DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

CERTIFIED MAIL

OCT 24 2013

Integrated Health Technology
Michael A. Stewart
Senior Vice President
2411 Old Crow Canyon Road, Suite 193
San Ramon, CA 94583

RE: Salinas Valley Memorial Hospital, Provider No. 05-0334, FYE 6/30/2007, Case No.: 10-0881

Dear Mr. Stewart:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Provider filed an initial appeal request on April 5, 2010 from a Notice of Amount of Change of Program Reimbursement dated December 17, 2009. The Board assigned case number 10-0881.

The appeal included three issues:

Labor Room Days removed from Total Patient Days & Medi-Cal Eligible Days;
The SSI Percentage, including the Realignment issue; and
Title XIX Days.

The Provider requested a remand of the SSI Ratio and Labor Room Days issues pursuant to CMS Ruling 1498-R by letters dated February 5, 2013.

Prior to processing the remands, additional information regarding the revised NPR was requested by letter dated July 19, 2013.

In response to the Board's request, the Provider's Representative sent a facsimile transmittal sheet indicating the appeal was not filed from a revised NPR.[1]

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a)(2004) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR.

The Board finds that this Provider is appealing from a revised NPR dated December 17, 2009, and not the original NPR dated July 22, 2008. Each NPR has distinct appeal rights, and the Provider cited the December 17, 2009 revised NPR in its April 5, 2010 appeal request.

[1] The Notice of Amount of Change of Program Reimbursement dated December 17, 2009 shows the date of the original NPR to be 7/22/08 and indicates the date of "Reop #1" as 12/17/09.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Labor Room Days:

The Board majority finds it lacks jurisdiction over this issue. Although the adjustment report submitted with the appeal request references Labor Delivery Room Days at adjustment 6, this adjustment was for total patient days, not Medicaid Labor Room Days. Medicaid Labor Room Days were included at adjustment 7 and, significantly, that adjustment increased Adult and Pediatric Days by 216. Because the Provider failed to submit the requested workpapers, there is insufficient evidence that the Medicaid Labor Room Days were adjusted. Based on this information, the Board majority denies jurisdiction over the Labor Delivery Room Days issue and denies the Provider's request for a standard remand pursuant to CMS Ruling 1498-R.

SSI Percentage:

With regard to the SSI Percentage issue, the Board denies jurisdiction. As noted, appeals from revised NPRs are limited to the specific matters revised in the revised (corrected) determination. Based on the adjustment report submitted, there is no adjustment to SSI on line 4.01– only to the DSH calculation on line 4.03. Consequently, the Board denies the Provider's request to remand the SSI Percentage issue pursuant to CMS Ruling 1498-R.

Eligible Days:

With regard to the Eligible Days issue, the Board finds that it does not have jurisdiction over the issue. Although there was an adjustment to Eligible Days where the Intermediary added back days, it cannot be determined whether the 164 days the Provider is appealing were part of the Intermediary's adjustment on the revised NPR. Again, the Provider did not provide the workpapers necessary to support an adjustment to the Eligible Days issue under appeal.

SSI Realignment:

Finally, the Board finds that the issue is premature. In its appeal request, the Provider indicates that it has requested a realignment to the hospital's fiscal year end, but provides no proof that the MAC has made a determination with regard to the request. The Board finds that this issue is premature. Pursuant to 42 C.F.R. § 405.1835:

> "The provider… has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if… [a]n intermediary determination has been made with respect to the provider."[2]

Because there was no final determination made by the MAC, the Board lacks jurisdiction over the SSI realignment issue and dismisses it from the appeal.

Since there are no remaining issues in the appeal the Board hereby closes this case. 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:
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq. (dissenting w/regard to Labor Room Days issue)

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877

cc: Noridian Administrative Services c/o First Coast Service Options
Darwin San Luis
JE Part A Provider Audit Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108 6782

Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association

[2] The language of 42 C.F.R § 405.1835 as it stood on FYE 2007 .

