PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D8

PROVIDER -
Autumn Bridge, LLC

Provider No.: 37-1633

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Adminstrators

DATE OF HEARING -
December 4, 2009

Hospice Cap Year Ended -
October 31, 2006

CASE NO.: 08-2068

INDEX

Issues:

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

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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine the payment amounts due the providers under Medicare law, regulation and interpretative guidelines published 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

[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] 48 Fed. Reg.38146, 38152 (August 22, 1983).
[5] Id. at 38152.
[6] Id. at 38162.

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 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 represent the portion of a patient's total stay in all hospices that was spent in that hospice. . . (Emphasis added.)

[7] 48 Fed. Reg. 38,146, 38,158 (August 22, 1983).

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 2006 cap year resulted in an overpayment of $720,991. Pursuant to 42 C.F.R. § 418.311 and 42 C.F.R. part 405, subpart R the Provider appealed the calculation, asserting that the regulation is invalid because it uses a different methodology than mandated by the statute. It asserted use of the regulatory method resulted in the overpayment and requested that the Board grant its request for expedited judicial review (EJR) pursuant to 42 C.F.R. §405.1842. On June 20, 2008, the Board granted the Provider's request for EJR. The Provider filed suit in the United States District Court for the Western District of Oklahoma (Court)[8] where a dispute over the amount in controversy arose. The Intermediary asserted that use of the statutory methodology would produce an even greater overpayment; therefore, the Provider could not show harm. Consequently provider not only failed to meet the $10,000 threshold for Board jurisdiction, it also lacked standing to challenge the regulation.

On August 10, 2009, the Court remanded the case back to the Secretary for further findings. The Court found that, based on the record before it, that it had no means by which to quantify the Provider's alleged injury because the Board's EJR determination did not indicate the specific amount it found in controversy. Without evidence from the Board to support the specific amount in dispute, the Court could not determine if Article III standing was met. The Court concluded that even if it ultimately agrees with the Provider's arguments, because, at the present time, there was no proof of injury or causation upon which to base any monetary judgment in the Provider's favor, a remand for supported fact finding regarding the specific amount in controversy was necessary

By order dated October 29, 2009, the Court denied the Plaintiff's "Motion for New Trial on Settlement, to Alter or Amend the Judgment." The CMS Deputy Administrator remanded the case to the Board on November 2, 2009 and ordered that:

> (1) the [Board] determine to the extent that, 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 were adopted in lieu of Medicare's calculation pursuant to the existing regulation;
>
> (2) the [Board], based on the above-determination and remand, demonstrate a more specific fact-finding on whether the [Provider] has shown that it is entitled to a hearing before the [Board] because $10,000 is in controversy, so that, if other conditions were met, the [Provider] may obtain judicial review of the legal issue presented in this action under [42 U.S.C. § 1395oo(f)].

Under the Secretary's remand order, the Board is required to issue a decision on these questions by December 22, 2009.

[8] Autumn Bridge, LLC v. Sebelius, Case No. CIV-08-0819-F

The Provider is represented by Linda G. Scoggins, Esq. and Sarah Glick, Esq. of Scoggins and Cross, Oklahoma City, Oklahoma and the Intermediary is represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

Positions of the Parties:

Provider's Position

The Provider asserts that if the Intermediary had proportionally applied the count of Medicare beneficiaries served by the Provider across the years those beneficiaries received care as required by the statute, 42 U.S.C. § 1395f(i)(2)(A) and (C), the amount of the alleged overpayment of $720,991 would be reduced by more than $10,000. The Provider submitted an affidavit from William Slaughter, along with a spreadsheet, demonstrating under its theory of the case that the difference in the Provider's cap liability under the regulation and the statute was at least $14,287.83.[9]

The Provider explains that during its first cap year, ending October 31, 2005 (FY 2005), the Provider had at least $161,084 in unutilized cap allocations. That is, the Provider's claims for reimbursement in FY 2005 were under the allocated cap amount by more than $160,000. For FY 2006, the Provider continued to serve many patients first admitted in prior FY 2005. Medicare paid the Provider for its services to these beneficiaries. However, because all of the available cap dollars for these patients were allocated to only the first year of service (FY 2005), no monies were allocated to FY 2006 for care provided in 2006. The Provider asserts it received improper and insufficient cap allocations for these patients. The Provider sought and received reimbursement of $3,783,629.74 in hospice services for FY 2006, but the cap (based on what it claimed was an artificially low count of beneficiaries) was $3,062,638.74. The Intermediary notified the Provider that it had exceeded its allowable cap by $720,991 and demanded repayment.

The Provider believes that the affidavit and spread sheet demonstrate that if the Intermediary had employed the calculation methodology required by 42 U.S.C. § 1395f(i)(2) the cap liability would have been no more than $707,000.70. Thus, the difference in the cap liability calculated by the Intermediary under the regulation, 42 C.F.R. § 418.309(b)(1), and the calculation performed by the Provider under the statute, 42 U.S.C. § 1395f(i)(2), is more than $10,000.

