CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **Interim Health of Oklahoma City** **Provider** **vs.** **BlueCross BlueShield Association/ Palmetto- GBA** **Intermediary**	**Claim for Hospice Cap Year Ending October 31, 2007** **PRRB Dec. No. 2010-D46** **Date: September 24, 2010**

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 42 CFR 405.1875. The parties were notified of the Administrator's intention to review the Board's jurisdictional decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether the Provider demonstrated that the amount in controversy under CFR 42 405.1835 was satisfied.

The Board relying on the court's holding in *Russell Murray Hospice v. Sebelius,* found that the Board was not to determine whether the Provider's calculation is right or wrong but whether it was made in good faith. The Board noted that the major difference in the Provider's and intermediary's claim of the amount in controversy revolved around beneficiaries who stay at hospices other than the Provider. The Board found the Provider's arguments, made in good faith, is that there is no way for the Provider to verify certify or have knowledge of a beneficiaries' continuing care at other hospices and therefore it did not reduce the 70.037837 beneficiaries claimed for the alleged care at other hospices. Regardless of the Intermediary reduction on any final conclusion of this appeal, the Board found that it must accept the Provider's good faith calculation. The Board also found that a more detailed review of the Provider's calculation is useless given that the

methodology presented by either the Provider or the Intermediary may not reflect the final outcome of the proceedings. The Board acknowledged that the potential for further adjustments diminishes with each succeeding year and so the final determination of the payments in excess of cap is also subject to modification with each successive year. In summary the Board found that the Provider's calculation of the amount in controversy of $232,886 was made in good faith and satisfies the amount in controversy requirement under 42 CFR 405.1835. The Provider recalculated the cap as $1,499,513 less the original cap applied in the final determination of $1,266,627. The cap limits were based on a finding of 70.037873 beneficiaries (Provider's calculation) compared to 59.1604 beneficiaries (final determination). (The Board stated it believed that the data available at the time of the appeal should be the basis for the determination of the amount in controversy, but that the Provider has not asserted that argument and therefore the Board most determine the amount in controversy based on the Provider's good faith pleadings.)

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)[1] 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 or “CWF.”

[1] 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.”

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 regarding the normal course of an individual's illness. CMS has recognized that predicting life expectancy is not always exact.[2]

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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> (2)(A) The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year may not exceed the "cap amount" for the year (computed

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

> under subparagraph (B)) multiplied by the number of Medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).
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> (B) For purposes of subparagraph (A), the "cap amount" for a year is $6,500, increased or decreased, for accounting years that end after October 1, 1984, by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year.
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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.

In addition the Hospice programs providing hospice care for which payment is made under this subsection are required to submit to the Secretary such data with respect to the costs for providing such care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines is 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 1 st 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.)[3]

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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> o The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.
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> o 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.

[3] 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."

> 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.[4] 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 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.[5]

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

[4] 48 Fed Reg. 38146 (Dec. 16, 1983).
[5] *Id. See also* Section 408 .B of the Hospice Manual (Dated 08-87)

> 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.[6]

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.[7]

For provider payment determinations, the Secretary promulgated a final rule which updated, clarify 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.[8] Under 42 CFR 405.1801, an intermediary determination means the following:

> (1) With respect to a provider of services that has filed a cost report under Sec. Sec. 413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to Sec. 405.1803

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

[7] In contrast to the provider payment determination appeals, Section 408 of the Hospice Manual addresses individual beneficiary coverage determinations that may be appealed 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.*)

[8] *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. …..")

> following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report…
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary", as those phrases are used in section 1878(a) of the Act.

The regulation at 42 CFR 405.1803 addresses the terms "intermediary determination" and "notice of amount of program reimbursement", stating that:

> (a) General requirement. Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (as described in Sec. 405.1835(a)(3)(ii)), furnish the provider and other parties as appropriate (see Sec. 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:
> (1) Reasonable cost. The notice must—
> (i) Explain the intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and
> (ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.
> …
> (3) Hospice caps. With respect to a hospice, the reporting period for the cap calculation is the cap year; and the intermediaries' determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations, shall serve as a notice of program reimbursement. The time period for filing cap appeals begins with receipt of the determination of program reimbursement letter. (Emphasis added.)

As set forth in 42 CFR Part 405, Subpart R, the regulation at 42 CFR 405.1835 (2008)[9] sets forth 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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[9] 73 Fed. Reg. 30249 (May 23, 2008); 73 Fed. Reg. 49356 (Aug. 21, 2008).

> (2) The amount in controversy (as determined in accordance with Sec. 405.1839 of this subpart) is $10,000 or more;

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.
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> (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[10]

The regulation at 42 CFR 405.1840 more fully sets out the criteria and procedures regarding jurisdiction stating generally that:

> 405.1840 Board jurisdiction.
> (a) *General rules.* (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.
> (2) The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met)…

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. Specifically, the regulation at 42 CFR 405.1842 entitled "Expedited judicial review", explains that:

> (a) Basis and scope. (1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal

[10] These provisions are further elaborated at paragraph (c).