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Refer to: 06-2349G

Certified Mail

OCT 31 2013

Eytan Ribner
Blumberg Ribner, Inc
315 South Beverly Drive
Suite 205
Beverly Hills, CA 90212

RE: Blumberg Ribner 1986-2004 Equitable Tolling Group
Provider Nos. Various
FYEs Various
PRRB Case No. 06-2349G

Dear Mr. Ribner:

The Provider Reimbursement Review Board (Board) has reviewed the record in the above referenced appeal. The Board's jurisdictional determination is set forth below.

Background

The Providers filed their request for hearing on September 12, 2006, requesting the Board consider equitable tolling because they lacked the specific information to know of the specific flaws in the Supplemental Security Income (SSI) percentage used in the disproportionate share calculation to file a timely appeal. The Providers contend that they could not know of the errors in the SSI percentage until the Board issued its decision in *Baystate Hospital v. Mutual of Omaha,* PRRB Dec. 2006-D20, March 16, 2006 (Medicare & Medicaid Guide (CCH) ¶ 81,468).

Decision of the Board

The Board finds that the appeal was not timely filed and hereby dismisses the case. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 and 405.1841 (1986), a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more and the request for hearing is filed within 180 days of the date of the final determination. In this case, the Providers filed their appeal more than three years after the relevant determination, clearly outside of the 180-day appeal period.

Equitable Tolling

The Supreme Court recently addressed the question of whether the Board can consider equitable tolling and found that equitable tolling does not apply to appeals pending before the Board. *See*

Sebelius v. Auburn Regional Medical Center, 133 S.Ct. 817 (2013). This appeal was not timely and the Board cannot consider equitable tolling to extend the time for filing.

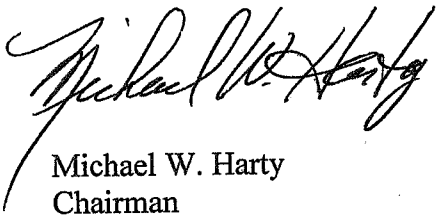
Since the Board has dismissed the case for lack jurisdiction over the appeal because it was not timely filed, the case is hereby closed.

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

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Kyle Browning, NGS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to: 13-2057

Certified Mail

OCT 31 2013

Mark S. Kennedy, Esq.
Kennedy Attorneys and Counselors at Law
12222 Merit Drive, Suite 1750
Dallas, TX 75251

RE: Tranquility Hospice, LLC
Provider No. 37-1679
Cap Period 11/1/2008-10/31/2009
PRRB Case No. 13-2057

Dear Mr. Kennedy:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's August 16, 2013 jurisdictional brief (received August 19, 2013) in the above-referenced appeal. The August 16th letter responded to the Board's August 5, 2013 denial of the Provider's request for expedited judicial review (EJR) for failure to respond to the Board's May 23, 2013 letter seeking additional information necessary to determine whether EJR was appropriate. The Board's letter advised the Provider that it had 15 days to file its jurisdictional brief or face dismissal of the case. The Board's jurisdictional determination is set forth below.

Statutory and Regulatory Background

Hospice Reimbursement under Medicare

Coverage for hospice care was provided through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248. It was designed to provide terminally ill patients with palliative care rather than curative care with individuals waiving all rights to Medicare payments for treatment underlying their terminal illnesses. 42 U.S.C. § 1395d(d)(2)(A).

Pursuant to 42 U.S.C. § 1395f(i), Medicare pays hospice providers on a per diem basis. *See* 42 C.F.R. § 418.302. The total payment to a hospice in an accounting year known as a cap year runs from November 1 through October 31 and is limited by a statutory cap. *See* 42 U.S.C. § 1395f(i)(2)(A). Payments in excess of the statutory cap are considered overpayments and must be refunded to the Medicare program by the hospice. *See* 42 C.F.R. § 418.308.

