PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D3

PROVIDER–
Vitas Healthcare CY 2013-2015 Hospice Cap Sequestration CIRP Group

Provider Nos.: 05-1770
05-1746

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services

RECORD HEARING DATE –
May 6, 2019

Cost Reporting Periods Ending –
October 31, 2013
October 31, 2014
October 31, 2015

Case No. – 19-2424GC

INDEX

ISSUE STATEMENT

Whether the MAC's inclusion of sequestered payments in the determination of the Providers' Cap on Overall Medicare Reimbursement was proper.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly applied sequestration to the Providers' aggregate cap payments at issue and correctly calculated the aggregate cap overpayment for each of the cap years at issue for each Provider.

INTRODUCTION

Vitas Healthcare Corporation – Milpitas ("Vitas-Milpitas") and Vitas Healthcare Corporation – Walnut Creek ("Vitas-Walnut Creek"), are two commonly owned hospice facilities (collectively, the "Providers")[2] affiliated with Vitas Healthcare Corporation. The Providers assert that Palmetto GBA and/or National Government Services (collectively the "Medicare Contractor")[3] improperly included sequestered payments in the calculation of the Providers' hospice cap liabilities. Vitas – Milpitas appealed its Hospice Cap determinations for cap years 2013 and 2014, while Vitas – Walnut Creek appealed its Hospice Cap determinations for cap years 2014 and 2015.[4] The Board will refer to the cap years appealed by Vitas-Milpitas and Vitas-Walnut Creek collectively as the "Disputed Cap Years." The Providers received revised Hospice Cap determinations for the Disputed Cap Years,[5] which were incorporated into the appeal for that respective year. On August 19, 2019, the Board consolidated these four appeals into the above captioned Common Issue Related Party ("CIRP") group.[6]

The Providers timely appealed this issue to the Board and met the jurisdictional requirements for a hearing. Accordingly, the Board granted the Parties' request for a record hearing on May 6, 2019. The Providers were represented by Elizabeth Carder-Thompson, Esq. of Reed Smith, LLP. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

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[1] Proposed Parties' Stipulation of Undisputed Facts and Principles of Law, ¶ 1.5 (Case Nos. 16-0949 and 16-2575) (Apr. 18, 2019) ("Vitas-Walnut Creek Stipulations"); Proposed Parties' Stipulation of Undisputed Facts and Principles of Law, ¶ 1.5 (Cases Nos. 16-0948 and 16-0119) (Apr. 18, 2019) ("Vitas-Milpitas Stipulations").

[2] The Medicare provider numbers assigned to Vitas – Milpitas and Vitas – Walnut Creek are 05-1746 and 05-1770 respectively.

[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] Case Nos. 16-0119, 16-0948, 16-0949, and 16-2575. The Board notes that the Providers submitted four substantially similar Final Position Papers and Exhibits for each of the original individual appeals. Citations in this opinion shall be to Case No. 16-0119 unless otherwise noted.

[5] Revised determinations were issued because of changes in the Medicare beneficiary counts.

[6] *See* Appendix A for the Schedule of Providers for Case No. 19-2424GC

STATEMENT OF FACTS

A. HOSPICE PAYMENT METHODOLOGY

In 1982, Congress created the hospice benefit pursuant to § 122 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").[7] The hospice benefit is an election that certain terminally-ill Medicare beneficiaries can make "in lieu of" other Medicare benefits. Congress set the amount of payment for hospice care at 42 U.S.C. § 1395f(i)(1)(A) "based on reasonable costs or such other test of reasonableness as the Secretary shall determine, *subject to a[] . . . limit or* ***cap*****[**.]"[8] Congress set this reimbursement or payment cap[9] as a cost containment mechanism: "[t]he intent of the cap was to ensure that payments for hospice care would not exceed what would have been expended by Medicare if the patient had been treated in a conventional setting."[10]

While the TEFRA hospice legislation suggests Congress anticipated that CMS (then known as the Health Care Financing Administration or HCFA) would initially pay hospices on a reasonable cost basis,[11] CMS immediately exercised its discretion under 42 U.S.C. § 1395f(i) to base the initial reimbursement methodology for hospice care on an "other test of reasonableness." Specifically, CMS implemented the hospice benefit using a prospective payment system for hospice care as a proxy for costs.[12] Under this payment methodology, CMS established per-day payment amounts for four categories of hospice care services furnished to

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[7] Pub. L. No. 97-248, § 122, 96 Stat. 324, 356 (1982). Initially, Congress made the hospice benefit temporary benefit with a sunset in October 1986 but, in April 1986, Congress made it permanent. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9123(a), 100 Stat. 82, 168 (1986) ("COBRA '85").

[8] *See also* H.R. Conf. Rep. No. 97-760, at 428 (1982) *reprinted in* 1982 U.S.C.C.A.N. 1190, 1208 (emphasis added). *See also* Staff of H.R. Comm. On Ways and Means, 97th Cong., 2d Sess., Explanation of H.R. 6878, at 17 (Comm. Print 1982) (stating: "Under this provision, reimbursement for hospice providers of services would be an amount equal to the costs which are reasonable and related to the cost of providing hospice care (or which are based on such other tests of reasonableness as the Secretary may prescribe) subject to a 'cap amount'. . . . *The amount of payment* under this provision for hospice care provided by (or under arrangements made by) a hospice program . . . for an accounting year may not exceed the 'cap amount'. . . .") (emphasis added) (*available at*: https://catalog.hathitrust.org/Record/011346136) (hereinafter "Explanation of H.R. 6878").

[9] The hospice cap has been referred to as either a "reimbursement cap" or a "payment cap." *See, e.g.*, H.R. Rep. No. 98-333, at 1 (1983) *reprinted in* 1983 U.S.C.C.A.N. 1043, 1043 ("reimbursement cap") ("the bill . . . to increase the cap amount allowable for reimbursement of hospices under the Medicare program . . ."); Richard L. Fogel, U.S. Gov't Accountability Office, GAO/HRD-83-72, Comments on the Legislative Intent of Medicare's Hospice Care Benefit 1, 5 (1983) (stating: "In authorizing Medicare reimbursement for hospice services, the Congress, in section 122(c)(2)(B) of TEFRA, chose to impose a cap on the average reimbursement which a hospice program could receive for its Medicare patients.") (*available at*: https://www.gao.gov/assets/210/206691.pdf) (hereinafter "GAO Rep. GAO/HRD-83-72").

