PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2011-D8

PROVIDER -
Autumn Bridge, LLC

Provider No.: 37-1633

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
October 13, 2010

Hospice Cap Year Ended -
October 31, 2007

CASE NO.: 09-1927

INDEX

Issue:

1. Has the Provider demonstrated that it is entitled to a hearing before the Board because there is at least $10,000 in controversy?

   To what extent, if at all, Medicare's $397,228 demand for repayment from the Provider for fiscal year 2007, calculated pursuant to the existing regulation, would be decreased if the Provider's proposed manner of calculation is adopted.

Background:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare Administrative Contractors (MAC). FIs and MACs determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.[1]

Section 122 of Pub. L. 97-248 of the Tax Equity and Fiscal Responsibility Act of 1982,[2] provides coverage for hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Regulations issued to implement the statute established reimbursement standards and procedures[3] for hospices and include a prospective cost-based payment methodology[4] 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 upon the level of care.[5] The statute, 42 U.S.C. § 1395f(i)(2), provides for a limit or cap on the total Medicare reimbursement to a hospice. Payments are made to a hospice throughout its reporting period for each day of care furnished to Medicare beneficiaries; hospices are required to return payments that exceed the cap.[6] The intent 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.[7]

Congress mandated a method for calculating the amount each hospice care provider could be paid by Medicare per patient year of service. Payments to a hospice in any fiscal year (FY) may not exceed an aggregate cap, calculated as the product of the individual cap amount (adjusted for inflation) and the "number of Medicare beneficiaries" in the hospice program in an accounting year. The Medicare Act defines the "number of beneficiaries" as follows:

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[1] Both FI and MAC hereinafter referred to as intermediary.
[2] Codified as 42 U.S.C. § 1395x(dd).
[3] 48 Fed. Reg. 56008 (December 16, 1983).
[4] 48 Fed. Reg. 38146, 38152 (August 22, 1983).
[5] Id. at 38152.
[6] Id. at 38152.
[7] Id. at 38162.

> For the purposes of subparagraph (A), 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 under subsection (d) of this section with respect to the hospice program 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.

42 U.S.C. § 1395f(i)(2)(C) (Emphasis added.).

In the proposed regulation the Secretary acknowledged that the number of Medicare patients used in the calculation was to be adjusted to reflect the portion of care provided in the previous or subsequent report year or in another hospice. However, the Secretary's regulations credit hospice providers for a beneficiary's cap allocation only in the initial year of service, regardless of whether the patient continued to receive services in another accounting year.[8] The regulation, finalized in December of 1983, provides that:

> Each hospice's cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes –
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> (1) 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, in accordance with § 418.24 from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).
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> (2) In the case in which a beneficiary has elected to receive care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represent the portion of a patient's total stay in all hospices that was spent in that hospice. . . (Emphasis added.)

42 C.F.R. § 418.309(b)(1) and (2) (48 Fed. Reg. 56008, 56034 (December 16, 1983)).

[8] Id. at 38158.

Procedural History:

The Intermediary's determination for the Provider's 2007 cap year resulted in an overpayment of $397,228. Pursuant to 42 C.F.R. § 418.311 and 42 C.F.R. part 405, subpart R the Provider appealed the calculation, asserting that the regulation is invalid because it uses a different methodology than mandated by the statute. It asserted use of the regulatory method resulted in the overpayment and requested that the Board grant its request for expedited judicial review (EJR) pursuant to 42 C.F.R. §405.1842. On October 28, 2009, the Board granted the Provider's request for EJR. The Provider filed suit in the United States District Court for the Western District of Oklahoma (Court)[9] where jurisdictional concerns were raised by HHS as to the amount of injury caused by the cap.

On March 5, 2010, the Court remanded the case back to the Secretary for further findings similar to those required in Autumn Bridge, LLC v. Kathleen Sebelius, CIV-08-0819-F, (Autumn Bridge I). In that case the Court found based on the record before it, that it had no means by which to quantify the Provider's alleged injury because the Board's EJR determination did not indicate the specific amount it found in controversy. Without evidence from the Board to support the specific amount in dispute, the Court could not determine if Article III standing was met. The Court concluded that even if it ultimately agreed with the Provider's arguments regarding invalidity of the regulation, there was no proof of injury or causation upon which to base any monetary judgment in the Provider's favor, and so a remand for supported fact finding regarding the specific amount in controversy was necessary.