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care. 48 Fed. Reg. 56,008, 56,022 (December 16, 1983). Once a

beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.[1]

Hospice Payment Litigation and CMS Ruling CMS-1355-R (Ruling 1355-R)

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is inconsistent with the plain language of the Medicare statute and set aside the overpayment determinations.[2]

As a result of the outcome of the litigation, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1355-R which allowed certain providers to have their reimbursement determined using a patient-by-patient proportional methodology and, subsequently, issued a revised regulation implementing this elective methodology in future years. Under the ruling, hospice providers which had timely appeals pending under 42 U.S.C. § 1395oo could request that their reimbursement be recalculated using the proportional methodology. Under this methodology each Medicare beneficiary who received hospice care in a cap year is allocated to that hospice provider's cap year on the basis of a fraction. The numerator of the fraction is the number of patient days for that beneficiary in that hospice for that cap year and the denominator will be the total number of patient days for that beneficiary in all cap years in which the beneficiary received hospice services. The individual beneficiary counts for a given cap year will then be summed to compute the hospice's total aggregate beneficiary count (number of Medicare beneficiaries) for that cap year. A new payment cap would be calculated and a notice of overpayment determination would be issued.

CMS recognized that, at the time of recalculation using the patient-by-patient proportional methodology, a hospice beneficiary could still be receiving services resulting in an overstatement of a fractional allocation. Consequently, these providers' cap determinations would be subject to reopening under the reopening regulations and the reimbursement adjusted. Some portion of the hospice beneficiary's patient days will be counted toward the hospice cap in each cap year in which services were received.

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.[3]

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[1] Ruling 1355-R at 3-5.
[2] *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); Los Angeles Haven Hospice, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius, 717 F. Supp. 2d 696 (S.D. Tex. 2010).*
[3] Ruling at 9-11.

Changes to the Aggregate Cap Calculation Methodology Effective October 1, 2011

In the August 4, 2011 Federal Register[4] the Secretary announced changes to calculations of hospice cap calculations for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.[5]

The Secretary noted that there were hospices that had not filed appeals of overpayments determinations challenging the validity of 42 C.F.R. § 418.309 and which were awaiting cap determinations for cap years ending on or before October 31, 2011. As of October 1, 2011, those hospices could elect to have their final cap determination for those cap year(s), and all subsequent years calculated using the patient-by-patient methodology.[6] A hospice that did not challenge the methodology used for determining the number of beneficiaries used in the cap calculation could continue to have the streamlined methodology[7] used to calculate their reimbursement. Those hospices not seeking a change were not required to take any action.

With respect to changing hospice reimbursement methodologies, the Secretary noted in relevant part that:

> (4) Hospices which elected to have their cap determination calculated using the streamlined methodology could later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either:
>
> a. Electing to change to the patient-by-patient proportional methodology; or
> b. Appealing a cap determination calculation using the streamlined methodology to determine the number of Medicare beneficiaries.

76 Fed. Reg. 47302, 47310 (August 4, 2011).[8]

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[4] 76 Fed. Reg. 47302, 47308 (August 4, 2011).
[5] *See* Footnote 2.
[6] The regulation describing the patient-by-patient methodology is found at 42 C.F.R. § 418.309(c) (2011).
[7] The regulation describing the streamlined methodology is found at 42 C.F.R. §418.309(b) (2011).
[8] *See also* 42 C.F.R. § 418.309(d)(1)(ii) (a hospice that has filed a timely appeal regarding the methodology used for determining the number of Medicare beneficiaries in its cap calculation for any cap year is deemed to have elected that its cap determination for the challenged year and all subsequent years, be calculated using the patient-by-patient proportional methodology).

Provider's Comments Regarding Jurisdiction

The Provider submitted a request for hearing and EJR dated May 10, 2013 (received May 9, 2013) appealing its March 13, 2013 Implementation of Final Judgment and Order of Remand (revised cap determination). This March 13, 2013 notice stated that it was issued based on instructions from CMS and to implement the U.S. District Court's Final Judgment and Order of Remand. The notice explained that the Provider had originally been paid under the provisions of 42 C.F.R. § 418.309(b), the streamlined methodology, which the Federal district court found to be unlawful and set aside the determination.[9] The remand required recalculation of the hospice cap amount based on the proportional method found in 42 C.F.R. § 418.309(c). This revision resulted in a cap overpayment of $957,946.52.