[10] H.R. Rep. 98-333 at 1 (1983). *See also* GAO Rep. GAO/HRD-83-72, at 5-6 (quoting Explanation of H.R. 6878 at 18); 48 Fed. Reg. 56008, 56019 (Dec. 16, 1983).

[11] *See* GAO Rep. GAO/HRD-83-72, at 4-5.

[12] *See* 48 Fed. Reg. at 56008.

Medicare beneficiaries, consisting of routine home care, continuous home care, inpatient respite care, and general inpatient care.[13] Congress has periodically adjusted these payment rates.[14]

Notwithstanding CMS' promulgation of the hospice prospective payment system, Congress has never removed the hospice cap. The hospice cap is set on a per beneficiary basis and is adjusted annually for inflation.[15] The adjusted per-beneficiary cap is then applied to each hospice on an aggregate basis across each relevant 12-month fiscal year. Congress initially set the hospice cap "at 40 percent of the average Medicare per capita expenditure during the last six months of life for Medicare beneficiaries dying of cancer."[16] However, Congress later amended the hospice cap "to correct a technical error" because Congress learned that the data from the Congressional Budget Office ("CBO"), upon which the original hospice cap was based, contained two errors.[17] Specifically, Congress raised the hospice cap to $6,500 per Medicare beneficiary subject to an annual inflation adjustment in order to correct for these errors[18] (which coincidentally occurred between when CMS proposed and finalized the hospice prospective payment system).[19]

Accordingly, hospice care is paid under a unique hybrid reimbursement system involving prospective payments as a proxy for costs subject to an annual cap. Specifically, the total Medicare payments made to a hospice during a 12-month period is limited by a hospice-specific cap amount that is referred to as the "aggregate cap amount."[20] Each hospice's "aggregate cap amount" for a 12-month period is calculated by multiplying the adjusted statutory per-beneficiary cap amount[21] for that period by the number of Medicare beneficiaries served by the hospice during that period.[22] The 12-month period is referred to as the "cap year" and runs from November 1 of each year until October 31 of the following year.[23] 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.[24]

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[13] 42 C.F.R. § 418.302(c). The payment for inpatient services is limited by an "inpatient care cap" as described in paragraph (f) of this section. The inpatient care cap is not at issue in this appeal.
[14] *See, e.g.*, Pub. L. No. 98-617, 98 Stat. 3294, 3294 (1984); H.R. Rep. No. 98-1100 (1984) *reprinted in* 1984 U.S.C.C.A.N. 5703 (House report that is part of legislative history for Pub. L. No. 98-617); COBRA '85 § 9123(b), 100 Stat. at 168.
[15] 42 C.F.R. § 418.309(a).
[16] H.R. Conf. Rep. No. 97-760, at 428 (1982).
[17] H.R. Rep. No. 98-333, at 1-2 (1982). *See also* GAO Rep. GAO/HRD-83-72, at 5-6.
[18] Pub. L. No. 98-90, 97 Stat. 606, 606 (1983). *See also* H.R. Rep. No. 98-333, at 2 ("The outcome, therefore, is that the 'cap' amount for 1984, as calculated by the Department of Health and Human Services would be a little over $4,200. This is significantly lower than the $7,600 anticipated, necessitating this technical amendment [to raise the cap to $6,500].").
[19] *See* GAO Rep. GAO/HRD-83-72, at 5-6; 48 Fed. Reg. at 56019.
[20] 42 C.F.R. § 418.308(a).
[21] 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).
[22] 42 C.F.R. § 418.309.
[23] *See, e.g.*, 42 C.F.R. § 418.309(a).
[24] 42 C.F.R. § 418.308(d).

In addition to the aggregate cap, hospices have another limitation imposed on their payments on a cap-year basis referred to as an "inpatient care cap." Specifically, for each cap year for a hospice, "the total inpatient days reported for both general inpatient care and inpatient respite care may not exceed 20% of the total Medicare days reported by the hospice for a cap year."[25]

Finally, for every cap year, the Medicare program conducts a hospice-specific cap-year-end reconciliation and accounting process in which it calculates each hospice's aggregate cap amount and determines whether each hospice should be assessed an overpayment based on the total payments made to that hospice for the cap year. Similarly, as part of this cap-year-end process, CMS also determines if the hospice exceeded the inpatient care cap. The Medicare program then sends each hospice a "determination of program reimbursement letter, which provides the results of the inpatient ***and*** aggregate cap calculations" for that cap year[26] and, if that calculation identifies an overpayment, the determination provides notice of that overpayment amount.[27] If the hospice is dissatisfied with that determination, it may file an appeal with the Board.[28]

B. SEQUESTRATION

In 2011, Congress adopted the Budget Control Act of 2011, which includes a provision commonly known as "sequestration."[29] This sequestration provision requires the President to reduce discretionary spending across the board, including Medicare spending, by certain fixed percentages in the event that budgeted expenditures exceed certain limits. The percentage reduction for the Medicare program is capped at 2 percent for a fiscal year[30] and applies "in the case of [Medicare] parts A and B . . . to individual payments for services. . . ."[31]

Pursuant to the procedures established by the sequestration provision, on March 1, 2013, the Office of Management and Budget ("OMB") issued a report that triggered sequestration and imposed a 2 percent sequestration reduction to Medicare spending.[32] Consistent with this report and associated Presidential Order,[33] CMS then directed its Medicare contractors to reduce Medicare payments with dates of services or dates of discharge *on or after April 1, 2013* by 2 percent.[34] As part of this implementation, on March 3, 2015, CMS issued a Technical Direction

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[25] Medicare Benefit Policy Manual, CMS Pub. 100-02 ("MBPM"), Ch. 9, § 90.1 (in effect prior to the May 8, 2015 revisions). *See also* 42 C.F.R. § 418.302(f); MBPM, Ch. 9, § 90.1 (in effect after the May 8, 2015 revisions).
[26] *See* 42 C.F.R. § 405.1803(a)(3) (emphasis added).
[27] *See* 42 C.F.R. § 405.1803(c).
[28] *See id.*
[29] Pub. L. 112-25, 125 Stat. 240 (2011) (codified at 2 U.S.C. Ch. 20).
[30] 2 U.S.C. § 901a(6)(A).
[31] 2 U.S.C. § 906(d)(1)(A).
[32] Office of Management and Budget, Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013 (2013) (*available at*: https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf).
[33] A copy of this order was published at 78 Fed. Reg. 14633 (Mar. 6, 2013). *See also* Provider's Exhibit 14.
[34] *See* CMS Medicare FFS Provider e-News (Mar. 8, 2013) (announcing that "Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment.") (*available at*: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2013-03-08-standalone.html?DLPage=1&DLEntries=10&DLFilter=2013-03&DLSort=0&DLSortDir=descending); Medicare Claims Processing Manual, CMS Pub 100-04, Transmittal 2739 (July 25, 2013) (creating new claim adjustment reason code "to identify claims in which payment is reduced due to

