PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D17

PROVIDER -
Hospice 2009 BNAF Group
Bluegrass 2009 BNAF Group

Provider Nos.: Various

FYE - 2009

vs.

CASE NOs.: 09-0764G and 09-1053GC

INTERMEDIARY –
Blue Cross Blue Shield Association/
Palmetto Government Benefit
Administrators

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Issue

Should the Provider Reimbursement Review Board (Board) grant expedited judicial review over the question of whether Secretary's elimination of the budget neutrality adjustment factor (BNAF) used in the calculation of hospice payment rates was proper?[1]

Statutory and Regulatory Background

The hospice regulations were issued to implement section 122 of Pub. L. 97-248 of the Tax Equity and Fiscal Responsibility Act of 1982,[2] which provides coverage for hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. The regulations establish, among other things reimbursement standards and procedures[3] for hospices and includes a prospective cost-based payment methodology.[4]

The Secretary[5] enacted a prospective capitated payment methodology for hospice care in which a hospice would generally be paid one of several predetermined rates for each day a Medicare beneficiary was under care. The rates vary depending on the level of care.[6] The statute, 42 U.S.C. § 1395f(i)(2), provides for a limit or cap on total Medicare reimbursement to a hospice. Payments are made to a hospice throughout its reporting period for each day of the care furnished to Medicare beneficiaries; hospices are required to return payments that exceed the cap.[7] The intention of the cap was to ensure that payments for hospice care would not exceed the amount that would have been spent by Medicare if the patient had been treated in a traditional setting.[8]

The payment rates are adjusted for wage differences based on definitions of Metropolitan Statistical Areas (MSAs) issued by the Office of Management and Budget. Through an annual notice published in the Federal Register, the Centers for Medicare & Medicaid Services (CMS) issues a hospice wage index based on the most current available hospital wage data, including definitions of MSAs.[9] Any proposed changes to the payment methodology are required to be published in the Federal Register.[10]

The original hospice wage index was based on 1981 Bureau of Labor Statistics hospital data and had not been updated since 1983. In 1994, because of the disparity in wages from one geographical location to another, the Hospice Wage Index Negotiated Rule-making Committee was established to negotiate a wage index to be used to update the

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[1] See, 73 Fed. Reg. 46464 (August 8, 2008) Provider Hearing Request Ex. P-B. This change was included in the hospice wage index final rule and was implemented on October 1, 2008.
[2] Codified as 42 U.S.C.1395x(dd).
[3] 48 Fed. Reg. 58008 (December 16, 1983).
[4] 48 Fed. Reg. 38146, 38152 (August 22, 1983).
[5] of the Department of Health and Human Services.
[6] 48 Fed. Reg 38146, 38152 (August 22, 1983).
[7] Id. and 42 C.F.R. § 418.309(b).
[8] Id. at 38162.
[9] 42 C.F.R. § 418.306(c).
[10] 42 C.F.R. § 418.30(d).

hospice wage index. The new methodology was published in the August 8, 1997 Federal Register. This methodology used pre-floor and pre-reclassified hospital wage index for the hospice benefit. These raw wage index values were subject to either a budget neutrality adjustment or the application of the hospice floor to compute the hospice wage index used to determine payments to hospices.[11]

Budget neutrality means that, in a given year, estimated aggregate payments for hospice services will be updated using the updated hospice values with equal estimated payments that would have been made for the services if the 1983 hospice wage index values had remained in effect, after adjusting the payment rates for inflation. The BNAF has been computed and applied annually to the labor portion of the hospice payment.[12]

The final rule for the hospice wage indices for Federal fiscal year (FFY) 2009 implemented a phase out of the BNAF. The BNAF is to be phased out over three years: reduced by 25 percent in FFY 2009, 50 percent for a total of 75 percent in FFY 2010 and eliminated completely in 2011.[13] On February 17, 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) (P.L. 111-5)[14] which delayed the phase-out until FFY 2010.

Providers' Request for EJR

The Providers explain that subsequent to the publication of the final rule phasing out the use of the BFNA in the hospice wage index, but before it was implemented, the National Hospice and Palliative Care Organization (NHPCO), on behalf of its members, filed a lawsuit in Federal District Court in the District of Columbia against CMS and the Department of Health and Human Services. The lawsuit sought to enjoin the defendants (the Government) from implementing the BNAF phase out on the grounds that the rule is contrary to law and does not comply with the requirements of the Administrative Procedure Act because it is arbitrary, capricious and an abuse of discretion.