The issue statement attached to the hearing request[10] explained that the revised cap determination calculated the Providers reimbursement in accordance with CMS Ruling 1355-R and was calculated using the proportional methodology.[11] The Provider contended that the revised cap notice incorporated the continued use of the streamlined methodology which has been invalidated by numerous Federal courts.[12] The Provider argue that the determination is based upon a calculation using the flawed ruling, consequently, the overpayment should be considered void and set aside.

The Provider's EJR request explained that it was challenging the validity of CMS Ruling 1355-R and the final rule establishing the proportional methodology found in the August 4, 2011 Federal Register[13] which purports to establish a cap calculation consistent with the Medicare Act. However, the Provider believes that both the Ruling and the newly promulgated regulation incorporate the continued use of the streamlined methodology, 42 C.F.R. § 418.309(b), established under an invalid hospice cap regulation. Since the Board lacks the authority to determine the validity of a regulation, the Provider requests that the Board find that EJR is appropriate.

On May 24, 2013, the Board advised the parties that it needed additional information in order to determine if EJR was appropriate. This request affected the 30-day period to respond to the request for EJR. In this letter, the Board requested that parties discuss whether the Board has jurisdiction to hear a question involving overpayments. When there was no response forthcoming from the Provider, the Board denied the Provider's request for EJR on August 5, 2013 and advised that a response to the request for jurisdictional briefs must be filed within 15 days or the appeal would be dismissed.

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[9] The PRRB appeal which resulted in this decision was case number 11-0547, the Provider's appeal of its original cap determination. The Board granted the Provider's request for EJR on March 29, 2011 and closed the case. The EJR request challenged the validity of 42 C.F.R. § 418.309(b).

[10] Provider's May 10, 2013 Hearing Request, Tab 3.

[11] *See also* Medicare Administrative Contractor's June 20, 2013 response to the Board's request for additional information. (The MAC recalculated the Provider's cap amount using the proportional methodology pursuant to a mandatory judicial order of remand.)

[12] *See* Footnote 2.

[13] 76 Fed. Reg. 26731 (August 4, 2011)

In its August 16, 2013 jurisdictional brief, the Provider reiterated its position that it was contesting the validity of Ruling 1355-R because it believes the ruling fails to validly implement the statutorily prescribed proportional methodology. It argues the fact that the Ruling provided for and included what the Provider alleged to be an invalid methodology established by 42 C.F.R. § 418.309(b). Further, the Provider believes that case law establishes that only the proportional methodology meets the requirements of 42 U.S.C. § 1395f(i)(2)(c) and, thus, the determination of its overpayment is invalid.

The Provider points out that Ruling 1355-R states, among other things, that appeal tribunals will no longer have jurisdiction over properly pending administrative appeals calculated under 42 C.F.R. § 418.309(b).[14] The administrative tribunals were required to remand such appeals to the MAC for recalculation using the patient-by-patient proportional methodology and would apply to cap years prior to 2012[15] and the fiscal years 2012 and thereafter would be addressed in the new regulation.[16]

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal and hereby dismisses the case. The Provider is challenging the validity of the Ruling 1355-R because it endorses the continued use of 42 C.F.R. § 418.309(b)(1), even though it was found to be invalid as it applies to this Providers cap period ending October 31, 2009.[17] However, the Provider in this case was paid under the provisions of 42 C.F.R. § 418.309(c), the patient-by-patient proportional methodology. This regulatory provision comports with the statutory requirements found in 42 U.S.C. § 1395f(i)(2) that states that the amount of payment for an accounting year may not exceed the "cap amount" for the year multiplied by the number of Medicare beneficiaries in the hospice program in that year. Since the revised cap determination was not issued as a result of a remand under Ruling 1355-R and the Provider was not reimbursed under the provisions of 42 C.F.R. § 418.309(b), it lacks standing to challenge the validity of the regulation. Once an election to receive reimbursement under § 418.309(c) is made, a provider cannot revert to being paid under § 418.309(b)(1). *See* 42 C.F.R. § 418.309(d)(2)(i).