Letter ("TDL") directing Medicare contractors to make sequestration adjustments for hospices subject to the aggregate cap in the following manner:

> - The sequestration amount reported on the Provider Statistical and Reimbursement (PS&R) report for each hospice shall be added to the net reimbursement amount reported on the [PS&R].
>
> - The resulting amount shall be compared to the hospice's aggregate cap amount to calculate a *pre-sequester* overpayment; and
>
> - The *pre-sequester* overpayment shall be reduced by 2% to reflect the actual amount paid to the hospice. The 2% overpayment reduction cannot be greater than the actual sequestration amount reported on the PS&R report.[35]

Under this methodology, the first two bullets determine whether there would be an overpayment if there had been no sequestration and, if so, what that "pre-sequester" overpayment would have been. To any resulting "pre-sequester" overpayment, the TDL reduced that overpayment by the lesser of the following: (a) 2 percent of the "pre-sequester" overpayment; or (2) the sequestration reported on the PS&R (*i.e.*, the aggregate sequestration amount already collected during the cap year). The resulting amount becomes the overpayment amount assessed for the cap year.

Significantly, only a portion of the 2013 cap year was subject to sequestration. As sequestration began on April 1, 2013 and the 2013 cap year ran from November 1, 2012 through October 31, 2013, sequestration only impacted the last seven months of the 2013 cap year (*i.e.*, April 1, 2013 through October 31, 2013). This case focuses on the cap-year-end reconciliation and accounting process and how CMS accounted for the sequestered payments made during the course of the affected portion of cap year 2013, and cap years 2014 and 2015 (*i.e.*, the Disputed Cap Years), in relation to applying the aggregate cap to the Providers' Medicare payments.

Sequestration.") (*available at*: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2739cp.pdf).

[35] *See* Provider's Exhibit 15 (emphasis added). CMS distributed the TDL to the MACs, and while the actual TDL was not distributed to the public, Palmetto GBA published a document which reprinted the material provisions of the TDL, minus specific instructions from CMS to the MACs. The Medicare Contractor's document is attached at Provider's Exhibit 15. The Board has attached a copy of TDL-150240 to this Decision as Appendix B. This document is publicly available and has been referenced in prior Board decisions on the same issue in this case.

C. THE PROVIDERS' AGGREGATE CAP CALCULATIONS

For each cap year at issue for each of the Providers in this group appeal, the Medicare Contractor issued initial and revised Hospice Cap Determination Notices that imposed a cap liability based on a calculation that included sequestered funds in the amount of payments made to the Provider.[36] The Providers have appealed these final determinations because they disagree with the Medicare Contractor's treatment of sequestered funds.

The Providers have not raised any dispute about the accuracy of the Medicare Beneficiary Counts or the adjusted statutory per-beneficiary cap amounts.[37] Rather, the Providers assert that CMS improperly altered the hospice cap calculation by instructing its contractors to include certain funds that were sequestered but never paid to the Providers in the amount of payment made to the Providers.[38] Specifically, the Providers assert that CMS improperly modified the aggregate cap calculation and that CMS lacked the authority to alter that calculation without Congress first modifying the relevant Medicare statutory provisions governing hospice payment.[39] The Providers believe that CMS was required to use the net reimbursement (actual amount received by the hospice) in determining how much they exceeded their aggregate caps.[40]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

APPLICATION OF SEQUESTRATION TO PROVIDERS' PAYMENTS

The Providers contend that, under the Medicare statute, since the Medicare program sequestered hospice payments made during the applicable cap years, the aggregate caps should simply be measured against the actual net amount of payment received by the hospice provider.[41] Specifically, the Providers point to 42 U.S.C. § 1395f(i)(2)(A) which states:

> The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).

The Providers assert that CMS' methodology that adds the sequestration amount to the "amount of payment made" violates 42 U.S.C. § 1395f(i)(2)(A) and 42 C.F.R. § 418.308 because the sequestration amount was never actually paid to the Providers.

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[36] *See* Provider's Exhibits 7-9 (PRRB Case No. 16-0119); Exhibits 7, 13, & 19 (PRRB Case Nos. 16-0948 & 16-0949); Exhibits 6, 12, & 18 (PRRB Case No. 16-2575).
[37] *See* Provider's Final Position Paper at 13-14 (noting the Medicare Beneficiaries Count and aggregate cap amounts were revised as new final determinations were issued, but that the subject of the appeal is the allegedly flawed methodology used to incorporate sequestration).
[38] *Id.* at 5-7.
[39] *Id.* at 11.
[40] *Id.* at 13-14.
[41] *Id.* at 6-8.

The Providers point out that the Medicare Statute sets forth precise rules for both the "payment made" and "cap amount" components of the hospice cap. The Providers argue that CMS violated federal statute by adding the sequestration onto the amount actually paid for hospice stays during the Disputed Cap Years because this sequestration amount was never actually paid.[42] The Providers assert that the aggregate cap is an upper limit of potential payment to hospices that can only be altered or reduced by Congress,[43] and that while individual, per diem payments may be reduced by sequestration, the cap remains the same.[44]

As explained more fully below, the Board finds that CMS did not make any statutory or regulatory changes to the hospice payment when implementing sequestration. Rather, CMS implemented the sequestration order by directing its Medicare contractors to reduce Medicare payments by 2 percent beginning with dates of service or dates of discharge on or after April 1, 2013.[45] Specifically, CMS instructed its contractors on how sequestration should be applied to certain Medicare payments including:

1. Claims payments;[46]
2. Cost report payments, including those made to IPPS-exempt hospitals;[47]
3. Electronic health record payments;[48] and
4. Hospice payments.[49]

In connection with hospices, as previously discussed, CMS issued the March 3, 2015 TDL directing Medicare contractors on how to implement sequestration when reconciling a hospice's interim payments made during the cap year to the aggregate cap determined at the end of the cap year.