Based on its calculation method under the regulation, in its first fiscal year (2005), the Provider had at least $161,389.96 in unutilized cap allocations. The Provider contends 42 U.S.C. § 1395f(i)(2)(A) reflects Congress' intent for a beneficiary's cap allocation to be spread across his or her years of service so that the portion of the applicable cap allocation more closely matches the Provider's actual expenditures for care in that year. To recalculate the cap amount, the Provider obtained beneficiary names from its records and the Common Working File (CWF).[10] This record contained the dates of service for beneficiaries that were previously and

[9] Provider's Position Paper at 10.

[10] The CWF contains Medicare entitlement, utilization, Medicare Secondary Payor, Health Maintenance Organization and history data for each Medicare beneficiary. All Medicare Part A and Part B claims are process through this file prior to claims payment. CMS Pub. 100-4, § 3800.

subsequently serviced by hospices other than the Provider and were used to ascertain the current eligibility of beneficiaries discharged from the Provider.[11]

The Provider's spreadsheet containing the Medicare beneficiaries listed by name in chronological order by the starting date of service by the Provider contained five (5) different categories of beneficiaries: (1) beneficiaries who are now deceased and only received services from the Provider prior to their deaths; (2) beneficiaries who are now deceased and received hospice services from a provider other than Autumn Bridge either prior to or subsequent to receiving hospice services from Autumn Bridge; (3) beneficiaries who are currently living but no longer receive hospice services from Autumn Bridge and who received hospice services from at least one provider other than Autumn Bridge either prior to or subsequent to receiving hospice services from Autumn Bridge; (4) beneficiaries who are currently living but not receiving any hospice services; and (5) beneficiaries who are currently living and receiving hospice care from Autumn Bridge and never received care from another hospice.[12]

Intermediary's Position

The Intermediary believes that the Court did not view the amount in controversy as the amount of the over payment demand ($720,991), but rather, the amount in controversy should be determined by how much less the overpayment would have been if the Provider's methodology would have been used. Under the Intermediary's recomputation, it believes the Provider's overpayment would increase to $776,891 from $720,991, an increase of $55,900. This results from a decrease in the count of beneficiaries from 148.778 to 146.0618. This increase in the overpayment was calculated by multiplying the number of "Medicare Beneficiaries Initially Electing Hospice Care" (148.7773) times the Statutory Cap Amount of $20,585.39.[13]

The Parties' Reconciliation of Data

The parties' methodologies for computation under the statutory method were consistent. After exchanging information and data in preparation for the hearing on remand, both parties discovered errors in their data and then were able to come to agreement on some of the discrepancies . The parties were also able to agree on the impact of data that was contested. However, because of the short time frame for the parties to present their case and for the Board to issue a decision, the parties discovered at the hearing that some refinement in the data and calculations had to be done post hearing. This resulted in some further agreement on data and calculations submitted to the Board post hearing.

Board Decision and Discussion

Under the statutory method, the Provider's and Intermediary's calculations produced on remand are not materially different as to application, or for the most part, the data to be used. There does remain a dispute as to whether certain beneficiaries should be counted at all. However, as the

[11] Provider's Position Paper, Ex. A (Affidavit of William Slaughter, Chief Financial Officer of Autumn Bridge, LLC, the Provider), ¶ 7.
[12] Id. ¶ 9.
[13] Intermediary Position Paper, Ex.7A (Declaration of Stephanie Josephik) ¶ 6.

Intermediary states, the most important question in determining whether the provider meets jurisdictional requirements is the point in time at which the cap is calculated.[14]

Unlike the typical final determination of Medicare reimbursement, under the statutory method of determining the cap, the determination of the number of beneficiaries counted for a particular year, in this case cap year 2006, will reduce with each succeeding year. As the Intermediary points out in its Post Hearing Submission at page 7, this is due to the fact that care for some beneficiaries continued for years. Some beneficiaries have periods of no services, then either resume service with Autumn Bridge or elect another hospice provider. Under these circumstances, the Intermediary's position is consistent with the Provider's statement that ". . . when a beneficiary's cap allowance is counted in fractions across multiple years of service . . . a change in any year [resulting from a patient's continuing service in subsequent year] will necessitate a change in other years." [15]

Based on the evidence presented at the hearing, the Board finds that under the statutory method the number of Medicare beneficiaries will fluctuate, therefore 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 adjustment for a particular year diminishes then with each successive year but, until every patient who received services in the year in 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.