> question relevant to a specific matter at issue in a Board appeal *if there is Board jurisdiction to conduct a hearing on the matter (as described in Sec. 405.1840 of this subpart*), and the Board determines it lacks the authority to decide the legal question (as described in Sec. 405.1867 of this subpart, which explains the scope of the Board's legal authority).
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
> (3) The Administrator may review the Board's jurisdictional finding, but not the Board's authority determination.
> (4) The provider has a right to seek EJR of the legal question under section 1878(f)(1) of the Act only if—
> (i) The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue and a determination by the Board that it has no authority to decide the relevant legal question; or
> ….
> (b) General—(1) Prerequisite of Board jurisdiction. The Board (or the Administrator) must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.

Finally, as explained in 42 CFR 405.1875(2)(ii) the Administrator may immediately review: "A Board EJR decision, but only the question of whether there is Board jurisdiction over a specific matter at issue in the decision; the Administrator may not review the Board's determination in a decision of its authority to decide a legal question relevant to the matter at issue (as described in § 405.1842(h) of this subpart)."

The record in this case shows that the Provider filed its appeal and requested EJR by letter dated October 14, 2009 of its July 13, 2009 "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" for the period November 1, 2006 through October 31, 2007. The Provider in its Statement of Issue stated that if the Intermediary had "applied the cap across the accounting years in which Interim rendered hospice service to its patients, the amount of overpayment would have been $109,458.98 which is substantially less than $691,356" claimed due. Therefore, the Provider claimed that the amount in controversy for purposes of the appeal was $581,897.05. The Provider did not supply any documentation to support this claim and on review by the Administrator, the case was remanded for further development of the record.

Pursuant to the remand order, the Intermediary submitted calculations and data to the Provider. The Provider in turn submitted calculations to the Board it claimed showed that, if its appeal were successful, the Provider's total program reimbursement for the cap period would increase by at least $10,000. The Provider stated that its calculation of the beneficiaries it services during the cap year 2007 shows a total of 70.037837 beneficiaries. The Provider's method to determine the cap limits was based on a finding of 70.037873 beneficiaries (Provider's calculation) compared to 59.1604 beneficiaries (final regulatory determination). The Provider recalculated the cap as $1,499,513 less the original cap applied in the final determination of $1,266,627. Based on its beneficiary count, the Provider calculated the amount in controversy of $232,886 and stated that it satisfied the amount in controversy requirement under 42 CFR 405.1835.

The Provider rejected the Intermediary calculation, alleging it was based on assumptions not known by the Provider. The Provider stated that the Intermediary made adjustments to the beneficiary count based on the possibility a beneficiary sought care at other hospices. The Provider objected to their inclusion in the calculation claiming that this information was not known also by the Provider.

The Intermediary contended that the Provider's calculation failed to include those fractional beneficiaries to account for beneficiary elections at other hospices. When the beneficiaries are allocated so as to recognize the election to other hospices, the Intermediary stated that the beneficiaries allocated to the 2007 cap year are 55.7162 (reduced from the regulation method of 59.1604) and the cap overpayment determination is increased to $765,096 from the original overpayment determination of $691,356. At the hearing, the Intermediary pointed out the specific beneficiaries elections to other hospices which reduced the Provider's calculation and, therefore, increased the overpayment. As an example, the Intermediary pointed to the second patient listed on the Provider's calculation (3 rd item) with a start date of 9/30/07 and end date of 10/16/2007 with 17 days of hospice care and an allocation of 1.0 beneficiary. The Intermediary's calculation has that patient listed as the second patient, with an allocation of .0299, because of 551 days of the 568 of hospice care were elected at another hospice and only 17 days at the Provider.[11] Thus, pursuant to the Intermediary's calculation the Provider does not meet necessary amount in controversy and in fact incurs a greater overpayment determination based on its allocation method.

Notably, the issue in this case involves Board jurisdiction which is separate and distinct from the issue of establishing “standing” to pursue an action in court. The Board's jurisdiction is a primary threshold determination required for a provider to be granted its

[11] Transcript of Oral Hearing (Tr.) 17-20. The Intermediary also stated that, although the Provider claimed it could not verify the Intermediary's calculation, the data was available through, *inter alia*, the common working file if the provider chose to refute the Intermediary's figures. Tr. 25-26.

request for expedited judicial review. As noted in the 1983 preamble setting forth the hospice appeal rights, the right to a hearing in this case is authorized by the regulation only. That is, the right to a Board hearing and the right to expedited judicial review are strictly regulatory and do **not** originate from the statute at section 1878.

In order for Board jurisdiction to be met, a provider must demonstrate, *inter alia*, that the amount in controversy requirement is met. To demonstrate that a provider has met the amount in controversy requirement for Board jurisdiction, 42 CFR 405.1839 requires that "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."

Notably, the total amount of program reimbursement is a term of art. The "notice of program reimbursement" is the notice of the intermediary's determination of "total program reimbursement due the provider." For hospices, under 42 CFR 405.1801, the intermediary determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations, serves as the "notice of program reimbursement" for the hospice. Thus, for purposes of demonstrating it meets the amount in controversy requirement, the hospice must demonstrate that if its appeal were successful, the intermediary letter setting forth the aggregate cap calculation for each cost reporting period under appeal would increase its reimbursement by at least $10,000.

As the Intermediary noted, several courts have agreed with the Secretary's conclusion that the provider is required to show that under its method of calculating the cap, that the cap demand is decreased by at least $10,000 and have required a remand for such a showing by the providers. Moreover, even assuming, arguendo, that a court would find the regulation invalid, the result would still require the application of a cap in effectuating such a decision for the determination of the total amount of program reimbursement, or in the case of a hospice, the determination of the inpatient and aggregate cap calculations.[12]

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[12] Even the nonbinding and non-controlling district court holdings the Provider cites as supporting for its theory are not inconsistent with the foregoing conclusion The Provider cites to *Los Angeles Haven Hospice, Inc. v. Sebelius*, Case No. CV08-4469-GW(RZx) which did not address the Board jurisdictional issues set forth in this case but rather addressed standing. By order dated August 20, 2009, the district court specifically stated that, while the Secretary was ordered "to return prior payments by Haven Hospice on the 2006 demand with interest except that, at any time prior to such return, HHS may credit any portion of such prior payments with interest to a new cap repayment demand to Haven Hospice for 2006, such demand to be calculated in accordance with 42 CUSC 1395f(i)(2)." Thus, any return of payments in that case would still be contingent on the recalculation of a cap amount, which may not result in an actual decrease in a new cap repayment demand letter to the provider. Another case cited by providers is *Lion Health Services v Sebeluis*, Case No. 4;09-CV-493-A, on its face erroneously suggested that

Even were a court to order the overpayment collections suspended and amounts paid returned, such an action does not demonstrate that the Provider will experience an increase in the total amount of program reimbursement due by at least $10,000 once the decision is effectuated, which is necessary for a finding of Board jurisdiction in this case.[13]

The Intermediary in this case claimed that the Provider's calculation did not reflect the proportional allocation of those beneficiaries that were provided services at other hospices. While the Provider alleged it had no ability to verify, certify or have knowledge of the beneficiary continuing care at other hospices, the Intermediary pointed out the Administrator order instructed the Intermediary to provide any information needed for the calculation, which it did, and that the Provider could also have independently sought the data. The Administrator recognizes that the calculation can change because of the nature of the calculation method proposed by the Provider. But that does not make it speculative, as it will only change in a manner that further reduces the amount in controversy. Thus, at any point in time that the amount in controversy is reduced to below $10,000, a provider will not be able to later demonstrate that it meets the amount in controversy using data from a subsequent date in time.

As the Intermediary stated, and the Provider agreed, the law makes clear that a hospice does not get the full cap amount for every Medicare beneficiary who elects its care without consideration of care at other hospices. The Provider specifically stated that the statute requires that the Intermediary make a proportional allocation of each patient's cap allowance across the years of service and admitted that by law the count of the beneficiaries must recognize beneficiaries' election of care at other hospices. The Intermediary's data, using the Provider's methodology, shows that the Provider does not meet the $10,000 amount in controversy, but rather would experience a greater overpayment determination if the Provider's methodology were used to calculate the cap. The regulation specifies that a provider must show that if it were successful in its appeal that the amount of program reimbursement would be increased by at least $10,000. In addition, if a good faith allegation alone were sufficient to demonstrate the amount in controversy under the regulation, *inter alia*, the regulation would not provide that when "a more accurate assessment of the amount in controversy, the Board does not retain jurisdiction." The Administrator finds that, as the Provider fails to meet the $10,000 amount in controversy threshold for Board jurisdiction, the case is dismissed.

Board jurisdiction need not first be determined in an EJR request. However, the court's primary focused was on standing, which is not the issue before the Administrator. While the court enjoined the Secretary from enforcing against "plaintiff overpayment determination calculated by use of 42 CFR 418.309(b)(1)," the court again does not prohibit the use of a cap in any overpayment determinations for the years involved in the case.

[13] The Administrator's reference to the Provider's method as the alleged "statutory" method does not concede that this method is required under the statute.

DECISION

The jurisdictional decision of the Board is reversed and vacated in accordance with the foregoing opinion.

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

Date: 11/22/10

/s

Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services