CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **Autumn Bridge, LLC** **Provider** **vs.** **Blue Cross Blue Shield Association/ Palmetto Government Benefits Administrators** **Intermediary**	**Claim for Hospice Cap Year Ending October 31, 2006** **PRRB Dec No. 2010-D8 (PRRB Case No. 08-2068)** **Date: December 22, 2009**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is pursuant to the court order in Autumn Bridge, LLC v. Sebelius, Case No. CIV-08-0819. The Intermediary requested that the Administrator review the determination of the Board. The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider requesting that the Board's jurisdictional decision be affirmed. The CMS Office of Financial Management (OFM) submitted comments requesting that the Board's decision be reversed. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD'S DECISION

The issues before the Board, pursuant to the court ordered remand, were:

> 1) Has the Provider demonstrated that it is entitled to a hearing before the Board because there is $10,000 in controversy?
> 2) To what extent, if at all, Medicare's $720,991 demand for repayment from the Provider for fiscal year 2006 would be decreased if the Provider's proposed manner of calculation of the amount in the hospice

> cap is adopted in lieu of the Intermediary's calculation which was issued pursuant to the existing regulation.

The Board concluded that, under the Provider's proposed method (referred to by the Board as the "statutory method"), the Provider and Intermediary calculations produced on remand are not materially different as to application and, for the most part, are also not materially different with respective to the data that is used by the parties. The Board found there was a dispute as to whether certain beneficiaries should be counted, but that the most important question in determining whether the Provider meets jurisdictional requirements is the point in time at which the cap is calculated.

The Board found that, unlike the final determination of Medicare reimbursement, under the Provider's method of determining the cap, the determination of the number of beneficiaries counted for a particular year (cap year 2006 in this case) will reduce for that year, with each succeeding year. This is due to the fact that care for some of the beneficiaries continues for years. Under these circumstances, both parties agreed that, when a beneficiary's cap allowance is counted in fractions across multiple years of service, a change in any year (due to a patient's continuing service in a subsequent year) will necessitate a change in other years. The Board found that, under the Provider's "statutory" method the number of Medicare beneficiaries will fluctuate, therefore, causing the cap amount to be adjusted in the first year after the cap year in issue and likely to adjust again in the second year. The potential for adjustment for a particular year diminishes then with each successive year, but until every patient who received services in the year at issue expires, the cap amount is subject to change and so the final determination of the payments in excess of the cap amount is also subject to modification with each successive year.

Because the beneficiary count for a particular year will be modified in successive years, based on additional beneficiary days, the parties and the Board agree that a calculation based on the most recent figures available is a more accurate projection of what would ultimately be applied in successive years if the statutory method were used. However, the Board noted that, an appeal must be filed within 180 days from a final determination and it is conditioned on receipt of a specific determination. In this case, the FY 2006 cap year determination was made in December 2007 and was based on patient numbers as of October 31, 2007. Therefore, that data available as of that date should be used for the Provider's computation. The Board concluded that, if the Provider's "statutory" method is applied utilizing the beneficiary count data as of the date of the final determination appealed, the overpayment would have been reduced by at least $12,278.95 according to the Intermediary's calculation at Intermediary Post-Hearing Submission at 10, thus, satisfying the $10,000

jurisdictional threshold. While there were several distinctions in the parties' calculations, the Board found that the Intermediary conceded that the jurisdictional threshold is met if the data as of October 2007 is used.

The Board concluded that the data from the same time period used for the Intermediary's final determination from which this appeal arises must also be applied for determining the amount in controversy as it is the only data relevant to the final intermediary determination. The Board concluded that, at the time a final determination is made, or the time of an appeal, any attempt to project how the amount of the final determination might be modified would be conjecture in most cases. When a beneficiary cap allowance is counted in fractions across multiple years of service a change in any year will necessitate a change in other years.

The Board also concluded that three of the disputed beneficiaries must be included in the calculation which would further reduce the overpayment. The discrepancies in the parties' positions as to the data to be used were reconciled except for three beneficiaries for which the Provider failed to bill and a fourth for whom payment was denied by Medicare. The Intermediary asserted that they should not be included in the cap because no payments were made on their behalf. The Board concluded that those beneficiaries filed notices of election and they were identified in Medicare's common working file but the Provider did not receive payment for them. Tr. 79, 80, 86-91) The Board claimed that the Intermediary conceded that the beneficiaries actually received services from the Provider. The Board concluded that as the only two statutory conditions were satisfied, they must be included in the statutory method. The Board was unable to determine based on the evidence presented, whether the rejected ? beneficiary should be counted.

The Board further stated that, for the sake of judicial economy, if the court finds the Board decision was incorrect as to the time period for calculating the amount in controversy and to comply with the court's request to develop the record on the dollar amount of injury, the Board addressed the calculation using the most recent cap data of October 31, 2009.[1] Under that theory, the Board found that the amount in controversy does not exceed $10,000.

In sum, the Board concluded that, as of October 31, 2007, that the amount in controversy is at least $12,278.95 using data most favorable to the Intermediary. The Provider has therefore satisfied the jurisdictional requirements for expedited judicial review previously addressed in the Board's June 20, 2008 decision,

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[1] This data, first set forth at Provider Exhibit A is also referred to as the November 2009 data as it was submitted by the Provider with a November 2009 Affidavit.

