PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D26

PROVIDER –
Canon Healthcare Hospice, LLC
New Orleans, Louisiana

Provider No.: 19-1555

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrator

DATE OF HEARING -
June 8, 2010

Cap Year Ended -
November 1, 2004 - October 31, 2005

CASE NO.: 08-0384

INDEX

ISSUE:

Whether a full or partial waiver is permissible for the Provider's hospice inpatient day limitation overpayment for the cap year November 1, 2004 through October 31, 2005.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

The Medicare program provides coverage for terminally ill beneficiaries who elect to receive care from a participating hospice. 42 U.S.C. § 1395x(dd). The term ``hospice program'' means a public agency or private organization or a part of either that is primarily engaged in providing specified services to terminally ill individuals and their families and that meets certain conditions of participation. 42 U.S.C. § 1395x(dd)(2). Relevant to the instant case, as a condition of participation in Medicare, the hospice program is required to ensure that the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in any 12-month period during the hospice's participation in the Medicare program, do not exceed 20 percent of the total number of days of hospice coverage provided to those beneficiaries. 42 U.S.C. §1395(x)(dd)(2)(A)(iii). This statutory provision was implemented at 42 C.F.R. § 418.98(c) and reflects the statute's requirements governing the provision of short term inpatient care and the emphasis on the provision of care primarily in the home.[1]

Medicare reimbursement for hospice care, includes the costs which are reasonable and relate to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations. 42 U.S.C §1395f(i)(1)(A). Medicare also limits total reimbursement to a hospice for a fiscal year. That limit, the cap amount, is calculated by multiplying the cap amount by the number of Medicare beneficiaries admitted to the hospice program in that year. 42 U.S.C. §1395f(i)(2). 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 had the patient been treated in a traditional setting.

The hospice implementing regulations provide for payment in one of four prospectively-determined rate categories (routine home care, continuous home care, inpatient respite care, and general inpatient care) based on each day a qualified Medicare beneficiary is under a hospice election. 42 C.F.R. § 418.302. The regulations impose a limitation on payment for inpatient

[1] 48 FR 38146, 38149 (August 22, 1983).

care days, which is ". . . subject to a limitation that total inpatient care days for Medicare patients not exceed 20 percent of the total days for which these patients had elected hospice care." 42 C.F.R. § 418.302(f). In the final rule, CMS explained, "[b]y making the 20 percent limit a reimbursement limit, the regulations provide an incentive for hospices to remain in compliance with the statutory requirement."[2] Any excess reimbursement is considered an overpayment and must be refunded by the hospice.[3]

Congress has allowed for waiver of recovery of overpayments in certain circumstances. Section 1870 of the Social Security Act, 42 U.S.C. §1395gg. In pertinent part, states:

> (b) Incorrect payments [made] on behalf of individuals; payment adjustment
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> Where--
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> (1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount. . .

(42 U.S.C. § 1395gg(b)(1)).

Congress has also authorized the Secretary to waive Medicare requirements during national emergencies.[4] Section 1135 of the Social Security Act, 42 U.S.C. § 1320b-5. In pertinent part, the statute states the purpose and the Secretary's authority in granting the waiver, as follows:

> (a) Purpose.
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> The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1))—
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> (1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under subchapters XVIII, XIX, and XXI; and

[2] 48 FR 56018 (December 16, 1983).
[3] *Id.*
[4] In this case, the then Secretary Michael Levitt signed § 1135 Waiver on September 4, 2005, due to the effects from Hurricane Katrina. *See*, Provider's Exhibit P-5. Hurricane Katrina hit the central Gulf Coast States on August 29, 2005, causing widespread devastation to the cities of New Orleans, Louisiana; Mobile, Alabama; and Gulfport, Mississippi. *See*, *Hurricane Katrina National Oceanic and Atmospheric Administration National Climatic Data Center* at www.ncdc.noaa.gov/specialreports/katrina.htmlhttp.

> (2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.
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> (b) Secretarial authority.
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> To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to—
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> (1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers,
> (B) program participation and similar requirements for an individual health care provider or types of providers, and
> (C) pre-approval requirements;
>
> (2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

42. U.S.C. § 1320b-5(a)-(b).

The fiscal intermediary notifies the hospice of the determination of program reimbursement at the end of the cap year. 42 C.F.R. § 418.308(c) (cross reference 42. C.F.R. § 405.1803). A hospice dissatisfied with a fiscal intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (the Board) within 180 days of the issuance of that determination. 42 C.F.R. § 418.311; 42 C.F.R. § 405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Canon Health Care Hospice, LLC (Provider) is a Medicare certified hospice located in New

Orleans, Louisiana. Palmetto Government Benefits Administrator (GBA) (herein the Intermediary) is the Provider's Medicare fiscal intermediary.