Further, the appeal is moot because the validity of payment under the 42 C.F.R. § 418.309(b) has been successfully litigated in Federal court by the Provider subsequent to a grant of EJR in case number 11-0547, the appeal of its original cap determination for this cap year. It is that litigation that gave rise to the issuance of the revised cap determination appealed in this case and is reflected in the reference line of the revised cap determination.[18] The MAC's action in granting the relief the Provider was seeking, payment under 42 C.F.R. § 418.309(c), the proportional methodology, renders the request moot. *See Goldstar Home Health System, Inc. v. Sebelius, 2013 WL 3096190 (N.D.Tex.).*

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[14] *See* 76 Fed. Reg. 26731, 26734 (May 9, 2011).
[15] *Id.*
[16] *Id.*
[17] *See* MAC's June 21, 2013 Letter, Ex. 2 Final Judgment and Order of Remand in *Tranquility Hospice v. Sebelius (case number 11-CV-324-TCK-TLW, August 9, 2012).*
[18] See Provider's May 10, 2013 Hearing Request, Tab 1 "Implementation of Final Judgment and Order of Remand."

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

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

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA
Robin Sanders, Esq., BCBSA
Cecile Huggins, Palmetto GBA

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Refer to:

OCT 31 2013

13-1996
Certified Mail

Mark S. Kennedy, Esq.
Kennedy Attorneys and Counselors at Law
12222 Merit Drive, Suite 1750
Dallas, TX 75251

Cecile Huggins, Supervisor
Provider Audit-Mail Code AG-380
Palmetto GBA
300 Springdale Drive, Bldg. ONE
Camden, SC 29020-1728

RE: Tranquility Hospice, LLC[1]
Provider No. 37-1679
Cap Period 11/1/2010-10/31/11
PRRB Case No. 13-1996

Dear Mr. Kennedy and Ms. Huggins:

The Provider Reimbursement Review Board (Board) has reviewed the record in the above-referenced appeal subsequent to issuing its June 3, 2013 decision denying the Provider's request for expedited judicial review (EJR) and, a related matter, an appeal for this Provider for the hospice cap period ending October 31, 2009, which was assigned case number 13-2057. The Board is electing to remand the appeal to the Medicare Administrative Contractor (MAC) for payment for the reasons set forth below.

Statutory and Regulatory Background

Hospice Reimbursement under Medicare

Coverage for hospice care was provided through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248. It was designed to provide terminally ill patients with palliative care rather than curative care with individuals waiving all rights to Medicare payments for treatment underlying their terminal illnesses. 42 U.S.C. § 1395d(d)(2)(A).

Pursuant to 42 U.S.C. § 1395f(i), Medicare pays hospice providers on a per diem basis. *See* 42 C.F.R. § 418.302. The total payment to a hospice in an accounting year known as a cap year runs from November 1 through October 31 and is limited by a statutory cap. *See* 42 U.S.C. § 1395f(i)(2)(A). Payments in excess of the statutory cap are considered overpayments and must be refunded to the Medicare program by the hospice. *See* 42 C.F.R. § 418.308.

In 1983, the Secretary adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive

[1] The Provider's appeal of cap year ending10/31/2010 was assigned case number 13-0050. The Provider was reimbursed under the provisions of 42 C.F.R. § 418.309(c), the patient-by-patient proportional methodology. The Board dismissed the Provider's appeal of § 405.309(b) because in the final determination appealed the Provider was not reimbursed under that regulation and lacked standing to challenge the regulation.

the preponderance of his or her care. 48 Fed. Reg. 56,008, 56,022 (December 16, 1983). Once a beneficiary is counted for a given hospice, the beneficiary is not counted in the cap in subsequent years if services continue into more than one cap year.[2]

Hospice Payment Litigation and CMS Ruling CMS-1355-R (Ruling 1355-R)

In 2006, Providers began filing appeals objecting to the current counting methodology used in calculating hospice reimbursement, seeking to have the overpayment determination calculated under the methodology described above invalidated. The Federal district courts and courts of appeals that ruled on the question have issued decisions concluding that the methodology is inconsistent with the plain language of the Medicare statute and set aside the overpayment determinations.[3]