COMMENTS

The Intermediary commented, requesting modification of the Board's decision. The Intermediary contended that the Board's decision is incorrect finding jurisdiction. The Intermediary argued that, contrary to the Board's decision, the proper response to the court's remand, is to use the most recent data available, not the data as of an October 31, 2007 cut-off. With respect to the computation, the Intermediary argued that the computation most compliant with the Court's order is 147.1829 beneficiaries with an *increase* of the overpayment of $32,821.30. The Intermediary concluded that, had the Provider's proposed manner of calculation been utilized, its overpayment would have increased, and it would have been worse off. Thus, the Provider had not demonstrated that the minimum amount in controversy for a Board hearing had been met. In additional, the Intermediary pointed out that the three fractional beneficiaries totaling .8368 for which an election was filed, but no claims ever submitted, should not be counted. Contrary to the Board's statement, there was no evidence that covered services were in fact provided. In addition, the Intermediary claimed that the Board should not accept the Provider's argument that whatever the damages are, these damages should be increased by interest computed on that differential. The Intermediary argued that there is no statutory or regulatory basis for additional damages based on interest.

The Provider commented, requesting that the Board's decision stand. The Provider generally challenged the Intermediary's request for Administrator's review. The Provider argued that the Board's findings should be sent back to the Court undisturbed because the Intermediary has failed to identify any error on the part of the Board that would justify review by the Administrator. The Provider argued that the Board's finding that as of October 31, 2007, the amount in controversy is at least $12,278.92 is correct. The Provider asserted that the court clearly requested a comparison of the 2006 demand (which used data existing as of October 31, 2007) with the Provider's calculation as to the same data. In addition, the Board properly addressed the calculation using the most recent cap data, October 2009, and noted that, under that theory, the amount in controversy would not exceed $10,000. Finally, the Provider noted that the other "errors" asserted by the Intermediary were misidentified.

The CMS' Office of Financial Management (OFM) also commented. OFM stated that the Provider originally claimed that CMS had improperly applied the statute and was seeking an expedited review in accordance with 42 CFR 405.1842. OFM pointed out that, as such, the Provider may not add additional issues to the appeal and, therefore, the Provider cannot add additional beneficiaries to the underlying calculation. OFM stated that this issue represents a separate appeal of the beneficiary

counts used by the Intermediary in its calculation. Since the Provider did not appeal, nor dispute, the validity of the beneficiaries used in the overpayment hospice cap determination, it would be improper to now change the factual dynamics by adding beneficiaries to the cap calculation. Thus, the Board erred by allowing the inclusion of any additional beneficiaries to enter into its decision making process, and should have rendered its decision based on the first column on the Calculation of Injury Spreadsheet, labeled "excluding both pts rejected and unbilled." This column shows that, by excluding the beneficiaries in contention, the Provider would have owed Medicare an additional $32,821.29. Thus, the Provider did not establish the minimum amount in controversy for a Board hearing.

Further, OFM argued that the Board erred by not allowing the most current data to be used in determining whether the Provider met the $10,000 threshold for Board hearing. OFM noted the regulation, at 42 CFR 405.1839(c)(5)(B), which states that when a provider has requested a hearing and the amount in controversy changes to an amount less than the minimum for a Board appeal due to a more accurate assessment of the amount in controversy, the Board does not retain jurisdiction. OFM explained that in order to effectuate the Hospice cap, the intermediary needs to make its calculation using the best available data in determining the length of stay of the beneficiary. However, OFM noted that, it was not stating that the beneficiary count should be changed, instead it was pointing out how the intermediary must determine the length of stay for each beneficiary and be able to apply it as a pro rata adjustment over the various years including the year under appeal as this Provider requested. OFM further explained that, if the Intermediary did not correctly apply a proportionate adjustment using the latest available data, the resulting beneficiary count for all affected fiscal years would be improperly stated and could result in overpayments in other cost years. Thus, OFM concluded that, the only correct way to apply the Provider's interpretation of the statute is to gather the latest available data, in this case October 2009, and to determine the appropriate allocation of the original beneficiary count over the Provider's cost year. Based on this, the Provider did not meet the $10,000 threshold for the amount in controversy.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The controlling hospice payment provisions are set forth at section 1861(dd)(2)(A)(iii), section 1814(i) and section 1861(v)(1)(A)[2] of the Social Security Act. Generally, Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his hospice election period. Election/termination dates are retained on the common working file (CWF).

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment

[2] Section 1861(v)(1)(A) provides, inter alia, that: "Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs."

regarding the normal course of an individual's illness. CMS has recognized that predicting life expectancy is not always exact.[3]

The statute provides for two caps on payments one on inpatient days described in section 1861(dd)(2)(A)(iii) and an aggregate cap on total payments in section 1814(i)(2)(A)-(C) of the Act and also incorporates the Secretary's reasonable cost limitation under section 1861v(1)(A) of the Act. Relevant to this case, Section 1814(i)(1)(A) states that:

> Subject to the limitation under paragraph (2) and the provisions of section 1813(a)(4) and except as otherwise provided in this paragraph, the amount paid to a hospice program with respect to hospice care for which payment may be made under this part 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 (including those authorized under section 1861(v)(1)(A)), except that no payment may be made for bereavement counseling and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.
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> (C) For 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) 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.
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> (D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.
> (3) Hospice programs providing hospice care for which payment is made under this subsection shall submit to the Secretary such data with

[3] *See* Medicare Claims Processing Manual, Section 80, et seq., Overview.

