PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D2

PROVIDERS –
Hospice Complete, Inc.
Hospice Complete, Inc./Southern Care
2008 Hospice Cap CIRP Group

See APPENDIX I

Provider Nos.: 01-1600 and 01-1662

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING -
December 19, 2012

Cost Reporting Periods Ended –
October 31, 2006; October 31, 2007;
October 31, 2008

CASE NOS.: 09-1888; 09-1889
and 10-1057GC

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ISSUE:

Whether the Providers' cap liability for 2006-2008 should be recalculated in light of SouthernCare Hospice's monetary settlement of the *qui tam* lawsuits filed against it in the United States District Court for the Northern District of Alabama ("U.S. District Court for Northern Alabama") at case numbers 2:05-cv-00873 and 2:07-cv-02325.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. The Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and 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 ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982[3] established Medicare coverage for in-home hospice care for terminally-ill Medicare beneficiaries who elect to receive care from a participating hospice.[4] Regulations issued to implement the statute established payment standards and procedures for hospices and include a prospective payment methodology by which a hospice would generally be paid one of several predetermined rates for each day a Medicare beneficiary was under care.[5] The rates vary depending on the level of care.[6]

The statute provides for a limit or "cap" on the total Medicare payment to a provider.[7] Payments are made to a hospice throughout its reporting period for each day of care furnished to Medicare beneficiaries; however, hospices are required to return payments that exceed the cap.[8] 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 Medicare beneficiary had been treated in a traditional setting.[9]

Congress mandated a method for calculating the amount each hospice care provider could be paid by Medicare per patient year of service. In particular, 42 U.S.C. § 1395f(i)(2) specifies that payments to a hospice in any fiscal year may not exceed an aggregate cap. 42 C.F.R. § 418.309

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] Pub. L. 97-248, 96 Stat. 324 (1982).
[4] 42 U.S.C. § 1395x(dd).
[5] 48 Fed. Reg. 56008 (Dec. 16, 1983); 48 Fed. Reg. 38146, 38152 (Aug. 22, 1983).
[6] 48 Fed. Reg. 38146, 38152 (Aug. 22, 1983).
[7] 42 U.S.C. § 1395f(i)(2).
[8] 48 Fed. Reg. at 38152.
[9] 48 Fed. Reg. at 38162.

(2009) implements this statutory provision and specifies that the hospice cap is calculated as follows:

> (b) 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 –
>
> (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* during the period beginning on September 28 (35 days from the beginning of the cap year) and ending on September 27 (35 days before the end of the cap year).
>
> (2) In the case in which a beneficiary received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stays in all hospices that was spent in that hospice.[10]

Thus, the cap applies to Medicare beneficiaries who elect to receive hospice care in accordance with 42 C.F.R. § 418.24 which specifies that "[a]n individual who meets the eligibility requirement of § 418.20 may file an election [to receive hospice care] with a particular hospice." 42 C.F.R. § 418.20 describes eligibility for a hospice election as follows:

> In order to be eligible to elect hospice care under Medicare, an individual must be—
>
> (a) Entitled to Part A of Medicare; and
> (b) Certified as being terminally ill in accordance with § 418.22.

42 C.F.R. § 418.22(b) specifies that a physician's certification of a Medicare beneficiary as terminally ill must be "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." Thus, an individual's eligibility for hospice care depends primarily on a physician's certification that that individual is terminally ill.

The Intermediary notifies the hospice of the determination of program reimbursement at the end of the cap year.[11] A hospice dissatisfied with an Intermediary's determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the issuance of that determination.[12]

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[10] (Emphasis added.)
[11] 42 C.F.R. § 418.308(c).
[12] 42 C.F.R. § 418.311.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

These cases involve two providers, both named Hospice Complete, Inc., with separate facilities--Pelham (Provider No. 01-1600) and Jasper (Provider No. 01-1662) in Birmingham, Alabama (collectively referred to as the "Providers" and individually as Pelham and Jasper). Each of the Providers is Medicare certified and received payment for hospice services to Medicare beneficiaries. The Providers each had a fiscal year ending October 31 and appeal encompasses cost reporting periods for fiscal years (FYs) 2006, 2007, and 2008 for Pelham and for FY 2008 for Jasper. The Providers' Medicare fiscal intermediary is Palmetto Government Benefits Administrator ("Intermediary").