On June 11, 2007, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount," advising the Provider that it was overpaid by Medicare because it exceeded the twenty percent limitation on inpatient days for the hospice cap year ended October 31, 2005.[5]

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. § 418.311 and 42 C.F.R. §§ 405.1835-1841. The Provider was represented by Lester W. Johnson, Jr., Esquire of Breazeale, Sachse & Wilson, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that recoupment of the overpayment should be waived, or in the alternative be partially waived, due to the devastating effects of Hurricane Katrina. The Provider acknowledges that it exceeded the twenty percent limitation in the months prior to Hurricane Katrina; however, the impact of the hurricane caused a significant decrease in its outpatient census relative to its inpatient census. The disproportionate shift in services from inpatient to outpatient made compliance with the twenty percent inpatient day limitation difficult, if not impossible, during the last two months of the cap year ending October 31, 2005.[6] This is because the only way to adjust for the shift was to discharge all of its inpatients and avoid new inpatient admissions at a time when the Provider was one of the few, if not the only, hospice agencies still operating in the New Orleans area following Hurricane Katrina.

The Provider also contends that principles of equity preclude the Intermediary from collecting the overpayment. Specifically, the Provider maintains that it relied to its detriment on the Intermediary's initial determinations for cap years ending 2003 and 2004 that the Provider did not exceed the twenty percent limitation on inpatient days.[7] Those were apparently erroneous determinations, because the Intermediary subsequently notified the Provider that it exceeded the 20 percent inpatient limitation for cap years 2003 and 2004. The Provider believes that if they had been correctly informed in the Intermediary's initial determinations for cap years 2003 and 2004, the Provider would have been able to take corrective action for any overages for cap year 2005. Moreover, the Provider contends that its reliance on the Intermediary's statements in the aftermath of Hurricane Katrina, assuring the Provider that it need not worry about exceeding the inpatient days limitation justifies that recovery of the overpayment be waived, or at the very least be reduced to reflect the hurricane's impact on the Provider's inability to comply with the twenty percent limitation on inpatient days.[8]

The Provider further argues that recovery of the overpayment should be waived in accordance

[5] Provider's Exhibit P-1.
[6] Provider's Position Paper at 4, Transcript (Tr.) at 12, 60-63.
[7] Provider's Position Paper at 6 and 7; Tr. at 19.
[8] Tr. at 13.

with 42 U.S.C. § 1395gg, because it was without fault in causing the overpayment.[9] The Provider acknowledges the Board has interpreted that this statutory provision applies only to individual overpayments and not aggregate payments. The Provider maintains that in interpreting the statute, the Board looked at congressional intent and concluded that if the statute would apply to "aggregate payments" it would be impossible to determine which individual beneficiary would be subject to liability for the overpayment. The Provider advises that given the very clear and unambiguous language of the statutory provision, it is unnecessary to consider congressional intent as a means to interpret the statute. Moreover, for aggregate payments, the statute provides sufficient safeguards that a beneficiary would not be liable for such overpayments because the beneficiary would be without fault in causing the overpayment.

Finally, the Provider contends that waiver of recovery of the overpayment is permissible based on the § 1135 waiver issued by Secretary Michael Levitt on September 4, 2005. [10] The Provider asserts that absent a specific list of waived conditions, the § 1135 waiver operates to waive noncompliance with any condition of participation or regulation pertaining thereto that may cause a provider to be ineligible for reimbursement for services furnished in good faith during the Hurricane Katrina emergency period.[11] The Provider asserts that the inpatient day limitation payment regulation pertains to the statutory provision for conditions of participation. This is because when implementing the regulation, CMS explained the sole purpose for the regulation was to encourage compliance with the statutory provision of conditions of participation regarding the twenty percent limitation on inpatient days.[12] The Provider requests that the § 1135 waiver be applied to waive recovery of the entire 2005 cap year overpayment, or in the alternative, that the waiver be partially applied to the period of time, e.g. August, September and October 2005, directly affected by Hurricane Katrina.[13]

The Intermediary contends that despite the devastating effects of Hurricane Katrina, the Board has no authority to waive recovery of the overpayment. First, it is undisputed that the overpayment amount is correct and that the Provider was properly notified of the overpayment.[14] Second, with regard to the Provider's request for equitable relief, the Board's authority is prescribed by statute and regulation, in which no equitable powers have been assigned.[15] Third, the waiver provision of 42 U.S.C. § 1395gg does not apply to the instant case because the provision applies only to overpayments involving individual claims. The overpayments in this case pertain to aggregate payments. Moreover, the Provider acknowledges that the Board has held that the waiver provisions under 42 U.S.C. § 1395gg apply only to overpayments of individual claims and not aggregate payments.[16] Finally, as to the § 1135 waiver, the Intermediary maintains that the Secretary has the sole discretion on how to apply the § 1135 waiver, and therefore it is not within the Board's authority to incorporate the § 1135 waiver into the binding regulatory framework.[17]