> respect to the costs for providing such care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines necessary.

The provisions that implement the statutory provision are set forth at 42 CFR Part 418. The regulation at 42 CFR 418.308 provides, regarding the limitation on the amount of hospice payments, that the total Medicare payment to a hospice for care furnished during a cap period is limited by the hospice cap amount specified in §418.309. The intermediary notifies the hospice of the determination of program reimbursement at the end of the cap year in accordance with procedures similar to those described in §405.1803 of this chapter. The regulation at paragraph (d) explains that payments made to a hospice during a cap period that exceed the cap amount are overpayments and must be refunded. The cap period runs from November 1st of each year through October 31 of the next year.

Regarding the calculation of the Hospice aggregate cap amount at 42 CFR 418.309, the hospice cap amount is calculated using the following procedures:

> (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—
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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 represents the portion of a patient's total stay in all hospices that was spent in that hospice. (The hospice can obtain this information by contacting the intermediary.)[4]

[4] The regulation at 42 CFR 418.310, which provides the reporting and recordkeeping requirements, states that: "Hospices must provide reports and keep records as the Secretary determines necessary to administer the program."

Section 407 of the Hospice Manual (Rev. 08-99) explains that:

> The computation and application of the "cap amount" is made by the intermediary at the end of the cap period. The material is presented here for your benefit as an aid to planning. You are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the intermediary. This must be done within 30 days after the end of the cap period.
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> Follow these rules in determining the number of Medicare beneficiaries who have elected hospice care during the period:
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> - The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.
>
> - The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicare beneficiary during the current cap year. This slight adjustment is necessary to produce a reasonable estimate of the proportionate number of beneficiaries to be counted in each cap period.
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> Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included. (This could occur when the beneficiary has breaks between periods of election.)
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> When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary.

The hospice administrative appeal provisions were established in 1983 pursuant to the December 16, 1983 final hospice rule.[5] The Secretary explained that:

> A hospice that believes an error has been made in the determination of the amount of Medicare payments may appeal the determination. Since

[5] 48 Fed Reg. 38146 (Dec. 16, 1983).

> the normal administrative appeals process under section 1878 of the Act applies only to issues related to cost reimbursement, we are creating an appeals procedure that is comparable to the statutory procedure but that is not based on section 1878. For example, the hospice may appeal the intermediary's determination as to which payment level is applicable for each day, or the intermediary's determination as to whether services provided outside the hospice program are related or unrelated to the terminal illness. The methods and standards for the calculation of the payment rates by HCFA would not be subject to an administrative appeal.
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> …. The hospice would present evidence to indicate that an error has been made in the calculations or that the intermediary did not apply the correct procedures in determining the amount of reimbursement. The hospice would also be permitted to appeal these issues to the Provider Reimbursement Review Board (PRRB) if the amount in controversy is $10,000 or more. The appeals process is set forth in 42 CFR Part 405, Subpart R. The intermediary or PRRB hearings are not appropriate for disputes involving the substance of the regulations or the law, such as the calculation of the payment amounts by HCFA.[6]

The regulation at 42 CFR 418.311 provides that:

> A hospice that believes its payments have not been properly determined in accordance with these regulations may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least $1,000 or $10,000, respectively. In such a case, the procedure in 42 CFR Part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under §405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the payment rates by CMS are not subject to appeal.[7]

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[6] Id. See also Section 408 .B of the Hospice Manual (Rev.08-87)(" Provider Payment Determinations.)

[7] In 2009, the last sentence was changed to "the methods and standards for the calculation of the statutorily defined payment rates by CMS are not subject to appeal" from the above referenced language in order to clarify that "the payment rates referred to are the national rates which are set by statute and updated according to the

The Hospice payment determination appeals under 42 CFR 405.1801, et seq., are in contrast to beneficiary appeals for denials of hospice benefits under 42 CFR 405.701 et seq. or those circumstances where the hospice takes on the full appeal rights of the beneficiary under part 405 Subpart G (42 CFR 405.701, et seq.) for denial of benefits.[8]

For provider payment determinations, the Secretary promulgated a final rule which updated, clarified and revised various provisions of the regulations governing provider reimbursement determinations and appeals before the PRRB set forth at 42 CFR 405.1801, *et seq.*, which were effective for all appeals pending as of, or filed on, or after August 21, 2008.[9]

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statute using the hospital market basket (unless Congress has instructed the rates differently)." 74 Fed Reg. 18912, 18920 (April 24, 2009)

[8] In contrast to the provider payment determination appeals, Section 408 Of the Hospice Manual states, regarding individual beneficiary coverage determinations that: "A. Individual Determinations.—1. Beneficiary Appeals.—A hospice beneficiary is entitled to the full range of appeal rights for cases involving a denial of benefits in accordance with the procedures in Part 405, Subpart G of the regulations (i.e., 42 C.F.R. §§405.701 et seq. …. Hospice Appeals.—A hospice, as is the case with any Medicare Part A provider, is entitled to appeal a claim filed on behalf of an individual only if the individual does not exercise his appeal rights and if the initial determination involves: (1) An intermediary finding that the items or services are not reasonable and necessary (§1862(a)(1) determination), and (2) An intermediary finding that either they or the beneficiary provider, or both, knew or could reasonably have been expected to know that such items or services were excluded from coverage. The authority for such provider appeal is found in §1879(d) of the Act."