On October 17, 2007, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" to Pelham notifying it that it had exceeded its cap amount by $820,490 for FY 2006.[13] On March 4, 2009, the Intermediary issued a "REVISED Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" to Pelham notifying it that it had exceeded its cap amount by $842,403 for FY 2006, and informed Pelham that an additional $21,913 was due the Medicare Program.[14] Also, on March 4, 2009, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" to Pelham notifying it that it had exceeded its cap amount by $644,366 for FY 2007.[15] Finally, on January 13, 2010, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" to Pelham notifying it that it exceeded its cap amount by $519,007 for FY 2008.[16]

On January 5, 2010, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" to Jasper notifying it that it exceeded its cap amount by $23,422 for FY 2008.[17]

The Providers appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 418.311 and 405.1835-1841. The Provider was represented by Lucy W. Jordan, Esq., of the Kee Law Firm, LLC. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS

The Providers contend that their hospice cap liabilities (specifically concerning FYs 2006 through 2008 for Pelham and FY 2008 for Jasper) should be recalculated in light of a monetary settlement entered into by SouthernCare, Inc. ("SouthernCare"), a hospice which had two *qui tam* lawsuits filed against it in the U.S. District Court for Northern Alabama by two former employees. The complaints each alleged that SouthernCare had engaged in a practice of fraudulently enrolling patients who were not terminally ill in hospice care and submitting false

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[13] CN 09-1889 Provider's Final Position Paper Exhibit P-1. For FYE 12/31/06, Provider's Exhibit P-1 and P-2, pgs 5-24 and Intermediary's Exhibit I-1 and I-2 inexplicably list the Provider as "Kindred Care Hospice" rather than Hospice Complete Inc., however, the provider number is given as 01-1600 which is the same provider number for subsequent years.

[14] Provider Exhibit P-2 (Case No. 09-1889).

[15] Provider Exhibit P-1 (Case No. 09-1888).

[16] Provider Exhibit P-2 (Case No. 10-1057GC).

[17] Provider Exhibit P-1 (Case No. 10-1057GC).

claims to the Medicare program for hospice care services furnished to these patients.[18] On January 15, 2009, SouthernCare entered into a settlement agreement with the Department of Justice to make a substantial payment to settle these allegations.[19]

The Providers assert that they should be given full credit in their hospice cap calculations for any of those fractional beneficiaries who had been first admitted as a hospice patient by SouthernCare under the premise that those fractional beneficiaries were falsely admitted and, thereby, not eligible for hospice care.[20] In other words, their cap credit for each of those fractional beneficiaries should be increased by the amount of the allowances allocated to SouthernCare for those beneficiaries. When the Providers' hospice cap liabilities are recalculated under this premise, the calculations yield the following results for each affected cap year and facility:

Pelham FY 2006[21]

SouthernCare allowances	22.13
Cap amount	$20,585.39
Total SouthernCare credit amount	$455,554.68
Total Cap overpayment calculated for Pelham	$842,403.00
Adjusted Cap overpayment	$386,848.32

Pelham FY 2007[22]

SouthernCare allowances	15.99
Cap amount	$21,410.04
Total SouthernCare credit amount	$342,346.53
Total Cap overpayment calculated for Pelham	$644,366.00
Adjusted Cap overpayment	$302,019.47

Pelham FY 2008[23]

SouthernCare allowances	1.453
Cap amount	$22,156.96
Total SouthernCare credit amount	$32,194.06
Total Cap overpayment calculated for Pelham	$519,007.00
Adjusted Cap overpayment	$486,812.94

Jasper FY 2008[24]

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[18] *See* Provider Exhibits 4-5 (Case Nos. 09-1889, 10-1057GC); Provider Exhibit 4 (Case No. 09-1888).
[19] *See* Provider Exhibit 3 (Case Nos. 09-1889, 10-1057GC); Provider Exhibit 2 (Case No. 09-1888). These exhibits are simply a copy of the press release from the U.S. Department of Justice announcing the settlement of the *qui tam* lawsuits with SouthernCare. The Providers did not enter into the record a copy of the actual settlement agreement.
[20] Provider's Final Position Paper at 11 (Case No. 09-1888); Provider's Final Position Paper at 11 (Case No. CN 09-1889); Provider's Final Position Paper at 8 (Case No. 10-1057GC).
[21] Provider's Final Position Paper at 14 (Case No. 09-1889).
[22] Provider's Final Position Paper at 13 (Case No. 09-1888).
[23] Provider's Final Position Paper at 12 (Case No. 10-1057GC).
[24] *Id.* at 11.