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[9] Provider's Position Paper at 8; Tr. at 44-45.
[10] Provider's Exhibit P-5.
[11] Provider's Position Paper at 11, Tr. at 45 – 48.
[12] Provider's Position Paper at 11, Tr. at 46 and 47.
[13] Tr. at 23 and 24.
[14] Tr. at 36.
[15] Tr. at 39.
[16] Intermediary's Position Paper at 9.
[17] Tr. at 41.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

After considering the Medicare law and guidelines, the parties' contentions and evidence submitted, the Board finds and concludes as follows:

Regarding the Provider's assertion that waiver of recovery of the overpayment is permitted due to the extraordinary circumstances associated with Hurricane Katrina, the Board finds the fact undisputable that Hurricane Katrina had a devastating impact in New Orleans, Louisiana, the Provider's service area. The Board, however, is without authority to waive recovery of the overpayment due to extraordinary circumstances. This is because the Board is obligated to follow the applicable statutes, regulations and CMS rules when rendering its decision.[18] In this case, the applicable payment regulation at 42 C.F.R. § 418.302(f) does not specify extraordinary circumstances as a means to waive recovery of an overpayment exceeding the twenty percent limitation on inpatient days. Consequently, the Board finds no authority to grant the Provider relief due to extraordinary circumstances.

Next, the Board evaluated the Provider's request that principles of equity should allow waiver of recovery of the overpayment because it relied to its detriment on the Intermediary's initial determinations for cap years 2003 and 2004 that it was in compliance with the twenty percent limitation on inpatient days,[19] and also on erroneous guidance and assurances from the Intermediary following Hurricane Katrina.

The Board does not have the legal authority to waive recovery of the overpayment based on equity principles. As previously explained, the Board is obligated to follow the applicable statutes, regulations and CMS rules when rendering its decision. The applicable payment regulation at 42 C.F.R. § 418.302(f) does not specify that the Board may consider equitable principles as a basis to waive recoupment of an overpayment. Consequently, the Provider's request for equitable relief is denied.

Moreover, the Board considered the Provider's request to waive recovery of the overpayment under 42 U.S.C. § 1395gg because it was without fault in causing the overpayment. The Board has determined that the waiver provision under 42 U.S.C. § 1395gg pertains to overpayments of individual claims and not aggregate payments. The Provider has acknowledged the Board's interpretation. The overpayment at issue involves aggregate payments that exceeded the twenty percent limitation of inpatient days. Consequently, the waiver provision under 42 U.S.C. § 1395gg does not apply in this case, and the Provider's request for relief under the statute is denied.

Finally, the Board examined the Provider's request that the § 1135 waiver issued by the

[18] 42 C.F.R. § 405.1867.

[19] For the fiscal years 2003 and 2004 determinations, the Intermediary notified the Provider that the initial determinations were erroneous and issued a notice of overpayment that the Provider exceeded the twenty percent limitation on inpatient days. The Provider appealed the determinations to the Board. The Board issued a decision concluding that the Intermediary did not properly re-open the 2003 and 2004 determinations. *See, Canon Healthcare Hospice, LLC v. Blue Cross Blue Shield/Palmetto Government Benefits Administrator*, PRRB Dec No. 2010-34 Medicare & Medicaid Administrative Decisions (CCH) ¶82. 662 (June 4, 2010), *rev'd*, CMS Administrator Medicare & Medicaid Administrative Decisions (CCH) ¶ 82,656 (August 2, 2010).

Secretary on September 4, 2005 be applied to waive either a full or partial recovery of the overpayment.

Congress has authorized the Secretary to issue § 1135 waivers during an emergency period.[20] In pertinent part, the Secretary is authorized

> [T]o temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to--
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> > (1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers.[21]

The purpose of § 1135 waiver is to ensure, to the maximum extent feasible, in any emergency area and during an emergency period, that:

> 1) sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under titles XVIII, XIX, and XXI; and
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> 2) health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but are unable to comply with one or more of the requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.[22]

On September 4, 2005, the Secretary issued a § 1135 waiver due to the effects of Hurricane Katrina. The waiver had a retroactive effective date of August 29, 2005 in Louisiana, the state where the Provider is located. The waiver expired on January 31, 2006.[23] In pertinent part, the Secretary waived the requirements of titles XVIII, XIX and XXI of the Social Security Act or regulations thereunder as it pertains to:

> 1. Certain conditions of participation, certification requirements, program participation or similar requirements, or pre-approval requirements for individual health care providers or types of health care providers, including as applicable, a hospital or other provider

[20] 42 U.S.C. §1320b-5.
[21] 42 U.S.C. § 1320b-5(b).
[22] 42 U.S.C. § 1320b-5(a).
[23] 71 FR 18654, 18656 (April 12, 2006).