With respect to the TDL, it is important to clarify what is in dispute. The Providers' dispute arises from the TDL's cap-year-end reconciliation and accounting process. As laid out in the TDL, this process involves the following inputs and factors:

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[42] *Id.*
[43] *Id.* at 11.
[44] *Id.* at 8-9.
[45] *See* CMS Medicare FFS Provider e-News (Mar. 8, 2013) (announcing that "Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment.") (*available at*: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2013-03-08-standalone.html?DLPage=1&DLEntries=10&DLFilter=2013-03&DLSort=0&DLSortDir=descending).
[46] Medicare Claims Processing Manual, CMS Pub 100-04, Transmittal 2739 (July 25, 2013) (creating new claim adjustment reason code "to identify claims in which payment is reduced due to Sequestration") (*available at*: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2739cp.pdf).
[47] Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), Ch. 40, Transmittal 4 (Sept. 2013) (instructions for Form CMS-2552-10) (*available at*: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R4P240.pdf).
[48] Mandated Sequestration Payment Reductions Beginning for Medicare HER Incentive Program (Apr. 11, 2013) (*available at*: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ListServ_SequestrationUpdate_EHR_Program.pdf).
[49] Appendix B (copy of TDL-150240).

1. The net prospective payments received during a cap year as listed on the Provider's PS&R for that cap year;
2. The sequestered amounts deducted during a cap year as listed on the Provider's PS&R for that cap year;
3. The number of beneficiaries served during the cap year;
4. The adjusted per-beneficiary statutory cap for the cap year; and
5. The Provider's aggregate cap for the cap year as determined by ## 3 and 4.

The Providers do not dispute ## 3 to 5.[50] Therefore, sequestration has no impact on how the aggregate cap for the Providers' applicable cap years were calculated because they were calculated in exactly the same manner as before sequestration.[51] The dispute in this appeal then centers on how the aggregate cap is applied to and interfaces with the Providers' interim payments under the hospice prospective payment system and sequestration.

The Providers assert that CMS' methodology violates the Medicare statute and regulations by adding the sequestered funds to the net reimbursement for the Disputed Cap Years because 42 C.F.R. § 418.308 states "the total Medicare payment to a hospice . . . is limited by the hospice cap amount" and "total Medicare payment" cannot include the sequestered funds because the sequestered funds were never paid.[52] The Board disagrees because it finds nothing in the Medicare statutory or regulatory provisions governing hospice payment that identifies a hospice's "total Medicare payment" as the *net* reimbursement to the hospice.[53] Rather, the Board finds these provisions establish payment *rates* for the various hospice services, direct how these payment *rates* will be updated,[54] and require payment be made to the hospice for each day during which a beneficiary is eligible and under the care of the hospice.[55] Contrary to the Providers' assertion, it is a hospice's *gross* payment that reflects these established rates, not the hospice's *net* reimbursement.

The Providers believe that the practice of the Medicare Contractor to use the full payment amount rather than the net reimbursement results in the Providers having to repay amounts they never received in the first instance.[56] The Board reviewed the Medicare Contractor's calculation and disagrees that the Providers have to pay back an amount they never received as explained below.

At the outset, how the hospice cap interacts with sequestration is key to understanding the issue in this case. In this regard, the Board notes that the hospice cap is an integral part of determining

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[50] *See* Provider's Final Position Paper at 13-14 (noting the Medicare Beneficiaries Count and aggregate cap amounts were revised as new final determinations were issued, but that the subject of the appeal is the allegedly flawed methodology used to incorporate sequestration).
[51] The aggregate cap is identified in Line 3 – Aggregate Cap Amount / Allowable Medicare payments. *See* Provider's Exhibits 7-9 (PRRB Case No. 16-0119); Exhibits 7, 13, & 19 (PRRB Case Nos. 16-0948 & 16-0949); Exhibits 6, 12, & 18 (PRRB Case No. 16-2575).
[52] Provider's Final Position Paper at 6-7.
[53] Net reimbursement refers to the interim payment amount following sequestration.
[54] 42 U.S.C. § 1395f(i)(1)(B); 42 C.F.R. § 418.302(c).
[55] 42 C.F.R. § 418.302(e)(1).
[56] Provider's Final Position Paper at 6-7.

"the [Medicare] amount paid"[57] to hospices to which sequestration must be applied. As explained below, the Board finds that, for hospices that exceed their aggregate cap (the two Providers in this case exceeded their aggregate caps for the cap years at issue), the aggregate cap then becomes the Medicare allowable payment for the applicable cap year and, therefore, sequestration must be applied to the resulting Medicare allowable payment.

Through the operation of 42 U.S.C. § 1395f(i)(1)(A) and the hospice regulations at 42 C.F.R. Part 418, Subpart G, hospices are reimbursed for "costs" over a twelve month period (*i.e.*, the cap year) subject to a cap or cost ceiling where the hospice prospective payment system serves as a proxy for those "costs." In this regard, 42 U.S.C. § 1395f(i)(1)(A) specifies that "[s]ubject to the limitation under paragraph (2) [*i.e.*, the hospice cap] . . ., the amount paid to a hospice . . . shall be an amount equal to the ***costs*** *which* are reasonable and related to the cost of providing hospice care ***or*** *which* are based on such other tests of reasonableness as the Secretary may prescribe in regulations[.]"[58] Essentially, this statutory provision specifies that, *for each hospice cap year*, hospices are to receive "an amount equal to" either their reasonable costs or the "***costs*** . . . which are based on such other test of reasonableness" "subject to the [hospice cap] limitation." As previously discussed, the Secretary opted to exercise her discretion under § 1395f(i)(1)(A) to establish an "other test of reasonableness" for determining "costs" – the hospice prospective payment system. Accordingly, for each hospice cap year, the "amount paid to a hospice . . . shall be equal to . . . ***costs*** . . . which are based on such other test of reasonableness [*i.e.*, the hospice prospective payment system] subject to the [hospice cap] limitation."

More simply, a hospice's reimbursable "costs" for a cap year are "based on" the hospice prospective payment system as a proxy for those "costs" "subject to" the hospice cap on those "costs" (*i.e.*, cost ceiling).[59] Accordingly, the Board concludes that the "amount paid" or the "amount of payment" to a hospice must be viewed on a cap year basis and it is that amount to which sequestration applies. Similarly, the Board finds that payments made to hospices during a cap year are effectively *interim* payments for "costs" that must be accounted for and reconciled at cap-year-end with the aggregate cap amount (*i.e.*, the hospice's cost ceiling) which is the maximum Medicare allowable payment that can be made for the cap year. Thus, following that process, the Medicare program issues a "determination of program reimbursement letter"[60] to, in essence, confirm the total Medicare allowable amount for the hospice's "costs" for that cap year.