SouthernCare allowances	4.042
Cap amount	$22,156.96
Total SouthernCare credit amount	$89,558.43
Total Cap overpayment calculated for Jasper	$23,422.00
Adjusted Cap overpayment	($66,136.43)

These calculations detail the Providers' aggregate claim for relief to reduce the Intermediary's calculated hospice cap overpayment determinations by $919,654. In addition, the Providers asserted that they should be reimbursed for the interest paid to date on the overpayment.

In their post hearing brief, the Providers revised their calculations downward to account for patients who were admitted not only by SouthernCare and then Hospice Complete, but also one or more other hospices subsequent to SouthernCare as well. The Provider also relinquished its claim for certain other SouthernCare fractional beneficiaries[25] which yielded the following results for each cap year and facility:

Pelham FY 2006[26]

SouthernCare allowances	15.23
Cap amount	$20,585.39
Total SouthernCare credit amount	$313,515.48
Total Cap overpayment calculated for Pelham	$842,403.00
Revised Adjusted Cap overpayment	$528,887.52

Pelham FY 2007[27]

SouthernCare allowancess	11.53
Cap amount	$21,410.04
Total SouthernCare credit amount	$246,857.76
Total Cap overpayment calculated for Pelham	$644,366.00
Revised Adjusted Cap overpayment	$397,508.24

Pelham FY 2008[28]

SouthernCare allowances	1.412
Cap amount	$22,156.96
Total SouthernCare credit amount	$31,285.63
Total Cap overpayment calculated for Pelham	$519,007.00
Revised Adjusted Cap overpayment	$487,721.37

Jasper FY 2008[29]

SouthernCare allowances	3.202
Cap amount	$22,156.96

[25] Provider's Post Hearing Brief at 2.
[26] *Id. at* Exhibit 1.
[27] *Id.* at Exhibit 3.
[28] *Id.* at Exhibit 7.
[29] *Id.* at Exhibit 5.

Total SouthernCare credit amount	$70,946.85
Total Cap overpayment calculated for Jasper	$23,422.00
Revised Adjusted Cap overpayment	($47,524.85)

These revised calculations reduce the Providers' aggregate claim for relief by $257,048 to $662,606. The Providers assert that these calculations constitute a good faith effort to make a fair claim consistent with the *qui tam* complaints that accused SouthernCare of improper admissions in which a "large majority" of the patients enrolled but never qualified for hospice during the term of their enrollment and that "at least one-half of the patients being admitted or enrolled for hospice benefits were not terminally ill or entitled to hospice benefits."[30]

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the Providers have submitted no factual evidence in the record that identifies specific Medicare beneficiaries who were falsely admitted to hospice care at Southern Care but were not eligible for such care and who then elected one of the Providers during the cap years at issue.[31] Absent such evidence of individual patient ineligibility, the Providers have no basis to receive any credit (whether partial or full) for SouthernCare's fractional beneficiaries in its hospice cap calculation. Furthermore, the Intermediary contends that there is no basis for the Board to make a determination to disregard prior elections at other hospices under the regulations at 42 C.F.R. § 418.309(b)(2) or any other authority.[32]

In summary, the Intermediary argues that it followed the proper Medicare rules and regulations when calculating the Provider's aggregate cap on hospice payments and asks that its hospice cap calculations for Pelham for FYs 2006 through 2008 and Jasper for FY 2008 be affirmed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties contentions, the Board finds and concludes that the Providers did not meet their burden of proof under 42 C.F.R. § 418.309(b) with respect to establishing that any of the specific Medicare beneficiaries who elected one of the Providers during the cap years at issue, and who had made prior elections at SouthernCare, were actually ineligible for the hospice care that SouthernCare furnished. Absent that proof, the Board cannot grant the relief sought by the Provider, *i.e.* increasing the fractional beneficiaries at issue by the amount of cap allowances allocated to SouthernCare and, thereby, reducing their cap overpayments.