The Government filed a motion to dismiss the case on jurisdictional grounds, arguing that since the claims arose under the Medicare Act, Federal court review was available only after NHPCO's member hospices had exhausted their administrative remedies. In response, NHPCO argued that there was no administrative review process available to NHPCO or its members, therefore the court provided the only opportunity for review. In particular, the plaintiffs cited to 42 C.F.R. § 418.311 which allows review of some matters by the Board, but states that "[t]he methods and standards for the calculation of the payment rates by CMS are not subject to appeal." In explaining this provision when the hospice regulations were promulgated, CMS stated in the Federal Register that "[t]he intermediary or the PRRB hearings are not appropriate for disputes involving the

[11] Id. at 73 Fed. Reg., above at nt. 1 .
[12] 73 Fed. Reg. 24000, 24002 (May 1, 2008).
[13] 73 Fed. Reg. at 46468
[14] See, www.whitehouse.gov/the_press_office/arra_public-review/

substance of the regulations or law, such as the calculation of the payment amounts by [CMS]."[15]

In response, the Government argued that there was a distinction been "payment rates" referenced in the regulation and the wage index adjustment at issue. It also asserted that the fact that the intermediary or Board hearing may not be appropriate for certain disputes does not mean that a hospice has no opportunity or obligation to file an administrative appeal, it simply reflects the fact that the intermediaries or the Board lack the authority to decide certain issues, and in such scenarios a provider may seek EJR. In support of this the Government cited three Federal district court cases brought by hospices concerning the aggregate cap Medicare payments for hospice care, each of which was filed after the Board granted EJR.[16]

The Providers state that they have appealed from a final determination of reimbursement and there are no issues of fact in dispute regarding the fiscal intermediaries' applications of the hospital wage indices as revised in the Federal Register notice. The Providers assert that the Board should find that EJR is appropriate in this case, as it did in another wage index group appeal concerning how CMS policy is made and conclude that the Board lacks the authority to dictate or fashion CMS policy.[17]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The Intermediaries did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 for a group appeal and the appeals were timely filed.

Prior to determining whether EJR is appropriate the Board must determine that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the hospice BNAF issue, there are no findings of fact for resolution by the Board;

3) it is bound by publication of the notice in the Federal Register; and

[15] 48 Fed. Reg. at 38159 (August 22, 1983).
[16] See, Providers' Request for EJR at 3, ftnt 9. Sojourn Care Inc. v. Leavitt, No. 07-CV-375GKF-PJC, (N.D. Okla., February 13, 2008) (decision invalidating the hospice cap in Tr. at 54-55 on motions for summary judgment, no written opinion); Heart to Heart Hospice, Inc. v. Leavitt, 2009 WL 272000 Slip Op.No. 1:07-CV289-MPM-JAD (N.D. Miss. February 5, 2009); Los Angels Haven Hospice, Inc. v. Leavitt, No. CV 08-4469GW(RZx) (C.D. Cal. Complaint filed July 8, 2008).
[17] Hunterdon/Somerset 2001 Wage Index Group v. Riverbend Government Benefit Administrator/Blue Cross Blue Shield Association. PRRB Dec. 2004-D13, Case No. 01-0881GE (April 14, 2004) Medicare and Medicaid Guide (CCH) ¶ 81,103.

4) it is without the authority to decide the legal question of whether the elimination of the BNAF used in the calculation of the hospice payment rates is valid.

The Board finds that it lacks jurisdiction over the BNAF issue for FFY 2009 because the ARRA of 2009 eliminated the implementation of the BNAF phase-out in the fiscal years in dispute. Consequently, the Providers' reimbursement based on the use of the BNAF in the hospice wage index was not reduced and there is no amount in controversy under dispute. As a result of the new legislation contained in the ARRA, the issue for FFY 2009 is moot. Since the reduction in the BNAF has been eliminated, the Providers cannot meet the jurisdictional threshold for a group appeal as set forth in the regulation, 42 C.F.R. § 405.1837(a)(3), which requires the amount in controversy must be at least $50,000 in the aggregate. The Board does not reach the question of whether it has jurisdiction over the budget neutrality adjustment factor issue.

Decision and Order

The Board hereby finds that it lacks jurisdiction over the appeals because there is no amount in dispute as required by 42 U.S.C. § 1395oo(a), 42 C.F.R. §§ 405.1835-405.1840 and 405.1842. Since jurisdiction over an appeal is a prerequisite to granting EJR, the Providers' request for EJR is denied. Because there are no other matters in dispute in these cases, the Board hereby dismisses the appeals.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Suzanne Cochran, Esq.
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FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Date: April 8, 2009

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers