PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2010-D49

PROVIDER –
Interim Health Care of Oklahoma City
Oklahoma City, OK

Provider No. 37-1635

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrator

DATE OF HEARING –
August 25, 2010

Hospice Cap Year Ended-
October 31, 2007

CASE NO.: 10-0056

INDEX

Issue:

Whether the amount in controversy requirement under 42 C.F.R. §405.1835 is satisfied.

Background:

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

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

Section 122 of Pub. L. 97-248 of the Tax Equity and Fiscal Responsibility Act of 1982,[1] provides coverage for hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Regulations issued to implement the statute established reimbursement standards and procedures[2] for hospices and includes a prospective cost-based payment methodology[3] in which a hospice would generally be paid one of several predetermined rates for each day a Medicare beneficiary was under care. The rates vary depending upon the level of care.[4] The statute, 42 U.S.C. § 1395f(i)(2), provides for a limit or cap on the total Medicare reimbursement to a hospice. Payments are made to a hospice throughout its reporting period for each day of care furnished to Medicare beneficiaries; hospices are required to return payments that exceed the cap.[5] The intention of the cap was to ensure that payments for hospice care would not exceed the amount that would have been spent by Medicare if the patient had been treated in a traditional setting.[6]

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

> For the purposes of subparagraph (A), the "number of Medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) of this section with respect to the hospice program

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

> and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.

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

In the proposed regulation the Secretary acknowledged that the number of Medicare patients used in the calculation was to be adjusted to reflect the portion of care provided in the previous or subsequent report year or in another hospice. However, the Secretary's regulations credit hospice providers for a beneficiary's cap allocation only in the initial year of service, regardless of whether the patient continued to receive services in another accounting year.[7] The regulation, finalized in December of 1983 provides that:

> Each hospice's cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes –
>
> (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).
>
> (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. . . (Emphasis added.)

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

Procedural History:

The Intermediary's determination for the 2007 cap year resulted in an overpayment of $691,356.[8] Pursuant to 42 C.F.R. § 418.311 and 42 C.F.R. part 405, subpart R, the Provider

[7] 48 Fed. Reg. 38146, 38158 (August 22, 1983).
[8] Per Request for Expedited Judicial Review dated October 14, 2009. Exhibit 1.

appealed the calculation, asserting that the regulation is invalid because it uses a different methodology than mandated by the statute. The Provider requests that the Board grant expedited judicial review (EJR) pursuant to 42 C.F.R. §405.1842.[9] On November 2, 2009, the Board granted the Provider's request for EJR.

On January 6, 2010, the Administrator remanded the case back to the Board for further findings. By order dated December 30, 2009, the Administrator required:

> THAT the Board's jurisdictional determination is vacated and this case is remanded to the PRRB; and
>
> THAT the Board is to determine, after allowing for briefing and evidentiary submissions by the parties, the reimbursement impact of the application of the cap if the Provider's method of calculating the cap were to be used to formulate the cap, instead of the methodology used pursuant to the 42 C.F.R. [§]418.309; and
>
> THAT in developing the evidentiary record, the Provider be given the opportunity to request information from the Intermediary that may be necessary to show the impact of its proposed method of calculating the hospice cap and that the intermediary will use best efforts to fulfill the Provider's request in a timely manner; and
>
> THAT the Board, based on the above, will make a finding on whether the amount in controversy requirement under 42 C.F.R. [§]405.1835 is satisfied because the Provider has demonstrated that, if its appeal were successful, the Provider's total program reimbursement for the cost reporting period under appeal would increase by at least $10,000 and that the Provider is otherwise entitled to a hearing before the Board because all other jurisdictional criteria have been met; and
>
> THAT the Board's jurisdictional determination will be subject [to] Administrator's review consistent with 42 C.F.R. [§]405.1875.

The Provider was represented by Perry E. Kaufman, Esq. of Goolsby, Proctor, Heefner & Gibbs, P.C., Oklahoma City, Oklahoma and the Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

[9] The Provider asserted in its original appeal request at Exhibit 3, the hospice cap overpayment collected by the Intermediary would have been reduced by $581,897.05 had the statutory methodology been used.

Provider's Contentions:

The Provider recalculated the number of beneficiaries it serviced during fiscal year 2007 in response to the Administrator's remand. The new listing of beneficiaries shows a total of 70.037837 beneficiaries.[10] This calculations take into account patient stays as early as July 29, 2004 and as late as October 1, 2009 in calculating the beneficiary count for fiscal year 2007. Based upon the recalculated number of beneficiaries, the Provider would have a hospice cap of $1,499,513[11] resulting in a $232,886[12] reduction in excess payments.

The Provider does not accept the Intermediary's "attempt" to recalculate the number of beneficiaries based on the Provider's method of calculating the cap as appealed. The Provider argues that it has no way to check the veracity of the information provided by the Intermediary. Therefore, the Provider disagrees with the Intermediary's adjustments for beneficiary stays at other hospices because it does not have the access to the information necessary to review the Intermediary's calculations, nor did the Intermediary provide any support for its calculations. The Provider agrees that 42 U.S.C. §1395f(i)(2)(C) requires any care provided to a beneficiary at other hospices be taken into account but only to the extent that the accuracy of the Intermediary's data can be proven.

The Provider offers that the invalidity of 42 C.F.R. §418.309 and the ambiguity of part of 42 U.S.C. §1395(f) are beyond the jurisdiction of the Board. The Provider concludes that the submission of its proposed calculations concerning the issue on appeal clearly show an increase in reimbursement in excess of $10,000 should they be successful in this appeal.

Intermediary's Contentions:

The Intermediary argues the fundamental flaw in the Provider's calculation is its failure to account for beneficiaries that were patients of other hospices. While the Provider has rejected the Intermediary's calculation[13] and presented its own, the Intermediary discounts the Provider's complaints about lack of information on other hospice stays since the law is clear a hospice does not get the full cap amount for every Medicare beneficiary who elects it without consideration of care at other hospices. The Intermediary proffered a calculation applying its interpretation of the Provider's method of calculating the cap, as appealed, and adjust for beneficiaries who elected care at other hospices.[14] Because the Intermediary's calculation decreases the Provider's hospital cap to $1,192,886 which is below the original cap as applied in the final determination, the Intermediary asserts that there would be an increase in excess payments and therefore the jurisdictional amount in controversy is not met.

[10] See Provider's Position Paper regarding Calculations of Amount in Controversy. Provider Exhibit 1.
[11] The Provider's recalculated beneficiary cap of 70.037837 times the per beneficiary cap limit of $21,410.04.
[12] The difference between the Provider's cap based on appeal of $1,499,513 (as rounded) less original cap applied in the final determination of $1,266,627 (as rounded).
[13] Described as a beneficiary-by-beneficiary case history analysis. See Tr. at 27.
[14] See Intermediary Exhibit 4.

Board Decision and Discussion:

The Board finds 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 C.F.R. §405.1835. In Russell-Murray Hospice, Inc. v. Sebelius (Russell-Murray), the D.C. District Court states, in pertinent part:

> The "amount in controversy" requirement set forth § 1395oo(a)(2) "is nothing more than a jurisdictional provision, comparable to the $75,000 amount-in-controversy provision applicable to diversity cases under 28 U.S.C § 1332." Baystate Med. Ctr. v. Leavitt, 545 F.Supp.2d 20,40 n. 26 (D.D.C.2008), *amended on other grounds,* 587 F.Supp.2d 37 (D.D.C.2008). The Circuit has made clear, in the comparable context of diversity jurisdiction, that no extensive fact-finding is necessary to determine that the amount in controversy exceeds the jurisdictional threshold. See Rosenboro v. Kim, 994 F.2d 13, 16-17 (D.D.Cir.1993) (stating that dismissal for failure to satisfy the jurisdictional amount is justified only if "from the face of the pleadings, it is apparent, to a legal certainty, that the plaintiff cannot recover the amount claimed" and that the sum claimed by the plaintiff controls so long as the claim is made in good faith (quoting St. Paul Mercury Indem. Co. v. Red Cab Co., 303 U.S. 283, 288-89, 58 S.Ct. 586, 82 L.Ed 845 (1938))).

Russell-Murray Hospice, Inc. v. Sebelius, F.Supp.2d, 2010 WL 2814411 (D.D.C.2010)(July 20, 2010), Medicare & Medicaid Guide (CCH) paragraph 303,493.

Based upon the Court's analysis, the Board is not to determine whether the Provider's calculation is right or wrong but whether it was made in good faith. The Board notes the major difference in the Provider's and Intermediary's calculations of amount in controversy revolves around beneficiaries who had stays at hospices other than the Provider. The Board finds the Provider's argument, made in good faith, is that there is "no way for Interim to verify, certify or have knowledge of a beneficiary continuing care at other hospices" [15] and therefore Interim did not reduce the 70.037837 beneficiaries claimed for alleged care at other hospices. Even if some or all of the Intermediary's reductions for other hospice stays may be proven to be necessary in the final conclusion of this appeal, the Board finds it needn't review and make findings on these beneficiaries but must accept the Provider's good faith calculation to determine the amount in controversy for jurisdiction based on the Provider's theory of the case.

Moreover, a 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.[16] The courts have unanimously found the regulation being challenged by the

[15] Provider's Position Paper Regarding Calculations, p.3

[16] This is reflected in the Russell-Murray case which stated, "Furthermore, the defendant fails to explain why a calculation performed by the PRRB following remand would be any less hypothetical or speculative than the calculation offered by the plaintiff, given the absence of a substitute regulation." Id. at FN13.

Provider to be in conflict with the statute on which it was based. However, the Secretary has yet to issue guidance via a new regulation or ruling establishing the method to be used in place of the regulation that is being opposed. The Secretary obviously was not satisfied that the statutory language describing the method to be used was sufficiently clear to stand on its own without further regulatory clarification. Even though several courts have found the Secretary's method improper, that does not shift the Secretary's authority to the Board or the Intermediary to create its own calculation method. There may be multiple methods consistent with the statute. The Intermediary's proposed methodology is especially questionable in that it would render all annual payment determinations for hospice to be non-final until every patient in the hospice in a particular fiscal year had expired. The Board concludes it is not proper for it to supplant the Secretary's authority by crafting a calculation methodology of its own[17] to determine the amount in controversy.

Both the methodologies presented by the Provider and the Intermediary are not yet final. Based on the evidence presented at the hearing, under both parties' interpretation of the statutory method, the number of Medicare beneficiaries for the year in dispute will continue to fluctuate, almost certainly causing the hospice 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 further adjustments diminishes with each successive year but, until every patient who received services in the year at issue expires, the cap amount for a particular year 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. To require the Board or the Provider to wait until the final amount can be determine would render nugatory the word "expedited" in EJR. Even the Administrator's remands could derail the EJR process.[18]

In summary the Board finds 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 C.F.R. §405.1835. This amount results from the Provider's recalculated cap of $1,499,513 less original cap applied in final determination of $1,266,627. The cap limits were calculated using

---

[17] The Board continues to believe the amount in controversy should be calculated with data available at the time the final determination is made. However the Provider has not asserted this argument and the Board must determine the amount in controversy based upon the Provider's good faith pleading. The Board's finding in a previous case was, "The Board concludes 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. It is the only data relevant to the final determination appealed. At the time the final determination is made or the time the appeal must be filed, any attempt to project how the amount of the final determination might be modified by future events would be conjecture in most cases. While future changes may be relevant to the merits of the case, the Board concludes it is not relevant to a determination of the amount in controversy for jurisdictional purposes." Autumn Bridge, LLC v. BlueCross BlueShield Association, PRRB Decision No. 2010-D8, December 22, 2009. Administrator's Decision Reversing, January 21, 2010.

[18] The court in Tri-County Hospice addressed the delays caused by remands as follows, "Accordingly, this court declines to follow those courts which (in connection with the inquiry as to standing) have remanded an EJR suit of this type to the PRRB for the purpose of obtaining factual findings as to evidence of harm to plaintiff from the regulation, i.e., the difference between the amount demanded for repayment using Medicare's calculation under the challenged regulation and any proposed calculation of plaintiff. The court finds that such a remand renders nugatory the word "expedited" in EJR. The PRRB has found that the estimated amount in controversy exceeds $10,000. Such an unadorned finding may well be sufficient to establish standing for the statutory *right* to seek judicial review of a question of law provided by 42 U.S.C. § 1395oo(f)(1)." Tri-County Hospice, Inc. v. Sebelius, 2010 WL 784836 (E.D.Okla. 2010)(March 8, 2010)(Footnote omitted.), CCH paragraph 303,466.

beneficiary caps of 70.037873 (Provider's calculation) and 59.1604 (final determination) multiplied by the same beneficiary cap limit of $21,410.04. The Board notes there are no other jurisdictional impediments related to this appeal.

Board Decision:

The Board finds that the amount in controversy is at least $10,000 using the Provider's good faith calculation. The Provider has, therefore, satisfied the jurisdictional requirements under 42 C.F.R §405.1835.

Board Members Participating

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

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Date: September 24, 2010