[9] *See* 73 Fed Reg. 30190 (May 23, 2008) ("Applicability Date: These regulations are applicable to all appeals pending as of, or filed on or after August 21, 2008 except as noted in Sections II.Y and II.Y of this final rule)73 Fed. Reg. 30240 ("Y. Effective Date• The rule is generally effective 90 days after publication in the Federal Register.• For appeals pending before an intermediary hearing officer(s) or the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of the later of the following periods: ++Sixty days after the expiration of the applicable 180-day period prescribed in § 405.1811(a)(3) (for intermediary hearing officer hearings). ++ Section 405.1835(a)(3) (for Board hearings); or (ii) 60 days after the effective date of this rule. For appeals filed on or after the effective date of this rule, the provisions of § 405.1811(c) and §405.1835(c) apply……")

As set forth in 42 CFR part 405 subpart R, the regulation at 42 CFR 405.1835 (2008)[10] provides for the " Right to Board hearing; contents of, and adding issues to, hearing request." The regulation states, in pertinent part, that:

> (a) Criteria. A provider … has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
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> (2) The amount in controversy (as determined in accordance with Sec. 405.1839 of this subpart) is $10,000 or more;

Notably, 42 CFR 405.1835[11] added paragraph (c) regarding the timeframe for adding issues. Paragraph (c) states that:

> (c) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
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> (1) The request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.
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> (2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.

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[10] 73 Fed. Reg. 30249 (May 23, 2008); 73 Fed. Reg. 49356 (Aug. 21, 2008).

[11] Prior to the clarification and revision of the final rule, 42 CFR 405.1841 provided that: "Time, place, form, and content of request for Board hearing. (a) General requirements. (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. *Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.*" (Emphasis added.)

> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.[12]

With respect to 42 CFR 405.1839, regarding the amount in controversy, the regulation states that:

> (a) Single provider appeals. (1) In order to satisfy … the amount in controversy requirement under Sec. 405.1835(a)(2) of this subpart for a Board hearing for a single provider, the provider must demonstrate that if its appeal were successful, the provider's total program reimbursement for *each* cost reporting period under appeal would increase … by at least $10,000 for a Board hearing, as applicable.[13]
> ****
> (5) When a provider … has requested a hearing before the Board under Sec. 405.1835 … of this subpart, and the amount in controversy changes to an amount less than the minimum for a Board appeal due to—
> ….
> (B) A more accurate assessment of the amount in controversy, the Board does not retain jurisdiction.

Finally, in order to grant expedited judicial review, the Board (or the Administrator) must first determine, pursuant to 42 CFR 405.1842(b), that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.

Pursuant to the court order, the issues to be decided are whether, with respect to the Provider's challenge of the regulatory method of calculating the aggregate cap payment, the Provider demonstrated that: 1) it is entitled to a hearing before the Board because there is $10,000 in controversy; and, 2) to what extent, if at all, Medicare's $720,991 demand for repayment from the Provider for fiscal year 2006 would be decreased if the Provider's proposed manner of calculation of the amount in the hospice cap is adopted in lieu of the Intermediary's calculation which was issued pursuant to the existing regulation.

On remand from the court, to support its allegations that the amount in controversy was met, the Provider submitted an affidavit of William Slaughter with a

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[12] See n. 9 for effective date.
[13] These provisions are further elaborated at paragraph (c).

spreadsheet.[14] Mr. Slaughter's affidavit described the method used by the Provider to arrive at the proper determination of the aggregate cap under the alleged "statutory" method. In particular, Mr. Slaughter explained that:

> In my efforts to calculate the [Provider's} cap liability under the method set forth in 42 USC 1395f(i)(l)(2) whereby the number of Medicare beneficiaries used in the cap calculation for each accounting year must be adjusted to reflect the time each such individual was provided hospice care in a previous or subsequent accounting year I received and researched [the Provider's] patient data base and the Common Working File. The Common Working File is an online data base provided through [the intermediary] to allow providers access to Medicare patient status.

Mr. Slaughter obtained beneficiary names and dates of service from patient records maintained at the Provider as well as the common working file. Mr. Slaughter used the common working file to identify dates of service for beneficiaries that were previously or subsequently serviced by hospice providers other than the provider and to ascertain the current certification/benefit status (eligibility) of beneficiaries who were discharged from the Provider.