> of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services.

The Provider asserts the § 1135 waiver operates to waive noncompliance with any condition of participation or regulation pertaining thereto. The Provider contends that the inpatient day limitation payment regulation pertains to the statutory provision for conditions of participation because the sole purpose for the regulation was to encourage compliance with the statutory conditions of participation. The Board agrees. In this regard, the statutory conditions of participation regarding the twenty percent limitation on inpatient days was implemented at 42 C.F.R. § 418.98(c). In addition, CMS promulgated a complementary payment regulation at 42 C.F.R. § 418.302(f). In implementing the payment regulation, CMS explained that "[b]y making the 20 percent limit a reimbursement limit, the regulations provide an incentive for hospices to remain in compliance with the statutory requirement."[24] Essentially, CMS acknowledged that the payment regulation was enacted as a method of enforcing compliance with the statutory provision limiting inpatient days. Because the payment regulation is the enforcement of the statutory conditions of participation, it follows that a nexus has been established between the regulation and the statute. The Board concludes that the payment regulation regarding the limitation on inpatient days pertains to the statutory conditions of participation and therefore is within the scope of the § 1135 waiver issue by the Secretary on September 4, 2005.

Next, while the Intermediary contends that Board has no authority to decide if a § 1135 waiver applies, the Board finds it can interpret the § 1135 waiver to the extent it is related to Hurricane Katrina. The facts in this case demonstrate that the hurricane caused the Provider to exceed the inpatient days limitation. Specifically, following the hurricane, there was a significant drop in the Provider's inpatient days from a total of 681 inpatient patient days in August 2005 down to 286 patient days in September 2005 and 443 patient days in October 2005.[25] The record also shows a more significant drop in routine home care days from 2508 days in August 2005 down to 461 days in September 2005 and 736 days in October 2005.[26] The drastic drop in the patient care days was attributed to the massive relocation of the patients as a result of the hurricane. Moreover, the significant drop in the Provider's routine home care days relative to its inpatient days resulted in a distortion of the inpatient percentages, indicating that the Provider would have difficulty in complying with the twenty percent limitation on inpatient days. As the Provider explained, it was unable to remedy the situation to comply with inpatient day limitations, because doing so would have required it to discharge all of its inpatients and avoid new inpatient admissions. This was a difficult if not impossible solution considering the Provider had 38 out of the 48 total hospice beds in the entire region following the hurricane.[27] Moreover, it was the only hospice in New Orleans that was in operation during the period immediately following the hurricane.[28]

While the Board finds the § 1135 waiver applies in this case, the Board denies the Provider's

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[24] *Supra*, n. 2.
[25] Provider's Exhibit P-7 at 3; Tr. at 60 -62.
[26] *Id.*
[27] Tr. at 127.
[28] Tr. at 64.

request for a waiver of the entire overpayment. Specifically, the Provider conceded that it had problems with its internal monitoring of inpatient percentages during the months before the hurricane. [29] Indeed, the Provider commented that it was unaware of its overages during the early months of cap year 2005 until its inpatient percentages jumped to nearly 70% following the hurricane.[30] Considering the Provider's statements, and had the hurricane never occurred, the Board finds it too speculative that the Provider would have been able to remedy its case mix ratio to be in compliance with the twenty percent inpatient days limitation for its cap year ending October 31, 2005. Consequently, the Board concludes that as specified in the § 1135 waiver, a partial waiver of recovery of the overpayment is permitted during the period of time directly related to Hurricane Katrina.

The § 1135 waiver indicates an effective date for Louisiana, of August 29, 2005. The waiver expired on January 31, 2006. Based on the effective date, the Board concludes that a partial waiver of recovery of the overpayment is permitted for the period August 29, 2005 through October 31, 2005, the end of the cap year.

DECISION AND ORDER

The § 1135 waiver issued by the Secretary applies in this case. The Board finds that a partial waiver of recovery of the overpayment is permitted from August 29, 2005 through October 31, 2005, the cap year end. The Intermediary's determination is partially reversed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: APRIL 15, 2011

[29] Provider's Post-hearing brief at 10.
[30] *Id*.