PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D15

PROVIDER –
Canon Health Care Hospice, LLC
New Orleans, Louisiana

Provider No.: 19-1555

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING –
June 8, 2011

Cost Reporting Period Ended -
October 31, 2006

CASE NO.: 09-0008

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, 2005, through October 31, 2006.

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. *See* 42 U.S.C. § 1395 *et seq*. 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 (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. § 1395h and § 1395kk-1; 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). As a condition of participation in Medicare, a hospice program is required to ensure that the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in any twelve-month period during the hospice's participation in the Medicare program, do not exceed twenty percent of the total number of days of hospice coverage (inpatient and outpatient) 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.[2]

Medicare reimburses hospices for 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)(A). The intent of the cap is to ensure that payments for hospice care do 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

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[1] FIs and MACs are hereinafter referred to as intermediaries.

[2] 48 FR 38146, 38149 (August 22, 1983).

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 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."[3] Any excess reimbursement is considered an overpayment and must be refunded by the hospice.[4]

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, the statute 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.[5] 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))—
> >
> > (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

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[3] 48 FR 56018 (December 16, 1983).

[4] *Id.*

[5] In this case, the then Secretary Michael Leavitt signed a § 1135 Waiver on September 4, 2005, due to the effects from Hurricane Katrina. *See*, Provider's Exhibit P-7. 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 http://www.ncdc.noaa.gov/special-reports/katrina.html.

> (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.

(b) Secretarial authority.

> 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;
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> (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 receipt 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 GBA (Intermediary) is the Provider's Medicare fiscal intermediary.

On April 28, 2008, 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, 2006.[6]

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 Liles Parker, PLLC, formerly of Breazeale, Sachse & Wilson, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S 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 outpatient to inpatient 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, as well as throughout the entire cap year ending October 31, 2006.[7] The only way the Provider could have adjusted 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.[8] Those initial determinations were erroneous because the Intermediary subsequently notified the Provider that it had exceeded the twenty percent inpatient limitation for cap years 2003 and 2004. The Provider believes that had the Intermediary's initial determinations for cap years 2003 and 2004 been correct, 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 ability to comply with the twenty percent limitation on inpatient days.[9]

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[6] Provider's Exhibit P-1.

[7] Provider's Final Position Paper at 4-6, Transcript (Tr.) at 17-21.

[8] Provider's Final Position Paper at 8-9; Tr. at 22-23.

[9] Provider's Final Position Paper at 4-5; Tr. at 23, 63-64.

The Provider further argues that recovery of the overpayment should be waived in accordance with 42 U.S.C. § 1395gg, because it was without fault in causing the overpayment.[10] 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 applied 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 clear and unambiguous language of the statute, it is not necessary to use 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 Leavitt on September 4, 2005.[11] 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.[12] 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.[13]

The Provider requests that the § 1135 waiver be applied to the entire 2006 cap year overpayment. The Provider distinguishes this case from the prior period that while the majority of the 2005 cost reporting year occurred prior to Hurricane Katrina's landfall, fiscal year 2006 began when the major effect of Hurricane Katrina was being experienced.[14] In the alternative, if the waiver were to be partially applied to the months that were directly affected by Hurricane Katrina, e.g., November and December 2005, and January 2006,[15] the Provider argues that the effect would be to prevent the application of the rule for the entire cap year since neither the statutory nor regulatory condition of participation mentions calculating the rule on any basis other than a complete twelve-month period.[16]

INTERMEDIARY'S CONTENTIONS:

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

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[10] Provider's Final Position Paper at 10-11; Tr. at 24-27.

[11] Provider's Final Position Paper at 12; Exhibit P-7.

[12] Tr. at 58-60.

[13] Provider's Final Position Paper at 13-14, Tr. at 32-33, 61-62.

[14] Tr. at 29-30.

[15] The section 1135 emergency period ended on January 31, 2006. 71 FR 18654, 18656 (April 12, 2006).

[16] Tr. at 30-31, 34, 35; Provider's Post-hearing Brief.

overpayment amount is correct and that the Provider was properly notified of the overpayment.[17] Second, with regard to the Provider's request for equitable relief, the Board's authority is prescribed by statute and regulation, to which no equitable powers have been assigned.[18] 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, even 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.[19] 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 its binding regulatory framework.[20]

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:

With regard to the Provider's assertion of extraordinary circumstances associated with Hurricane Katrina, the Board concludes it is undisputable that Hurricane Katrina had a devastating impact in New Orleans, Louisiana, the Provider's service area. However, the Board is without authority to waive recovery of the overpayment due to extraordinary circumstances since the Board is obligated to follow the applicable statutes, regulations, and CMS rules.[21] In this case, the applicable payment regulation at 42 C.F.R. § 418.302(f) does not specify extraordinary circumstances as a basis for waiving recovery of an overpayment because of 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,[22] and also on erroneous guidance and assurances from the Intermediary following Hurricane Katrina.

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[17] Intermediary's Final Position Paper at 5.