Because of the Provider's methodology, the spreadsheet contained five different types of beneficiaries: 1) Beneficiaries who are now deceased and only received hospice services from the Provider; 2) Beneficiaries who are now deceased and received hospice services from another provider either prior to or subsequent to receiving services from the Provider; 3) Beneficiaries who are currently living but are no longer receiving hospice services through the Provider and who received hospice services from at least one provider other than the Provider either prior to, or subsequent to receiving services at the Provider; 4) Beneficiaries who are currently living and but not receiving any hospice care; 5) Beneficiaries who are currently living and receiving hospice care from the Provider and who have never received hospice care from any other provider.

Mr. Slaughter explained that the days for each beneficiary for which the Provider provided service were calculated and allocated to all cap years in which days of service were provided. The Provider's first cap year was a 17 month period of June 2, 2004 through October 31, 2005. (Note that the hospice cap year at issue is the

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[14] Provider Exhibit A, Slaughter Affidavit, dated November 23, 2009, with spreadsheet.

Provider's second cap year, November 1, 2005 through October 31, 2006.) Mr. Slaughter stated that:

> No matter how long he or she may have been on service with [the Provider], each beneficiary in the spreadsheet has a total value of one. If a beneficiary data of service fell over multiple cap years, then the fractional amounts were allocated to the appropriate years. For those beneficiaries who experienced days of service with other hospice providers, I added those days to days of [the Provider's] service to obtain the total days of service and then allocated the fractional amount (i.e., the proportional of hospice care provided by [the Provider] to the appropriate years.)
>
> … The assigned values were then totaled for each cap year to arrive at the number of total Medicare Beneficiaries Electing Hospice Care. Id. at Paragraphs 12, 13.

The Provider stated that these calculations were based on data available to it in early November 2009.[15] The Provider claimed that based on this initial computation, the amount of the overpayment would have been no more than $707,000, in contrast to the original December 12, 2007 overpayment determination of $720,991, thus, meeting the jurisdictional $10,000 threshold. This was based on a determination that there were 149.4569 Medicare beneficiaries electing hospice care.[16]

The Intermediary similarly computed the number of beneficiaries using the Provider's proposed methodology for litigation purposes, using data available as of February 28, 2009. The Intermediary explained that it compiled data for CMS:

> That showed all beneficiaries with any paid Medicare hospice service from this hospice in the period 11/01/05 through 10/31/06. Further it was requested that the data contain the beneficiary's entire length of hospice service and was to include service prior to and or subsequent to the 10/31/06 cap period. Each allocation was to be the ratio of hospice care at Autumn Bridge in the 10/31/06 cap period to the total of all

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[15] Provider Closing Statement With Proposed Findings of Fact at p. 2, *see also* Exhibit A spreadsheet showing "discharge" dates including 2009. Intermediary Post-hearing Submission at 7.

[16] Provider Exhibit A at 10. The Provider data showed for the first 17 month cap year of 2004-2005 that the Provider had 166.5734 Medicare beneficiaries electing hospice care.

> hospice care delivered to the beneficiary. The sum total of all these allocations created the total allowable beneficiary count for purposes of calculating the 10/31/06 cap limitation.[17]

The Intermediary determined that for the November 11, 2005 through October 31, 2006 cap year, using the Provider's proposed methodology, there were 146.0618 total allowable beneficiaries[18] The hypothetical decrease in the beneficiary count would result in an increase of the overpayment by $56.800.[19]

Date of Data to be Used

The Administrator finds that, in order for Board jurisdiction to be demonstrated an appeal favorable to the provider on the specific matter at issue in the appeal must increase the program reimbursement for the provider in the cost reporting period at issue by an amount that equals or exceeds the $10,000 applicable amount in controversy threshold. Moreover, the amount in controversy requirement is not satisfied if the result of a favorable appeal decreases program reimbursement for the provider in the cost reporting year at issue in the appeal. The regulation at 42 CFR 418.311 only provides for the appeal of payments that the provider believes are not properly determined. This language is not expanded by any language in 42 CFR 405.1801, *et seq.*, which would allow for the inclusion of interest in the amount of controversy computation.

In addition any jurisdictional determination is also limited to the period under appeal and does not allow for the aggregation of periods to meet the amount in controversy. Therefore, the Provider cannot add the alleged "injury" to this cap year appeal, the alleged subsequent (rolling) impacted on the next cap year as a result of the 2006 cap determination. Finally, the Board does not retain jurisdiction when a more accurate determination of the amount in controversy results in a determination being made that less than $10,000 is in controversy.

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[17] Exhibit 7A, Declaration of Stephanie Josephik, dated March 24, 2009. Exhibit 7B.

[18] *See* Paragraph 19 Exhibit 7A resulting in a decrease of $55,900 in overpayments; Exhibit 7A(b) at p.148(stating 146.0604 is the correct number.)

[19] Exhibit 7B. The Intermediary also noted that the recomputation for cap year ending 10/31/05 also lowered the beneficiary count for the Provider in the first (and prior) cap year. The Intermediary determined there were 166.2581 allowable beneficiaries for the Provider's first cap year period of June 02, 2004 through October 31, 2005.