The statutory and regulatory requirements for hospice eligibility are set forth in 42 C.F.R. U.S.C. §§ 1395f(a)(7) and 1395x(dd) and 42 C.F.R. §§ 418.20, 418.24, 418.309. In the case of hospice care, the individual's attending physician and the medical director of the hospice program must certify in the first 90-day period in which hospice care is provided that the individual is

[30] *Id.* at 2.
[31] Intermediary's Post-Hearing Brief at 12-16.
[32] Intermediary's Final Position Paper at 8 (Case No. 09-1888); Intermediary's Final Position Paper at 8 (Case No. 09-1889).

terminally ill.[33] In each subsequent 60- or 90-day period in which the individual elects to receive hospice care, the attending physician must recertify that the individual is terminally ill, *i.e.*, certify that the individual has a medical prognosis that the individual's life expectancy is six months or less.[34]

The evidence provided by the Providers in these cases does not establish that any of their Medicare beneficiaries who had also received hospice services from SouthernCare failed to meet the hospice eligibility requirements as outlined in the statute. Mere allegations included in a *qui tam* complaint does not establish that any of the elections made by the specific Medicare beneficiaries at issue in this case for hospice care to be furnished by SouthernCare was in fact false or fraudulent.[35] Similarly, neither the mere joinder of the U.S. Department of Justice to that *qui tam* action nor the settlement of those allegations through the execution of a settlement agreement establish any acts of fraud specific to patients at issue.[36]

More specifically, the Board notes that there is no evidence that the payment by SouthernCare to settle the *qui tam* complaints filed against it reopened, revised, or rescinded any hospice eligibility determinations, including any of those Medicare beneficiaries at issue who were admitted to the Providers for hospice care. As previously discussed, pursuant to 42 C.F.R. §§ 418.20, 418.24, and 418.309, a Medicare beneficiary's eligibility to elect to receive hospice care depends primarily on a physician's certification that that beneficiary is terminally ill. For each of the Medicare beneficiaries at issue, the Medicare program paid SouthernCare for hospice care services and necessarily determined that each of these beneficiaries was eligible to elect hospice care and, thereby, had the requisite physician certification for being terminally ill. However, the Provider has not presented any evidence to establish that any of these specific payments made to SouthernCare were reopened and reversed in whole or in part.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the hospice cap calculation procedures specified in 42 C.F.R. § 418.309 which depends on "the number of Medicare *beneficiaries who elected to receive hospice care* from that hospice during the cap period."[37] As the Provider has not presented any evidence to establish that the elections made by the Medicare beneficiaries at issue to receive hospice care furnished by SouthernCare were in fact revised, rescinded, or otherwise waived, the Board is bound by 42 C.F.R. § 418.309 to recognize them. Accordingly, the Board finds that the Intermediary followed the proper Medicare rules and regulations when calculating the aggregate cap on hospice payments for each of the Providers for the fiscal years at issue.

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[33] 42 U.S.C. § 1395f(a)(7).
[34] 42 U.S.C. §§ 1395f a)(7)(A), 1395x(dd)(3)(A).
[35] The Board notes that the allegations in the complaint do allege examples of fraud wherein certain unnamed patients are described. However, even if the identify of these patients were known and one or more of those patients were one of the Medicare beneficiaries at issue in this case, the Board would still find the allegations contained in the complaints not relevant because the Providers have failed to present any evidence establishing that one or more of the Medicare beneficiaries at issue were not eligible to elect the hospice care furnished to them (in whole or in part) by SouthernCare.
[36] The Provider has not entered into evidence the actual settlement agreement and the existence of a settlement agreement between SouthernCare and the U.S. Department of Justice to settle these allegations does not confirm whether any of these allegations were in fact true, much less that one or more of the Medicare beneficiaries at issue were not eligible to elect the hospice care furnished to them (in whole or in part) by SouthernCare.
[37] (Emphasis added.)

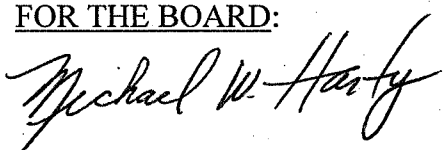
DECISION AND ORDER:

The Intermediary followed the proper Medicare rules and regulations when calculating the aggregate cap on hospice payments for FYs 2006 through 2008 for Pelham and for FY 2008 for Jasper. The Intermediary's calculations of the hospice cap amounts are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: NOV 27 2013

APPENDIX I

Case No.	Provider No.	Provider	Reporting Period
09-1888	01-1600	Hospice Complete, Inc. (Pelham)	10/31/07
09-1889	01-1600	Hospice Complete, Inc. (Pelham)	10/31/06
10-1057GC	01-1600	Hospice Complete, Inc. (Pelham)	10/31/08
	01-1662	Hospice Complete, Inc. (Jasper)	10/31/08