The CMS Deputy Administrator, acting for the Secretary, remanded the case to the Board on March 18, 2010 and ordered:

> (1) THAT the [Board] is to determine to (sic) the extent, if at all, Medicare's $397,228 demand for repayment from [the Provider] for fiscal year 2007 would be decreased if [the Provider's] proposed manner of calculation were adopted in lieu of Medicare's calculation pursuant to the existing regulation; and
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> (2) THAT the [Board], based on the above determination and remand, demonstrate a more specific fact-finding on whether [the Provider] has shown that it is entitled to a hearing before the [Board] because $10,000 is in controversy, so that, if other conditions are met, [the Provider] may obtain judicial review of the legal issue presented in this action under [42 U.S.C. § 1395oo(f)]. . . .

The parties performed the necessary calculations required by the remand order and stipulated to each other's findings. They then requested that this Board decision be made on-the-record, based upon the joint stipulations submitted as the unified position of both parties.

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[9] Autumn Bridge, LLC v. Sebelius, Case No. CIV-09-1290-F

The Provider was represented by Linda G. Scoggins, Esq. and Sarah Glick, Esq. of Scoggins and Cross, Oklahoma City, Oklahoma and the Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

Parties' Stipulations/Position:

The Parties have requested the Board use the Proposed Joint Stipulations Regarding Jurisdiction of the Board (stipulations) and its attachments[10] as the position of the parties. The stipulations are as follows:

> 1. Notice of the fiscal Year 2007 ("FY07") final determination appealed in this case was by letter dated April 15, 2009 and the hospice cap overpayment calculation therein ($397,228) was based on 42 C.F.R. §418.309 ("the regulatory method"). Applying the regulatory method, Palmetto, GBA ("the fiscal intermediary") determined that the total number of Medicare Beneficiaries Electing Hospice Benefits applicable to FY07 with Autumn Bridge was 134.2584. The regulatory method calculation was based on patient numbers on or about October 31, 2008.
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> 2. In accordance with the Notice of Reopening Pursuant to the Acting Deputy Administrator's Order for Remand ("Notice of Reopening") of May 3, 2010, which incorporated the Remand Order from the United States District Court for the Western District of Oklahoma ("District Court") of March 5, 2010 and the Order of the Administrator of March 18, 2010, both the Intermediary and the Provider have prepared calculations of Autumn Bridge's cap liability for FY07 based on a proportional allocation method that complies with 42 U.S.C. [§] 1395f(i)(2)(C) ("the proportional method"). [See District Court's Remand Order, Administrator's Order, and Notice of Reopening, attached hereto as Attachment A, B, and C, respectively.] The Provider prepared its calculations utilizing beneficiary count data as of 10/31/08, one year after the close of FY07 and consistent with the date recognized as appropriate by the PRRB Decision 2010-D8 for FY06. The Provider determined that the total number of Medicare Beneficiaries Electing Hospice Benefits with Autumn Bridge during FY07 was 144.9710. At a per beneficiary cap amount of $21,410.04, use of the proportional method calculation would have reduced the FY07 overpayment by at least $229,357.19 (10.7126 x $21,410.04), thus satisfying the $10,000 jurisdictional threshold for the PRRB.
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> 3. The Intermediary prepared its proportional method calculations utilizing the most recent data available, which was as of June 8, 2010. The Intermediary's calculations for FY07 resulted

[10] Documents referenced here as being attached are not attached to this decision but are attached to the documents referenced herein and furnished in their entirety as part of the record of this case.

in a total of 142.2041 Medicare Beneficiaries Electing Hospice Benefits with Autumn Bridge during the year. Thus, at a per beneficiary cap amount of $21,410.04, the Intermediary's calculations under the proportional method would have reduced the FY07 overpayment by at least $170,117.75 (7.9457 x $21,410.04). Thus, the Intermediary's calculations under the proportional method also demonstrate that Autumn Bridge more than satisfies the $10,000 jurisdictional threshold for the PRRB.

4. In PRRB Decision 2010-D8, which involved an identical remand by the District Court as to Autumn Bridge's cap liability for fiscal year 2006 ("FY06"), the PRRB concluded that:

> . . . the data from the same period used for the Intermediary's final determination from which this appeal arises must also be applied for determining the amount in controversy. It is the only data relevant to the final determination appealed. At the time the final determination is made or the time the appeal must be filed, any attempt to project how the amount of the final determination might be modified by future events would be conjecture in most cases. [See PRRB Decision 2010-D8, p. 8, attached hereto as Attachment D.]

5. The Administrator conducted a review of PRRB Decision 2010-D8 under the provisions of 42 C.F.R. [§] 405.2875. [See Administrator's Decision, attached hereto as Attachment E.] One of the questions considered in the Administrator's review was when the statutory calculation should be made in response to the Remand Order, The acting Deputy Administrator agreed with the Intermediary's position at page 17:

> Because of the nature of the computation, the later real-time data can only further decrease the value of the claim to the Provider and, thus, once a point in time is reached where the number of beneficiaries has been reduced to below that needed for the necessary amount in controversy, there is no more accurate data which will change that finding. Thus, the Administrator concluded that, in order to accurately determine whether the Provider is harmed as a result of the application of the regulatory methodology and meets that threshold amount in controversy, the Provider's methodology cannot be based on the date [sic] from October 2007, but rather should be based on the data from November 2009.