[18] *Id.* at 9; Tr. at 45.

[19] Intermediary's Final Position Paper at 10.

[20] *Id.*; Tr. at 46.

[21] 42 C.F.R. § 405.1867.

[22] 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 Decision, CCH ¶82,656 (August 2, 2010).

The Board does not have the legal authority to waive recovery of the overpayment based on equitable 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.

The Board also 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. In this case, the overpayment at issue involves aggregate payments. 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 be applied to waive either a full or partial recovery of the overpayment. In the review of PRRB Decision No. 2011-D26, the Administrator stated that the Board "has no authority or jurisdiction to grant a § 1135 waiver under section 1878 of the Act or the regulations at part 405 subpart R."[23] The Board concurs with that finding. In that case, the Board did not grant a waiver, but rather addressed whether the waiver issued by the Secretary on September 4, 2005 was applicable.

Congress has authorized the Secretary to issue § 1135 waivers during an emergency period.[24] 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.[25]

The purpose of a § 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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[23] *Canon Healthcare Hospice, LLC v. Blue Cross Blue Shield/Palmetto Government Benefits Administrator,* PRRB Dec. No. 2011-D26, CCH ¶82,725 (April 15, 2011), *rev'd,* CMS Administrator Decision CCH ¶82,750 (June 13, 2011) at 9.

[24] 42 U.S.C. § 1320b-5.

[25] 42 U.S.C. § 1320b-5(b).

> (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.[26]

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.[27] 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 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."[28] Essentially, CMS acknowledged that the payment regulation was enacted as a method of promoting compliance with the statutory provision limiting inpatient days. Because the payment regulation promotes compliance with 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 issued 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

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[26] 42 U.S.C. § 1320b-5(a).

[27] 71 FR 18654, 18656 (April 12, 2006).

[28] *Supra,* n. 2.

the Provider's inpatient days from a total of 691 inpatient patient days in August 2005 down to 286 patient days in September 2005 and 443 patient days in October 2005.[29] The record also shows a more significant drop in routine home care days from 2,508 days in August 2005 down to 461 days in September 2005 and 736 days in October 2005.[30] 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, making compliance with the twenty percent limitation on inpatient days difficult, if not impossible. As the Provider explained, it was unable to remedy the situation to comply with the inpatient day limitation, because doing so would have required it to discharge all of its inpatients and avoid new inpatient admissions. That was a difficult if not impossible solution considering the Provider had 38 of the 48 total hospice beds in the entire region following the hurricane.[31] Furthermore, it was the only hospice in New Orleans that was in operation during the period immediately following the hurricane.[32] In the 2006 cap year, the problems persisted, and although the Provider was able to reduce its percentage of inpatient days throughout the year, it was not able to reduce the percentage low enough to comply with the rule.[33]

The Administrator reversed the Board's decision in the prior case on the assertion that § 1135 waivers are available only if a provider formally requests a waiver and one is specifically granted to that facility.[34] However, the Administrator based that assertion on instructions published in November 2009.[35] At the time of the § 1135 waiver issued on September 5, 2005, in response to Hurricane Katrina, that CMS guidance did not exist and there was no process for individually applying for waivers within the statute, regulations or the waiver itself. Further, the CMS document indicates that "requests from Governor's offices, feedback from individual healthcare providers and associations, and requests to regional or field offices for assistance" would be considered within a body of evidence "in determining whether to invoke an 1135 waiver (once the conditions precedent to the authority's exercise have been met)."[36] Thus a specific application by the Provider would not be necessary in this case as the Secretary had already decided to invoke a § 1135 waiver that was applicable to the Provider's geographic area.

While the Board finds the § 1135 waiver applies in this case, the Board denies the Provider's request for a waiver of the entire overpayment. The § 1135 waiver indicates an effective date for Louisiana, of August 29, 2005, and the waiver expired on January 31, 2006. Consequently, the Board finds that a partial waiver of recovery of the overpayment is permitted for the period of time directly related to Hurricane Katrina, which in the current cap year is November 1, 2005,

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[29] Provider's Exhibit P-11 at 60-62.

[30] *Id.*

[31] Provider's Final Position Paper at 5.

[32] Provider's Exhibit P-11 at 64.

[33] Provider's Exhibits P-8, P-9, and P-10.

[34] *Canon Healthcare Hospice v. BlueCross BlueShield Ass'n/Palmetto Gov't Benefits Adm'r,* CMS Administrator Decision (Review of PRRB Dec. 2011-D26), CCH Medicare Guide 82,750 (June 13, 2011) at 8, note 12.

[35] CMS document, "Requesting an 1135 Waiver" (Revised Nov. 4, 2009). *See,* http://www.cms.gov/H1N1/Downloads/RequestingAWaiver101.pdf

[36] *Id.* at 2.

through January 31, 2006. The Board finds that a partial waiver for this period is not inconsistent with the requirement to calculate the cap over a twelve-month period.

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 for the period November 1, 2005, through January 31, 2006. The Intermediary's determination is modified.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: APR 13 2012