mailroom personnel.[38] Based on this information, the Board concludes that Seasons has not met its burden of proof and therefore, the notice is deemed received.

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[30] *Id*.
[31] *Id*.
[32] The mail box rule is the overwhelmingly dominant rule in the United States. *See Reserve Ins, Co. v. Duckett*, 249 Md. 108, 238 A.2d 536 (Md. 1968); *Morrison v. Thoelke*, 155 So. 2d 889 (Fla. Dist. Ct. App. 1963).
[33] Exhibit C-4; Tr. at 168-171.
[34] Seasons explained that it is located on the campus of Miami Jewish Health, and that both Seasons and Miami Jewish Health share the same mailing address.
[35] Tr. at 33-36.
[36] *Id.* at 36-38.
[37] Exhibit P-5 shows the February 17, 2017 letter to Mr. Stern was received February 23, 2017 and was scanned and sent to 3 rather than 4 individuals on March 7, 2017 – nine (9) work days later. The April 15, 2013 letter to Mr. Stern was date stamped June 3, 2013 and was only sent to one individual on June 4, 2013 and again on June 10, 2013.
[38] Tr. at 48:2-10.

In the alternative, Seasons argues that, even if the Medicare Contractor did, in fact, follow CMS' requirements by sending the notice with the December 5, 2013 cap determination, the Medicare Contractor failed to follow those requirements and inform the Hospice of it right to elect the streamlined method when it issued the revised 2012 cap determination on September 22, 2015.[39] The Board finds that there was no need for the election notice to be sent with the revised determination because the time period for Seasons to elect the streamline methodology had already expired and that, as a result, the proportional method had to be used for all future aggregate cap determinations for Seasons.[40] Seasons appeared to recognize this as it submitted its 2014 self-reported aggregate cap calculation on March 30, 2015 based on the proportional method.[41]

The Board finds that the Medicare Contractor correctly notified Seasons in the 2012 cap determination letter issued December 5, 2013 that Seasons had sixty (60) days from the date of receipt of that determination to elect the streamlined method. As Seasons did not elect the streamlined methodology timely the Board finds the Medicare Contractor was correct in calculating Seasons' aggregate cap determination based on the proportional methodology for 2012 and all future years.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that the Medicare Contractor was correct in using the proportional methodology to calculate Seasons' aggregate cap for 2012 and all future years.

BOARD MEMBERS:

Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/29/2019

X Charlotte F. Benson

Charlotte F. Benson, C.P.A.
Board Member
Signed by: PIV

[39] Provider's Final Position Paper at 10.
[40] 42 C.F.R. § 418.309(d)(2)(ii) (providing 60 days to request the streamlined method). Additionally, Seasons' 2013 cap determination dated July 16, 2014 was issued based on the proportional method (*see* Exhibit C-5-6) and, as stated in 76 Fed. Reg. at 47313, "a provider whose cap is calculated using the proportional methodology may not later decide to have its cap calculated using the streamlined methodology."
[41] *See* Exhibit C-5-6.