The fact that the payments made during the year are *interim* is further reinforced by the fact that payments made during the year are subject to not just the aggregate cap but also a cap related to inpatient care. As previously discussed, *for each cap year* for a hospice, "the total inpatient days reported for both general inpatient and inpatient respite care may not exceed 20% of the total Medicare days reported by the hospice for a cap year."[61]

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[57] 42 U.S.C. § 1395f(i)(1)(A).
[58] (Emphasis added).
[59] This conclusion is consistent with the *supra* discussion on the legislative history for the hospice benefit.
[60] 42 C.F.R. § 405.1803(a)(3), (c).
[61] MBPM, Ch. 9, § 90.1 (in effect prior to the May 8, 2015 revisions). *See also* 42 C.F.R. § 418.302(f); MBPM, Ch. 9, § 90.1 (in effect after the May 8, 2015 revisions).

The concept that Medicare payments to hospices must be viewed on a cap-year basis is also reinforced by the facts that: (1) for every cap year, the Medicare program sends each hospice a "determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations" for that cap year;[62] and (2) if the hospice is dissatisfied with that final determination for the cap year, it may file an appeal with the Board.[63] Finally, the Board notes that the Medicare statutes establish a similar reimbursement structure for hospitals exempt from the inpatient prospective payment system ("IPPS") where reimbursement is viewed on a fiscal year basis with a cost ceiling,[64] and these IPPS-exempt hospitals are subject to sequestration in a manner similar to hospices.[65]

This case then becomes a matter of how CMS executed and accounted for sequestration when it applied sequestration to each Provider's Medicare "amount paid" for the applicable Disputed Cap Years under operation of 42 U.S.C. § 1395f(a)(1)(A). As sequestration began during the middle of the 2013 cap year, the Board first analyzed a simpler situation, namely how sequestration would work if sequestration were applied to a *full* cap year.

The simplest way to analyze sequestration is to apply it to a full cap year and to wait to apply it *until the cap year has ended*. In this situation, the 2 percent sequestration would be applied to the resulting "amount paid" *after* the hospice aggregate cap itself has been applied. More specifically, if the hospice were under its aggregate cap, then the 2 percent would be applied to all the interim hospice payments received for that cap year's "costs." However, if that same hospice exceeded its aggregate cap, then the full amount in excess of its aggregate cap would be an overpayment and the resulting "amount paid" for "costs" for the cap year would be its aggregate cap amount (*i.e.*, the cost ceiling for that hospice). This resulting "amount paid" for "costs" for the cap year (*i.e.*, the aggregate cap *amount*) would then be subject to sequestration of 2 percent. The following Table 1 illustrates how sequestration would work if applied to a *full* cap year for 3 hypothetical hospices *following the end of that cap year* where they each have an aggregate cap of $200,000[66] for the cap year but: (1) the total payments for the hypothetical hospice 1 ("HH1") during the cap year is under the aggregate cap by $20,000; (2) the total payments for hypothetical hospice 2 ("HH2") for the cap year exceeds its aggregate cap by $50,000; and (3) the total payments for the hypothetical hospice 3 ("HH3") for the cap year grossly exceeds the aggregate cap by $250,000:

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[62] *See* 42 C.F.R. § 405.1803(a)(3).

[63] *See id. See also* 42 C.F.R. § 405.1835(a).

[64] The hospice cap functions in the same way as the ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital (also known as the "TEFRA target amount") functions for IPPS exempt hospitals (*i.e.*, hospitals that are paid based on reasonable cost basis). *See* TEFRA, § 101, 96 Stat. at 332 (codified at 42 U.S.C. §1395ww(b)). Indeed, Congress enacted both the hospice cap and the TEFRA target amount in the same legislation. *Compare* TEFRA § 122 (establishing hospice cap), *with* TEFRA § 101 (establishing TEFRA target amount for hospitals). The TEFRA target amount for certain IPPS-exempt hospitals functions as a reimbursement cap and is set using a base year adjusted for inflation. Unless an exception or an exemption applies, the Medicare program will reimburse the IPPS-exempt hospital its reasonable costs for a fiscal year up to the TEFRA target amount for that fiscal year.

[65] CMS has imposed sequestration on hospitals subject to the TEFRA target amount in a similar fashion to hospices. *See* PRM 15-2, Ch. 40, Transmittal 4 (Sept. 2013) (instructions for Form CMS-2552-10) (*available at*: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R4P240.pdf).

[66] As there is no dispute as to how the aggregate cap itself was calculated for the Providers (*See supra* n. 37), the Board examples use a flat aggregate cap in order to focus on the elements of the calculation that are in dispute.

	TABLE 1	HH1 (< aggregate cap)	HH2 (> aggregate cap)	HH3 (>> aggregate cap)
A	Aggregate cap for the cap year	$200,000	$200,000	$200,000
B	Total payments received for hospice care during the cap year *with no sequestration applied.*	$180,000	$250,000	$450,000
C	Payments in excess of aggregate cap (Amount Line B exceeds Line A)	$ 0	$ 50,000	$250,000
D	Amount to be recouped as an overpayment by operation of the aggregate cap alone. (Line C)	$ 0	$ 50,000	$250,000
E	Resulting "amount paid" for the cap year per 42 U.S.C. § 1395f(i). (Line B – Line D)	$180,000	$200,000	$200,000
F	Amount to be deducted by sequestration. (2 percent of Line E)	$ 3,600	$ 4,000	$ 4,000
G	Net amount paid for the cap year after application of the aggregate cap and sequestration. (Line B – Line D – Line F)	$176,400	$196,000	$196,000

Table 1 represents an ideal world in which the full cap year is subject to sequestration and sequestration is applied to hospice reimbursement *after* the cap year ends when the end-of-cap-year reconciliation and accounting occurs. It is the purest way to see how the cap is applied separately from sequestration.

Not surprisingly, CMS does not want to knowingly overpay providers, so it does not wait until the close of the cap year to apply sequestration to the Medicare allowable amount determined as part of the cap-year-end reconciliation and accounting process for the cap year. Rather, CMS applies sequestration up front throughout the cap year to any interim hospice payments made prior to the cap-year end. This up-front application of sequestration is practical given that most hospices will not exceed their aggregate cap (similar to HH1 in Table 2 below) and, thus, have no overpayment at the cap-year end.[67] Indeed, if CMS did not apply sequestration up front but rather waited until the cap-year-end reconciliation and accounting process as outlined in Table 1, then CMS would be assessing and collecting overpayments on ***all*** Medicare-participating hospices which would not be administratively practical. The hospices in Table 1 would be assessed an overpayment that equals the sum of Line D and Line F.