As the Provider must demonstrate that, if it is successful in the appeal, it will increase its program reimbursement by $10,000, it is critical that the data most likely to be used for calculation of payment be used. In this instance, because of the Provider's methodology, the most accurate data presently available is the November 2009 data in this case. If the Provider were to be successful in this case, the implementation of the Provider's method, by its nature, would require the use of "real-time" data to allocate the beneficiaries among cap years and other hospices. As the Intermediary noted, under the Provider's methodology, the numerator is the number of days for a beneficiary that are attributable to the Provider's cap year (regardless of the year the beneficiary elected hospice services). The numerator is determined and hence frozen at the end of the year. However, the farther out in time from the end of the cap year the data is acquired, the larger the denominator will be [i.e., the total number of days for hospice care for that beneficiary across all cap years/providers] thereby reducing the apportionment and final beneficiary count of the cap year at issue.[20] 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 concludes that, in order to accurately determine whether the Provider is harmed as a result of the application of the regulatory methodology and meets the threshold amount in controversy, the Provider's methodology cannot be based on the data from October 2007, but rather should be based on the data from November 2009.

In addition, it is not inconsistent to compare the October 2007 data-based regulatory determination to a November 2009 data-based "statutory" methodology. This is because the regulatory methodology, relative to the Provider's "statutory" methodology, is not subject to consistent and foreseeable reductions in the hospice cap determination with the passing of subsequent cap years and relies on a relatively uncomplicated determination of the Medicare beneficiaries who have first elected hospice service in that particular cap year. Although this determination may be adjusted for the days spent at other hospice providers by a beneficiary,[21] (the fractional

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[20] Intermediary Post Hearing Submission, pp 7-8.

[21] *See, e.g.*, Section 407 of the Hospice Manual: "When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary…. Each intermediary then adjusts the number of beneficiaries reported by these hospices based on the latest information available at the time the cap is applied." CMS also recognized that: "Readjustment of the hospice cap may be required if information previously unavailable to the intermediary at the time the hospice cap is applied subsequently

beneficiaries), the regulatory cap methodology is not sensitive to an ongoing re-allocation of the beneficiaries' length of stay in subsequent years, because under this method the days of service do not continue to be accumulated in the denomonator.[22]

Additional Disputed Beneficiaries

In determining the amount in controversy, the parties also disagreed with respect to the inclusion (in any proportional amount) of certain beneficiaries.[23] Before the Board, at some point, both parties agreed that one beneficiary that represents .8254 should be excluded from the Provider's November 2009 count because the claim was determined to have been rejected. The other three beneficiaries in dispute represent .8368 beneficiaries. These beneficiaries were identified by the Provider through its own patient data base and the common working file. The common working file identifies the Notice of Elections filed by the beneficiaries. However, the CMS data bases do not show any services actually rendered for which payment was made for the three beneficiaries representing .8368 beneficiaries.

This dispute is in contrast to the Provider's challenge of the regulatory methodology as it is, *inter alia*, factual in nature. While the Provider was challenging the regulatory methodology for determining the number of beneficiaries that elected to receive hospice care in 2006, it did not challenge the factual determination of identifying the beneficiaries to be used in the cap determination. The Provider in fact stated that the Intermediary had properly calculated the regulatory hospice cap and, likewise the

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becomes available regarding other hospices." See also Tr. 154 ("Q: Just so I understand you get the MSAD maybe on a certain date but you have the ability to go in and update it as close to real time in which you are working on doing the finalization for that period. A. Yes. Q… And do you make your best efforts to do the fractional beneficiary summary as close to the time in real time you're doing this workup that you can.? A. Yes..")

[22] By arguing for the use of the October 2007 data, the Provider is limiting its proposed statutory methodology to the allocation of patient length of stays and days only through the 2007 cap year See Provider Exhibit M. See in contrast Slaughter Affidavit at Exhibit A setting forth proposed methodology.

[23] The Intermediary and Provider agreed that two whole beneficiaries were inadvertently not included in the Intermediary's calculation dated February 2009 using the Provider's methodology. These beneficiaries appear to be represented in the Intermediary's calculation of the regulatory cap determination of December 2007, which shows two beneficiaries with respective 12/16/05 and 12/22/05 election dates that correspond to Exhibit L. See Provider Exhibit C Demand letter with attachments.

Medicare beneficiaries that had initially elected hospice care and made up that cap in 2006.

The record shows that the Provider filed its appeal on June 8, 2008, and the Board granted expedited judicial review on June 20, 2008. The Provider requested the Board review, or in the alternative, requested expedited judicial review of the "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" for the period November 1, 2005 through October 31, 2006, dated December 12, 2007 (demand letter). Specifically, the Provider stated that: "Autumn Bridge appeals the calculation used pursuant to 42 CFR 418.309 by the intermediary to calculate the hospice cap amount for the above year in the Demand letter." The Provider also stated that: "There is no dispute that the Intermediary used the invalid regulation to calculate the demand amount. Autumn Bridge does not dispute the accuracy of the demand amount as calculated under the invalid regulation and, without waving its right to appeal, paid the demand in order to avoid withholds from the payments for services rendered. Autumn Bridge did not contest that "the intermediary will have the right to deliver a new demand letter which is calculated pursuant to a valid regulation (namely one in accord with section 1395f(i)(2))."[24]

In granting expedited judicial review, the Board specifically found that, based upon the Provider's assertions regarding the hospice cap issue, there "are no findings of fact for resolution by the Board." This is a necessary criterion for expedited judicial review, because factual disputes are not proper for expedited review and determination in the first instance by the courts.