As a result of the outcome of the litigation, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1355-R (Ruling 1355-R) which allowed certain providers to have their reimbursement determined using a patient-by-patient proportional methodology and, subsequently, issued a revised regulation implementing this elective methodology in future years. Under the ruling, hospice providers, which had timely appeals pending under 42 U.S.C. § 1395oo, could request that their reimbursement be recalculated using the proportional methodology. Under this methodology each Medicare beneficiary who received hospice care in a cap year is allocated to that hospice provider's cap year on the basis of a fraction. The numerator of the fraction is the number of patient days for that beneficiary in that hospice for that cap year and the denominator is the total number of patient days for that beneficiary in all cap years in which the beneficiary received hospice services. The individual beneficiary counts for a given cap year will then be summed to compute the hospice's total aggregate beneficiary count (number of Medicare beneficiaries) for that cap year. A new payment cap would be calculated and a notice of overpayment determination would be issued.

CMS recognized that, at the time of recalculation using the patient-by-patient proportional methodology, a hospice beneficiary could still be receiving services resulting in an overstatement of a fractional allocation. Consequently, these providers' cap determinations would be subject to reopening under the reopening regulations and the reimbursement adjusted. Some portion of the hospice beneficiary's patient days will be counted toward the hospice cap in each cap year in which services were received.

Under the Ruling intermediaries and Medicare Administrative Contractors (MACs) were to identify properly pending appeals and recalculate the aggregate cap using the patient-by-patient methodology using the best available data. For hospices which had not filed appeals challenging the cap, the intermediaries and MACs were to use the reimbursement methodology that appeared in the regulation at 42 C.F.R. § 418.309(b)(1) for any cap year ending on or before October 31, 2011, unless CMS adopted a rule providing otherwise.[4]

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[2] Ruling 1355-R at 3-5.
[3] *See e.g. Lion Head Health Services v. Sebelius*, 689 F. Supp. 2d 849 (N.D. Tex. 2010); Los Angeles Haven Hospice, 2009 WL 5868513 (C.D. Cal.); *Hospice of New Mexico v. Sebelius*, 691 F. Supp. 2d 1275 (D.N.M. 2010); *IHG Healthcare, Inc. v. Sebelius, 717 F. Supp. 2d 696 (S.D. Tex. 2010).*
[4] Ruling at 9-11.

Changes to the Aggregate Cap Calculation Methodology Effective October 1, 2011

In the August 4, 2011 Federal Register[5] the Secretary announced changes to calculations of hospice cap calculations for cap years before October 31, 2011 and on or after October 31, 2012. This notice included a change in the hospice payment regulation, 42 C.F.R. § 418.309, allowing providers reimbursement to be calculated under either the new patient-by-patient proportional methodology or the streamlined methodology (the existing methodology). These changes were made as a result of the litigation resulting in Ruling 1355-R, described above, and the Secretary's requests for comments on potential modernization of the hospice cap calculation.[6]

The Secretary noted that there were hospices that had not filed appeals of overpayments determinations challenging the validity of 42 C.F.R. § 418.309 and which were awaiting cap determinations for cap years ending on or before October 31, 2011. As of October 1, 2011, those hospices could elect to have their final cap determination for those cap year(s), and all subsequent years calculated using the patient-by-patient methodology.[7] A hospice that did not challenge the methodology used for determining the number of beneficiaries used in the cap calculation could continue to have the streamlined methodology[8] used to calculate their reimbursement. Those hospices not seeking a change were not required to take any action.

With respect to changing hospice reimbursement methodologies, the Secretary noted in relevant part that:

> (4) Hospices which elected to have their cap determination calculated using the streamlined methodology could later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either:
>
> a. Electing to change to the patient-by-patient proportional methodology; or
> b. Appealing a cap determination calculation using the streamlined methodology to determine the number of Medicare beneficiaries.