[67] This assumes that these hospices did not exceed the inpatient care cap or have any other adjustments.

As a result of its choice to apply sequestration up front, CMS has to go through a more complex end-of-cap-year reconciliation and accounting process than the simplified approach laid out in Table 1. More specifically, because CMS applied sequestration to the interim payments rather than waiting until the final Medicare allowable amount is determined, CMS had to develop a cap-year end reconciliation and accounting process that simulated the proper process reflected in Table 1. The Board finds that this process does *not* "double dip" from any hospices. In particular, the TDL's methodology reverses and adds back any sequestration amounts already deducted during the year (*i.e.*, to restate payment to total "pre-sequester" payments) to ensure that the aggregate cap is applied separately from sequestration to prevent sequestration from affecting or interfering with or otherwise altering application of the aggregate cap in the first instance. The Medicare program then effectively reapplies sequestration after the aggregate cap has been applied so that both the overpayment amount and the amount of Medicare payment are properly stated. This does not run afoul of the Medicare statutory provisions in 42 U.S.C. §§ 1395f(i)(1)(A) governing overall hospice payment or 1395f(i)(2)(A) governing the hospice cap. As noted in the Medicare Benefit Policy Manual, CMS Pub 100-02, Ch. 9, § 90.2.1, the hospice cap applies to "[t]otal actual Medicare payments for services . . . regardless of when payment is actually made." The fact that payment is made on paper (*i.e.*, reverse sequestration to pre-sequester amounts) and then, in the same process, is taken away as an overpayment as part of the end-of-cap year reconciliation and accounting process does not in any way alter its validity. This is illustrated by comparing Table 1 above, to Table 2 below.

Table 2 illustrates how the TDL would apply to sequestration for a *full* cap year (*i.e.*, how the TDL would apply sequestration to all twelve months) using the same cap-year-end reconciliation and the same three hypothetical hospices as in Table 1. Rather than applying sequestration following the cap year end as done in Table 1, Table 2 illustrates how sequestration was applied to hospice payments as they were issued throughout a full cap year and how applying the TDL results in the same end points as Table 1 (it does so by reverse engineering the process). HH1 represents the majority of hospices which will not exceed their aggregate cap and, as a result, their interim payments made during the year represent in the aggregate their final payment amount for the cap year with sequestration already applied. HH2 and HH3 represent the situations where sequestration had to be reversed and reapplied because the hospice exceeded its aggregate cap.

	TABLE 2	HH1 (< aggregate cap)	HH2 (> aggregate cap)	HH3 (>> aggregate cap)
A	Aggregate cap for the cap year	$200,000	$200,000	$200,000
B	Sequestration amount reported on PS&R for cap year. (Line D x .02)	$ 3,600	$ 5,000	$ 9,000
C	Net reimbursement received per PS&R for cap year. (Line D-Line B)	$176,400	$245,000	$441,000
D	Gross pre-sequester payments where sequestration is reversed. (Line B + Line C)	$180,000	$250,000	$450,000
E	Pre-sequester overpayment. (Amount Line D exceeds Line A)	$ 0	$ 50,000	$250,000
F	Pre-sequester overpayment reduced by 2 percent. (Line E – (Line E x 0.02))). NOTE—This result is the net overpayment that should be assessed. The sequestration is credited and backed out of the overpayment since CMS need not pay it out and then collect it back as an overpayment.	$ 0	$ 49,000	$245,000
G	Net amount paid for the cap year after recoupment of net overpayment. (Line C – Line F)	$176,400	$196,000	$196,000

As Table 2 illustrates, for hospices that do not exceed their aggregate cap (similar to HH1), there is no overpayment as sequestration was withheld during the cap year. For hospices that exceed their aggregate cap (similar to HH2 and HH3), the overpayment amount to be refunded on Table 2 (Line F) will be smaller than the overpayment amount had their interim payments not been sequestered throughout the cap year as represented in Table 1. Specifically, a comparison of the overpayment amount in Table 1 to Table 2 confirms that:

1. Hospices receive the ***same*** net reimbursement regardless of whether interim payments were sequestered throughout the cap year (confirmed by comparing Line G from both tables).

2. The overpayment amount to be refunded is less if interim payments are sequestered throughout the cap year (confirmed by comparing the sum of Lines D and F in Table 1 to Line F in Table 2).

As the sequestration began on April 1, 2013 near the midpoint of the 2013 cap year, CMS had to refine the TDL to ensure that the reconciliation consistently treated those payments made prior to sequestration as not being subject to sequestration. The only scenario that CMS needed to address (which also appears extremely rare or improbable) is when a hospice's total interim payments for the five months prior to the sequestration alone surpass its aggregate cap for the 2013 cap year. It is ***only*** in this situation when the following caveat in the third bullet of the TDL would apply: "The 2% overpayment reduction cannot be greater than the actual

sequestration amount reported on the PS&R report." Applying the caveat for this situation ensures that the hospice would ***not*** be subject to sequestration for cap year 2013 because the hospice would have already hit the 2013 aggregate cap ***before*** sequestration had begun on April 1, 2013, thereby obviating the need to apply sequestration. In other words, based on the hospice's aggregate cap for the 2013 cap year, there would have been no additional payments following April 1, 2013 to which sequestration could have been applied for the 2013 cap year and, as a result, the hospice would have its payments simply reduced to the aggregate cap amount as if there were no sequestration.

Table 3 illustrates how the TDL works *for the 2013 cap year* where there is a ***partial*** year of sequestration (*i.e*., sequestration for seven months from April 1, 2013 to October 31, 2013). The facts in Table 3 otherwise stay the same except that the PS&R for the hypothetical hospices breaks out the pre-sequester payments, the net reimbursement, and sequestration amounts for the 2013 cap year as follows: (1) HH1 has $178,800 in net reimbursement with $1,200 as the associated sequestration amount; (2) HH2 has $247,400 in net reimbursement with $2,600 as the associated sequestration amount; and (3) HH3 has $446,400 in net reimbursement with $3,600 as the associated sequestration amount. Note that HH3 illustrates how the caveat in the third bullet of the TDL would apply where the hospice payments received from the first five months of the 2013 cap year alone exceed the aggregate cap.