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, an appeal must be filed within 180 days from the final determination and it is conditioned on receipt of a specific final determination. 42 U.S.C. § 1395oo(a)(1) & (3). The FY 2006 final determination appealed in this case was made in December of 2007 and was based on patient numbers as of October 31, 2007. It is the only determination from which the providers have an opportunity to challenge the cap. If the Provider's statutory methodology 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,[16] thus satisfying the $10,000 jurisdictional threshold.[17]

---

[14] Intermediary Post Hearing Submission at page 7, paragraph numbered 3.
[15] Provider's Closing Position Statement at page 6
[16] Intermediary's Post-Hearing Submission at 10.
[17] Under the Provider's theory, the amount would be $55,936.63 plus the interest Autumn Bridge has paid on the excess overpayment amount determined. See Provider's Closing Position Statement at page 3 and paragraph numbered 22 at 13-14. See also, Provider's Exhibit N. The Provider also calculated an alternative overpayment reduction amount of $21,657.84 based on the Intermediary's position that four beneficiaries whose services were either rejected or unbilled to Medicare should be omitted from the calculation. See, Provider's Revised Exhibit M. These distinctions are irrelevant to the question of amount in controversy in that the Intermediary concedes that the jurisdictional threshold is met if the same data used in the Intermediary's final determination as of October 31, 2007 are used.

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.[18] 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.

The Board also concludes 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 beneficiary for whom payment was denied by Medicare.[19] The Intermediary asserts they should not be included in the cap because no payments were made on their behalf. With regard to the three beneficiaries whose services were not billed, the evidence showed that a notice of election was filed for each of these individuals and, as a result, they were identified in Medicare's Common Working File but the Provider did not receive payment for them. TR. 79:8-80:20; 86:13-91:1.

The Medicare Act defines the "number of beneficiaries" to be used in the cap 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 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).

The Intermediary has not disputed that the notices of election were filed or that the beneficiaries actually received services from Autumn Bridge.[20] As these are the only two conditions the statute imposes on counting beneficiaries for the cap, the Board finds they must be included for any period in determining the amount in controversy under the statutory method of counting beneficiaries. The parties agree these three beneficiaries account for an additional .8368 beneficiary count.[21]

---

[18] Provider's Closing Position Statement at page 6: ". . . when a beneficiary's cap allowance is counted in fractions across multiple years of service . . . a change in any year will necessitate a change in other years."

[19] The Intermediary's Post Hearing Submission indicates it believed the Provider had agreed to omit the fourth beneficiary; however, the Provider's submission indicates that beneficiary may still in dispute. See, Provider Exhibits L and its original Exhibit M.

[20] Intermediary Post Hearing Submission at 9.

[21] See, Intermediary Post Hearing Submission at 9 and Provider Exhibit L and original Exhibit M.

The fourth beneficiary for whom payment was denied accounts for a .8284 beneficiary count. There was no evidence presented regarding the reasons for the denial of payment therefore, the Board is unable to determine whether the beneficiary should be counted.[22]

For the sake of judicial economy if the Court finds the Board's decision 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 will also address the calculation using the most recent cap data, October 31, 2009. Under that theory, the amount in controversy does not exceed $10,000.

The most recent data available used to determine the beneficiary count was as of October 31, 2009. The Intermediary submitted data it had calculated as of February 28, 2009 for the hearing before the Western District of Oklahoma and applied a time factor to update it for the Board hearing on remand. Under the Provider's theory, and giving the Provider the benefit of counting all disputed beneficiaries, the Provider calculated a $10,727.48 amount in controversy as of February 28, 2009.[23] This figure is comprised of an $8,654.10 reduction to the overpayment plus interest in the amount of $2073.38 the Provider had paid on that excess overpayment determination. See, Provider's original Exhibit M. When these figures are adjusted based on data available as of October 31, 2009, the amounts of which are undisputed, and giving the Provider the benefit of counting all disputed beneficiaries, (see Provider's Exhibit L) the beneficiary count is reduced to 148.8481 to produce a change in the overpayment from $720,991.00 to $719,533.60, a difference of $1,457.40, excluding any interest paid on the excess overpayment.[24] The attached comparative chart shows the calculations taking into account each of the disputed beneficiary counts.

Board Decision:

The Board finds 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

[22] Because the Board could not determine the circumstances for a rejection the Board has calculated the injury both including and excluding this beneficiary in the chart attached to this decision.

[23] Exhibit M used a time factor of 1.178 to adjust the October 31, 2009 data back to February 28, 2009. The Board does not have sufficient information to verify the accuracy of the factor; however it is not relevant to our decision in that the February 28 time period is not the most recent data available.

[24] Under the Provider's theory that interest paid on the excess overpayment should also be included in the amount in controversy, the Provider would not meet the jurisdictional $10,000 amount in controversy. Although there would be an additional 8 months of interest added to the 23 months shown on Provider's original Exhibit M, the principle on which the interest was applied for the entire period would have been reduced from $8654.10 to $1457.40. Although the terms of the repayment were not furnished to the Board, the interest would appear to fall far short of the $8542.60 needed to reach the jurisdictional amount of $10,000.

June 20, 2008 decision. The injury to the Provider using the most recent data available is $1,457.40 plus interest on the excess overpayment using data most favorable to the Provider.

Board Members Participating

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

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Date: December 22, 2009