The Administrator agrees that this matter represents an additional issue, which is also factual in nature and not originally raised in this appeal. The regulatory provision in effect at the time of the requested filing by letter dated June 8, 2008, allowed a provider to add an issue any time prior to hearing. (42 CFR 405.1835) No issue was added prior to the granting of the expedited judicial review request and the Provider did not note any factual issues in dispute. There is nothing in the implementation of the effective date of the new Board rules published August 21, 2008, which would suggest that the Provider can add the issue now.[25] Therefore, the issue involving

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[24] See Provider's June 9, 2008 letter, with attachments including Hospice Calculation showing 148.7773 Medicare beneficiaries first electing hospice care in 11/1/2005 to 10/21/2006 and 30928 days per both its and the PS&R Provider Summary Report.

[25] The record also does not show whether the Provider reported the number of Medicare beneficiaries electing hospice care during the period to the intermediary and included these individuals now in dispute.

whether these beneficiaries should be included in the data base cannot be added to this appeal now.

Moreover, even assuming *arguendo* that these beneficiaries did not present a new untimely added issue, the record does not support the inclusion of these subject beneficiaries in the Hospice cap calculation.[26] The days were identified in the Provider's patient system (Tr. 47-48) as Medicare eligible and the patients were in the common working file. A beneficiary notice of election will appear in the common working file,[27] but standing alone it does not demonstrate that hospice services were rendered. In this case, there is no evidence in the CMS data bases[28] or otherwise presented by the Provider that actual hospice services were provided as would be evidenced by payment. As the intermediary noted, the only acceptable supporting evidence in this type of proceedings would be the proper submission and acceptance of the claim.[29] The Administrator finds, as these days were not reflected

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[26] The Provider claimed, based on its patient data, that these three disputed beneficiaries received services at other hospices and respectively had 7, 5 and 3 days at the Provider in the hospice cap year. *See* Exhibit L.

[27] *See* e.g. Provider's Witness, Tr. at 90 (A: "The provider drops what's called a notice of election and that is where the patient signs up. We drop the NOE with Medicare and it shows up in the common working file and that's where I pulled this information from, [where]'it showed up on the common working file….")

[28] CMS explains that: "The Provider and Statistical Reimbursement (PS&R) System is a key tool for institutional healthcare providers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs) and CMS. The system accumulates statistical and reimbursement data applicable to the processed and finalized Medicare Part A claims. This data is summarized in various reports, which are used by providers to prepare Medicare cost reports, and by FIs and MACs during the audit and settlement process…..There are numerous reports that may be generated from the PS&R, but they are primarily grouped into two categories, Provider Summary Reports and Payment Reconciliation Reports. Provider Summary Reports contain accumulated data that can be used for cost reporting and data analysis, summarized by specific criteria. The Payment Reconciliation Reports (also known as Detail Reports) contain detailed, claim specific data that supports the Provider Summary reports." *See* http://www.cms.hhs.gov/psrr/.

[29] In addition, despite a hypothetical raised by a Board member, there was no evidence presented to the Board that there was any payment, much less delayed payment, because of a denial and successful beneficiary appeals of claims. The challenge to include these beneficiaries in the count of these beneficiaries now would appear to be limited to whether CMS data shows that services were rendered as

on the PS&R, the Provider has not demonstrated that "hospice services" were actually provided.

The record does not support a finding that the Intermediary conceded these subject beneficiaries received services. Rather, the Administrator finds that the Intermediary's witness testified that the beneficiaries should not be included because, based on her research, these individuals did not have any paid hospice services at this provider.[30] It is the Provider's burden to demonstrate that it has met the statutory and regulatory requirements to receive payment, which it has failed to do for these beneficiaries.[31]

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reflected in evidence of a claim having been made, processed and paid. Beyond that, any challenge is most appropriately raised in the context of an individual beneficiary appeal as allowed under 42 CFR 405.701, *et seq.*, and not in this forum. Whether a claim was made and should have been paid is not properly adjudicated in this forum.

[30] *See* Transcript of Oral Hearing (Tr.) at 135-155. (A; In the system, we can see that they file a notice of election. However there never were any claims submitted; or in one case, the claims that were submitted were rejected.") This was in contrast to the two patients who the Intermediary agreed should be added to its computation as the system showed pay dates for hospice services. *See* Tr. at 155. Q. "For the two that have found were missed because of some reason, do you know if those two patients were on the PS&R. A. They would be on the PS&R." Instead, the failure to include the two patients was due to the MSAD [Medicare Statistical and Data Analysis] program that actually does the fractional beneficiary summary which failed to identify the information. In this instance the MSAD was "written to comply with the court case, where it is trying to prorate all dates of service over cap years." Tr. at 158.) Notably, when the actual regulatory cap payment determination is done after the MSAD department provides the fractional beneficiary summary, the intermediary "will pull a PS&R to obtain payment, and that's the third piece of information that's used in the calculation." Tr. at 143.