	TABLE 3	HH1 (< aggregate cap)	HH2 (> aggregate cap)	HH3 (>> aggregate cap)
A	Aggregate cap for the cap year	$200,000	$200,000	$200,000
B	Sequestration amount reported on PS&R for cap year.	$ 1,200	$ 2,600	$ 3,600
C	Net reimbursement received per PS&R for cap year.	$178,800	$247,400	$446,400
D	Gross pre-sequester payments where sequestration is reversed. (Line B + Line C)	$180,000	$250,000	$450,000
E	Pre-sequester overpayment. (Amount Line D exceeds Line A)	$ 0	$ 50,000	$250,000
F	Pre-sequester overpayment reduced by 2 percent unless the 2 percent reduction exceeds Line B, then the reduction is capped at Line B. (Line E – (Line E x 0.02 or line B)). NOTE—This result is the net overpayment that should be assessed. The sequestration is backed out of the overpayment since CMS need not pay it out and then collect it back as an overpayment.	$ 0	$ 49,000	$246,400 (as 2 percent of Line E exceeded Line B, then Line E must be reduced by Line B)
G	Net amount paid for the cap year after recoupment of net overpayment is accounted. (Line C – Line F)	$178,800	$198,400	$200,000

A simple way to grasp how the TDL applies is to think about a cap year for a hospice as a jar with a line marked on it to represent that hospice's aggregate cap for that cap year (*i.e.*, any additional payment added to the jar above that line for the hospice would be an overpayment for that hospice). The TDL instructions approach the hospice's jar from the cap-year end (*i.e.*, after the jar is already filled with all of the hospice payments for that hospice for the cap year).

However, if one first thinks about the jar from the front end, *as it is being filled*, it is easier to understand for a particular cap year. In order to view the jar as it is being filled for a hospice, one first has to assume for the sake of illustration that CMS could know in advance what an individual hospice's aggregate cap was when the applicable cap year began, and that there is a line on the jar for this aggregate cap. As payments are made to the hospice during the course of the cap year, CMS places equivalent green chips into the jar for what is paid out on an interim basis to the provider (*i.e.*, the net amount) and, for any amount sequestered, it puts the equivalent red chips into the jar. CMS needs to put red chips representing the sequestered amounts because it is the ***full*** payment rate (*i.e.*, pre-sequester rate) that is the proxy *for the hospice's costs* for that service and it is the hospice's aggregate *costs* for the year that are capped at the hospice's aggregate cap (*i.e.*, the maximum Medicare allowable amount).

The first five months of the 2013 cap year were not subject to sequestration (sequestration did not begin until April 1, 2013). So, if the hospice's payments issued *prior to sequestration* resulted in the green chips hitting the aggregate cap line, then at that point the Medicare program would stop making payments and, as such, there would be no additional payments for the cap year to which sequestration could be applied.[68] As a result, the hospice's total Medicare payment for the 2013 cap year would be the aggregate cap itself, regardless of how many additional services the hospice furnished during the remainder of the 2013 cap year (this is HH3 in Table 3). In the alternative, if green chips from the first five months did *not* hit the aggregate cap but come close (for example, within exactly $20,000 gross), then all subsequent payments up to $20,000 gross would be subject to sequestration as represented by $19,600 green chips and $400 red chips going into the jar. However, once the $20,000 mark was reached, the Medicare program would make no more payments, regardless of how many additional services the hospice furnishes the remainder of the year, and $400 would be the amount sequestered for the cap year (this is similar to HH2 in Table 3).

Keeping with the jar analogy for the 2014 and 2015 cap years, it is clear that CMS cannot know in advance what the aggregate cap is for a hospice until after the cap-year end ***or***, *for that matter, cannot know in advance whether a hospice will actually exceed its aggregate cap for the cap year*. Accordingly, the methodology laid out in the TDL reverse engineers this process by starting with a filled jar consisting of all the green and red chips from payments made *in sequence* for the entire 2014 or 2015 cap years. CMS must calculate the aggregate cap and mark the jar with a line for the aggregate cap for each year after the jar is already filled.

[68] Again, this appears to be an extremely rare or improbable possibility for which CMS needed to account.

If the jar is filled *in sequence*, then the excess green and red chips above the aggregate cap line would represent the gross overpayment amount. The excess green chips themselves represent the overpayment amount that should be assessed, while the excess red chips are credited as amounts previously sequestered and are not part of the overpayment. Similarly, the green chips below the aggregate cap line represent the hospice's net reimbursement and the red chips below the aggregate line represent that amount that has been properly sequestered during the course of the cap year.[69]

The Board finds that the Medicare Statute establishes precise rules for determining all aspects of a hospice's aggregate cap. However, the Board points out that, as the above Tables illustrate, neither the sequestration order nor the CMS TDL altered *any* aspect of the calculation of the aggregate cap. Rather, CMS implemented sequestration in a manner to ensure that no aspect of those cap calculations was altered by sequestration and that sequestration is effectively applied after the aggregate cap.

All of the Providers in this appeal exceeded their aggregate caps for the appealed cap years and, but for sequestration, the total amount of Medicare payment for their "costs" under 42 U.S.C. § 1395f(i)(1)(A) would have been simply their 2013, 2014, or 2015 aggregate caps, as applicable (*i.e.*, cost ceiling). While the Providers in this appeal would like the Medicare Contractor to reduce their debts by the full sequestered amount, the Board disagrees because sequestration applies to the amount paid as determined by the applicable cap-year-end reconciliation and accounting process. If the Medicare Contractor reduced the Providers' debts by the full sequestered amount (such that it would be considered a payment), then each of the Providers' final Medicare payment for their "costs" would simply be their full aggregate cap amounts, and no portion of that payment would have been sequestered. This outcome clearly would violate the President's sequestration order.

In summary, although the Providers in this appeal would like to be paid their entire aggregate cap amounts despite the sequestration order,[70] the Board finds that the sequestration order requires that all Medicare payments, without exception, be reduced. Therefore, the Board concludes that the Providers must have their final Medicare payments sequestered, even though those payments were determined based on the aggregate cap.

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[69] Again, CMS makes the credit for the previously sequestered amount that it had just reversed on paper *(i.e.*, converted to pre-sequestered amount) because CMS would not pay out this amount only to then turn around and collect again as a sequestered amount. That is why it is handled administratively on paper.

[70] *See* Provider's Final Position Paper at 13-14.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly applied sequestration to the Providers' aggregate cap payments at issue and calculated each of the Providers' respective aggregate cap overpayments correctly.