6. On July 22, 2010, the District Court reversed the Administrator's Decision to the extent that it determined that $10,000 was not in controversy as to Autumn Bridge's claim for

FY06. The District Court also affirmed the PRRB's determination that the statutory calculation for FY06 should be made as of October 31, 2007 in response to the Remand Order. [See District Court Order of July 22, [2]010, attached hereto as Attachment F.] The Order of the District Court noted:

> The court reverses the Secretary's decision for two reasons.
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> First , the court's remand order made it clear that the principal purpose of the remand was to provide fact-findings to inform the court's determination of its own jurisdiction over Autumn Bridge I, a determination which depended on the correctness of the PRRB's original unsupported finding that at least $10,000 was in controversy. Understood in that manner, *i.e.* as a remand to help the court determine its own jurisdiction at the time this action was filed, the data which should have been used to compare the hypothetical demand for repayment per Autumn Bridge's proposed calculation method and the actual demand for repayment per the regulatory calculation method, is data which was in existence as of October 31, 2007. This is the cut-off date for data which the Intermediary used to calculate the amount of its demand for repayment from Autumn Bridge for fiscal year 2006, which is the subject of this action, and this is the data which the PRRB did, in fact, use to make its fact-findings on remand.
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> The Administrator, however, used data which included information regarding patients' dates of death after October 31, 2007. Obviously, this information was not in existence and was not knowable as of October 31, 2007. Depending upon when these patients died, some or all of this information may not have been in existence as of December 12, 2007 when Medicare's demand for repayment was sent; or on June 20, 2008 when the PRRB first notified Autumn Bridge of its finding that expedited judicial review was appropriate; or on August 8, 2008 when Autumn Bridge was filed alleging jurisdiction based on expedited judicial review; or even on August 10, 2009 when this action was remanded for fact-findings in support of jurisdiction.
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> While this type of subsequently available information could be relevant to the merits of the case, the purpose of the remand was to assist the court in determining whether expedited judicial review was available as a basis of jurisdiction in Autumn Bridge I. The Administrator's determination that $10,000 is not in controversy for jurisdictional purposes is

> arbitrary and capricious or otherwise not in accordance with the law to the extent that it is based on data which did not exist as of October 31, 2007, the [data] cut-off date used to calculate the $720,991 demand for repayment which is the subject of this action.
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> 7. Whether the PRRB uses the determination date proposed by the Intermediary, or the date proposed by the Provider and previously determined appropriate by the PRRB and the District Court, the jurisdictional amount of $10,000 is satisfied.

Based upon these stipulations the parties believe there are no facts in dispute.

Board Decision and Discussion:

The Remand from the Administrator addresses a single underlying issue, namely, determination of the amount in controversy, and whether that amount is at least $10,000, the threshold for Board jurisdiction.

In Stipulation 3, the Intermediary used the proportional method (see Stipulation 2) to calculate the effect on the overpayment, but based its calculation on data as of June 8, 2010. The parties agreed that using this date, the overpayment would be reduced by $170,117.75. As stated in the stipulation, "Thus, the Intermediary's calculations under the proportional method also demonstrate that Autumn Bridge more than satisfies the $10,000 jurisdictional threshold for the PRRB."

Consistent with the Courts' reversal of the Secretary's position in the prior identical case, the Provider prepared its calculations under the proportional method using a cutoff date of October 31, 2008, the date used by the Intermediary for its overpayment calculation. In Stipulation 2, the parties agreed that based on data available as of that date, the proportional method would have reduced the overpayment by at least $229,357.19, thus satisfying the $10,000 jurisdictional threshold for the Board.

In Stipulation 7, both parties agree that whether the Board uses the date proposed by the Intermediary, or the date proposed by the Provider, the jurisdictional amount of $10,000 is satisfied.

Based on these stipulations, the Board finds it is uncontested that the Provider met the $10,000 jurisdictional threshold. The Board also finds that the cutoff date for data used to determine the amount in controversy is October 31, 2008. That was the cutoff date for the Intermediary's final determination. The Board concludes that the data as of that same date must also be applied when determining the amount in controversy. Based on that data, the amount in controversy is $229,357.19.

Board Decision:

The Board finds that the amount in controversy is $229,357.19 based on data through October 31, 2008. The Provider has, therefore, satisfied the jurisdictional requirements for expedited judicial review, previously addressed in the Board's October 28, 2009 decision.

Board Members Participating:

Suzanne Cochran, Esq.
Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Date: November 10, 2010