76 Fed. Reg. 47302, 47310 (August 4, 2011).

When codified, the regulation, 42 C.F.R. § 418.309(3)(d), stated that:

> If a hospice that elected to have its aggregate cap calculated using the streamlined methodology under paragraph (d)(2)(ii) of this section subsequently elects the patient-by-patient proportional methodology or appeals the streamlined methodology, under paragraph (d)(2)(ii)(A) or (B) of this section, the hospice's

[5] 76 Fed. Reg. 47302, 47308 (August 4, 2011).
[6] *See* Footnote 3.
[7] The regulation describing the patient-by-patient methodology is found at 42 C.F.R. § 418.309(c) (2011).
[8] The regulation describing the streamlined methodology is found at 42 C.F.R. §418.309(b) (2011).

> aggregate cap determination for that cap year *and all subsequent cap years* is to be calculated using the patient-by-patient proportional methodology. As such, past cap year determinations may be adjusted to prevent the over-counting of beneficiaries, subject to existing reopening regulations. (emphasis added)

Procedural History

Through correspondence dated May 7, 2013 (received May 9, 2013), the Provider filed a request for hearing and EJR. The appeal and EJR were filed subsequent to the issuance of the Provider's April 9, 2013 Notice of the Effect of Inpatient Day Limitation and Hospice Cap Amount (Cap Amount) and challenged the reimbursement determined under 42 C.F.R. § 418.309(b), the streamlined methodology. The Provider challenged the overpayment calculation made under § 418.309(b), asserting that the regulation had been invalidated by numerous Federal courts[9] and that an overpayment calculated under the regulation was invalid.

The Board denied the Provider's request for EJR on June 3, 2013 and concluded that it had the authority to grant the relief sought, reimbursement under the patient-by-patient proportional methodology. The publication of the revision to the hospice cap regulations in 2011 permitted providers with cap years ending on or before October 31, 2011 to challenge reimbursement calculated using the streamline methodology by filing a timely appeal of its cap amount to the Board. *See* 42 C.F.R. § 418.309(d)(1).

In an earlier case for this Provider involving the cap period ending October 31, 2009, the Provider appealed its original cap determination in which reimbursement was determined under 42 C.F.R. § 418.309(b), the streamlined method. This appeal was assigned case number 11-0547. The Provider challenged the validity of the regulation under which it had been reimbursed and requested that the Board find that EJR was appropriate. The Board granted the request for EJR and the Provider filed an appeal in Federal court.[10] The Provider prevailed in its Federal court action and the case was remanded to the Secretary for payment utilizing a method consistent with the hospice statute, 42 U.S.C. § 1395f(i)(2). The MAC issued a revised Notice of Review and Hospice Cap Amount Pursuant to CMS Ruling 1355-R on October 3, 2012, reimbursing the Provider under the proportional methodology.[11] Remand under the Ruling reimburses providers using the patient-by-patient proportional methodology,[12] which is now codified at 42 C.F.R. § 418.309(c). The Provider appealed this revised determination which was assigned case number 13-2057.

Decision of the Board

The Board hereby by remands the calculation of the cap amount for the cap period ending October 31, 2011 to the MAC to calculate the Provider's cap reimbursement under the provisions of 42 C.F.R. § 418.209(c), the patient-by-patient proportional methodology. As

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[9] *Supra* note 2.
[10] The Federal court appeal was captioned Tranquility Hospice, Inc. v. Sebelius, No. 11-CV-324-TCK-TLW (N.D. Okla., August 9, 2012)
[11] *See* Blue Cross Blue Shield Association's June 20, 2013 letter Ex. 1 and 2 in case number 13-2057.
[12] *See* CMS Ruling No. CMS-1355-R at 8. Found on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/ Rulings/downloads/cms1355r.pdf

noted above, 42 C.F.R. § 418.309(d)(3) requires that, where a hospice has elected to be paid on the patient-by-patient proportional methodology, it will be paid using that methodology in the year of the election and all subsequent cap years. The Board is bound by the requirements of this regulation. *See* 42 C.F.R. § 405.1867.

Since the Provider successfully litigated the appeal of it cap amount for the cap year ending October 31, 2009, and, on remand of that cap year, was paid under the patient-by-patient per proportional methodology, it is required to be paid on the same basis in all subsequent fiscal years. This would include the 2011 cap year end which is the subject of this appeal. Since there is no other action for the Board to take with respect to his case, the case is hereby closed.

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

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

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA
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