BOARD MEMBERS:

Clayton J. Nix, Esq.
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:

2/7/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Appendix A – Summary of Providers

Provider Name	**Provider Number**	**Fiscal Year Ends Under Appeal**
Vitas Healthcare Corporation - Milpitas	05-1746	10/31/2013
Vitas Healthcare Corporation - Milpitas	05-1746	10/31/2014
Vitas Healthcare Corporation – Walnut Creek	05-1770	10/31/2014
Vitas Healthcare Corporation – Walnut Creek	05-1770	10/31/2015

Appendix B – TDL 150240

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

TDL-150240, 09/11/2014

MEMORANDUM

DATE: March 3, 2015

FROM: Acting Director, Financial Services Group
Office of Financial Management

Director, Chronic Care Policy Group
Center for Medicare

Director, Medicare Contractor Management Group
Center for Medicare

SUBJECT: Sequestration – Impact on Hospice Aggregate Cap Calculation

TO: See Addressees

On March 1, 2013, a sequestration order was issued, as required by law. The purpose of this Technical Direction Letter (TDL) is to provide instructions to the Part A and Part B Medicare Administrative Contractors (A/B MACs) with Home Health and Hospice workloads (HH&H MACs) on how the sequestration amounts shall be handled pertaining to the hospice cap calculation.

The HH&H MACs shall calculate the aggregate cap determination as follows:

- The sequestration amount reported on the Provider Statistical and Reimbursement (PS&R) report for each hospice shall be added to the net reimbursement amount reported on the PSchar_error
- The resulting amount shall be compared to the hospice's aggregate cap amount to calculate a pre-sequester overpayment; and
- The pre-sequester overpayment shall be reduced by 2% to reflect the actual amount paid to the hospice. The 2% overpayment reduction cannot be greater than the actual sequestration amount reported on the PS&R report.

Please see attachment A of this TDL for a sample calculation of a hospice aggregate cap calculation.

The sequestration amount reported on the PS&R report for the 2013 cap year was accumulated for services on or after 04/01/2013 so there is no need to split the PS&R report for periods 11/01/2012 – 03/31/2013 and 04/01/2013 – 10/31/2013.

The HH&H MACs shall perform the following steps if a 2013 hospice cap determination has been issued and the hospice was below the hospice aggregate cap:

- Determine if the hospice exceeds the aggregate cap when the sequestration amount is added to the net reimbursement.
- If the hospice exceeds the aggregate cap, the HH&H MAC shall:

    1. Issue a Notice of Reopening to revise the hospice cap determination to reflect the sequestration amount;
    2. Recalculate the hospice cap determination in accordance with the above and issue a revised hospice cap determination; and
    3. Issue a demand for the overpayment.

The HH&H MACs shall perform the following steps if a 2013 hospice cap determination has been issued and the hospice was above the hospice aggregate cap:

- Issue a Notice of Reopening to revise the hospice cap determination to reflect the sequestration amount;
- Recalculate the hospice cap determination in accordance with the above and issue a revised hospice cap determination; and
- Issue a demand for the corrected overpayment.

The HH&H MACs shall determine if a reopening of a 2013 hospice cap determination is necessary and shall issue a Notice of Reopening within 150 days from the date of this TDL.

The HH&H MACs shall send a listserv to providers explaining the sequestration impact on the hospice cap calculation and may post information regarding this issue on its website.

Provider Education

No national message will be distributed from CMS.

Contractors may use the information contained in this TDL to conduct normal operations in order to respond to inquiries from the provider community and to educate providers when appropriate, including the discretion to do local messaging as needed; however, the TDL number shall not be referenced.

A/B MAC Contract Numbers

Jurisdiction 6 ~ HHSM-500-2012-M0013Z
Jurisdiction 11 ~ HHSM-500-2010-M0001Z
Jurisdiction 15 ~ HHSM-500-2010-M0002Z
Jurisdiction K ~ HHSM-500-2013-M0015Z

This Technical Direction Letter (TDL) is being issued to you as technical direction under your MAC contract and has been approved by your Contracting Officer's Representative (COR). This technical direction is not to be construed as a change or intent to change the scope of work under the contract and is to be acted upon only if sufficient funds are available. In this regard, your attention is directed to the clause of the General Provisions of your contract entitled Limitation of Funds, FAR 52.232-22 or Limitation of Cost, FAR 52.232-20 (as applicable). If the Contractor considers anything contained herein to be outside of the current scope of the contract, or contrary to any of its terms or conditions, the Contractor shall immediately notify the Contracting Officer in writing as to the specific discrepancies and any proposed corrective action.

Unless otherwise specified, contractors shall be in compliance with this TDL within 10 business days of its date of issuance.

Should you require further technical clarification, you may contact your COR. Contractual questions should be directed to your CMS Contracting Officer. Please copy the COR and Contracting Officer on all electronic and/or written correspondence in relation to this technical direction letter.

/s/	/s/	/s/
Sherri McQueen	Laurence Wilson	Larry Young

Attachment(s)

Addressees:
John Kimball, Vice President, Operations, CGS Administrators, LLC
Steve Smith, President and Chief Operating Officer, CGS Administrators, LLC
Michael Kapp, President, National Government Services, Inc.
Joe Johnson, President & Chief Operating Officer, Palmetto GBA, LLC

cc:
James Doane, CGS Administrators, LLC
Melissa Lamb, CGS Administrators, LLC
Andrew Conn, National Government Services, Inc.
Jim Elmore, National Government Services, Inc.
Stacie Amburn, National Government Services, Inc.
Todd Reiger, National Government Services, Inc.
Trina Akridge, National Government Services, Inc.

Mike Barlow, Palmetto GBA, LLC
Ron Paige, Palmetto GBA, LLC
Yolanda Rocha, RRB
Randy Throndset, CM/CCPG/DHHHH
Zinnia Harrison, CM/CCPG/DHHHH
Brian Johnson, CM/MCMG
Carol Messick, CM/MCMG
David Banks, CM/MCMG
Jody Kurtenbach, CM/MCMG
Larry Young, CM/MCMG
Linda Tran, CM/MCMG
Margot Warren, CM/MCMG
Martin Furman, CM/MCMG
Marybeth Jason, CM/MCMG
All RAs, CMS
Nanette Foster Reilly, Financial Management & Fee-for-Service Operations
Christina Honey, OAGM
Holly Stephens, OAGM
Jacob Reinert, OAGM
Jeremy Steel, OAGM
Johnny Vo, OAGM
Kristen Lawrence, OAGM
Linda Hook, OAGM
Peter Haas, OAGM
Linda Uzzle, OFM/FSG
Mark Korpela, OFM/FSG
Owen Osaghae, OFM/FSG