[31] The Provider's attempt to include these disputed days also appears outside the scope of the court's ordered remand. Further, even if one assumed, arguendo, that these beneficiaries should be recognized in the November 2009 calculation, the inclusion of these beneficiaries would still be problematic for showing damages. On its face, if these patients were mandated to be included in the Provider's method, they would likewise need to be examined for the effect in the regulatory count. Their total exclusion from the regulatory count was not due, in the first part, because of the method being used, but rather because of claims-based reasons, not related to the Provider's regulatory challenge. As the individuals appear to have elected service in the 2006 cap year, (although perhaps apportioned with other hospices), it is likely that the regulatory cap would be marginally higher in comparison to their effect in the

Determination of the Amount in Controversy

The Administrator finds that, based on the record, the foregoing determination that the data available in November 2009 should be used, and that the disputed beneficiaries should be excluded from the calculation. The column labeled "excluding both pts rejected and unbilled" on the Board attachment referred to as "Calculation of Injury as of October 31, 2009," is properly determinative of the amount in controversy in this case and shows an additional overpayment increase of $32,821.39.[32] Based on these numbers, the Provider fails to meet the $10,000 jurisdictional amount in controversy threshold for Board review and would also experience an increase in the overpayment determination if its methodology were to be used in lieu of the regulatory methodology used to compute its cap.

Moreover, the record supports an even lower beneficiary count than that used in Column 1 of the Board's attachment. As noted above, the Provider, using data available as of November 2009, determined that there were 149.4569 Medicare beneficiaries electing hospice care.[33] The Intermediary determined that, using the Provider's proposed methodology and data available February 28, 2009, there were 146.0604 total allowable beneficiaries.[34]

In the process of reconciling the parties' beneficiaries numbers, the parties found the following discrepancies: 1) there were .8345 beneficiaries over counted by the Provider Exhibit A (representing 8 beneficiaries) [P-.8345],[35] 2) there was .3957

Provider's proposed allocation method (due to the few days overlap into the next period.) Therefore, it would seem very possible that the inclusion of these days in the statistics in both the Provider's proposed method and the regulatory method would result in a "wash" as far as the proving damages.

[32] However, even if the beneficiaries were included in the November 2009 data, Column 2 and 3 show that the amount in controversy would still not be met (showing a further increase of the overpayment of $15,595.54 for column 2 and a decrease of the overpayment of $1457.40 for column 3.)

[33] Provider Exhibit A at 10. The Provider data showed that for the first 17 month cap year of 2004-2005 that the Provider had 166.5734 Medicare beneficiaries electing hospice care.

[34] The Affidavit of Stephanie Josephick stated the number was 146.0618 (see also Tr. at 141) however, the spreadsheet shows 146.0604. The former was the number the Intermediary put forth in his arguments.

[35] *See* e.g. Intermediary Post-hearing Submission pp 8-9, Exhibit O with handwritten note. The Provider did not rebut this figure.

under counted by Provider (representing one beneficiary) [P+.3957], 3) there were 2 whole beneficiaries in the Provider count that the Intermediary concedes should be in its count [I+2]; 4) there were .8284 that the parties may agreed should be subtracted from the Provider's count (the "rejected" claim) [P-.8284], 5) there were .8368 (representing the three beneficiaries) that the parties disagree about being excluded from the providers count as elections were made at the Provider but no evidence of claims being submitted [P-.8368], 6) the parties agreed that a (minus)—.6088 would be subtracted from the Provider's Nov 09 data to adjust for more accurate data the intermediary had on the days of service at other hospices [P-.6088]; and 7) the Intermediary's February 28, 2009 starting point of 146.0618 would need to be adjusted to account for the date in time to be comparable to the Provider's original November 9, 2009 data submission by a (minus) -1.178 beneficiaries. [I-1.178]

If these adjustments are made to the Provider's total of 149.4569, the total is reduced to 146.7441.[36] Likewise, if the above applicable adjustments are made to the Intermediary's total of 146.0618, it is increased to 146.8838.[37] Based on the use of either 146.7441 or 146.8838 the Provider does not meet the amount in controversy and the Provider's overpayment (or liability) would not be decreased, but rather would be increased.[38] Accordingly, the jurisdictional decision of the Board is reversed and vacated in accordance with the foregoing opinion.

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[36] 149.4569 - [.6088+.8284+.8368+(.8345-.3957)]=146.7441.

[37] 146.0618+2 - 1.178='146.8838. The difference between the Provider's and Intermediary's two total numbers is .1388 (or $2857).

[38] Using 146.8838, the difference between it and the cap total of column 1 above (147.1829- 146.8838) is .299, which would increase the overpayment by another approximately $6173 (.299 x 20,0585.39 (cap). Using 146.7771, the difference between it and the cap total of column 1 above (147.1829 -146.7771) is .4388, which would increase the overpayment by another approximately $9032.

DECISION

The Administrator finds that: 1) the Provider failed to demonstrate that it meets the $10,000 in controversy and; 2) Medicare's $720,991 demand for repayment from the Provider for fiscal year 2006 would not be decreased if the Provider's proposed manner of calculation of the amount in the hospice cap is adopted in lieu of the Intermediary's calculation which was issued pursuant to the existing regulation. The jurisdictional decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 1/21/2010

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services