PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D4

PROVIDER –
Canon Health Care Hospice, LLC
Gulfport, Mississippi

Provider No.: 25-1627

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING –
May 7, 2013

Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount
Period Ended -
October 31, 2008

CASE NO.: 11-0010

INDEX

ISSUE:

Whether the Intermediary, Palmetto GBA, erred in calculating the Inpatient Day Limitation over a period greater than 12 months for the Provider's cap year ended October 31, 2008.[1]

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 under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Pursuant to § 122 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"),[4] the Medicare program provides coverage for certain terminally ill beneficiaries who elect to receive care from a participating hospice.[5] The term "hospice program" means a public agency or private organization (or subdivision of) that is primarily engaged in providing specified services to terminally ill individuals and their families and that meets certain conditions of participation.[6] As a condition of participation in Medicare, 42 U.S.C. § 1395x(dd)(2)(A)(iii) specifies that a 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 (inpatient and outpatient) provided to those beneficiaries. Federal regulations reflect the statute's requirements governing the provision of short term inpatient care and the emphasis on the provision of care primarily in the home.[7]

Medicare reimburses hospices for costs which relate to the cost of providing hospice care as well as other tests of reasonableness as the Secretary may prescribe in regulations.[8] Medicare also places limits, or "caps," on total reimbursement to an individual hospice for each year 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. 42 U.S.C. § 1395f(i)(2)(A)

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[1] There was a second issue addressing "Whether the Intermediary's calculations of the Inpatient Day Limitation are accurate." However, the Provider withdrew the second issue at the hearing. *See* Transcript ("Tr.") 105-106. As a result, the Board's decision does not address the second issue.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] Pub. L. No. 97-248, § 122(d)(3), 96 Stat. 324, 356 (1982).
[5] *See* TEFRA § 122(d)(3) (codified at 42 U.S.C. § 1395x(dd)).
[6] 42 U.S.C. § 1395x(dd)(2).
[7] 42 C.F.R. § 418.98(c) (2007). *See also*: 48 Fed. Reg. 38146, 38149 (Aug. 22, 1983).
[8] 42 U.S.C § 1395f(i)(1)(A).

specifies that the amount of payment made to a hospice program each year may not exceed the hospice's "cap amount" for the year multiplied by the number of Medicare beneficiaries in the hospice program in that year. Federal regulations at 42 C.F.R. § 418.3 (2007) define the "cap period" as "the twelve-month period ending October 31 used in the application of the cap on overall hospice reimbursement specified in § 418.309." The Medicare Claims Processing Manual, CMS Pub. No. 100-04 ("MCPM"), Chapter 11, § 80.2 defines the cap on overall hospice reimbursement as:

> **80.2 – Cap on Overall Hospice Reimbursement**
> Overall aggregate payments made to a hospice are subject to a 'cap amount,' calculated by the FI at the end of the hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total payment made for services furnished to Medicare beneficiaries during this period are compared to the 'cap amount' for this period. Any payments in excess of the cap must be refunded by the hospice.
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> **80.2.1 – Services Counted**
> ....
> The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for the entire cap year. In this situation, the initial cap calculations for newly certified hospices must cover a period of at least 12 months but not more than 23 months....

The hospice regulations also impose a second limit known as the "inpatient care day limitation" which is intended to limit the percentage of inpatient care to 20 percent of the total hospice services available to each beneficiary who has elected hospice care. To calculate this limit, federal regulations establish rate categories for four types of hospice care, including routine home care, continuous home care, inpatient respite care, and general inpatient care for each day a qualified Medicare beneficiary has elected hospice care.[9] In particular, 42 C.F.R. § 418.302(f) (2007) calculates the impatient care day limitation as follows:

> (f) Payment for inpatient care is limited as follows: (1) The total payment to the hospice for inpatient care (general or respite) 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.
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> (2) At the end of a cap period, the intermediary calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients.

[9] 42 C.F.R. § 418.302(c)(2007)

> (3) If the number of days of inpatient care furnished to Medicare patients is equal to or less than 20 percent of the total days of hospice care to Medicare patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount specified in § 418.309.
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> (4) If the number of days of inpatient care furnished to Medicare patients exceeds 20 percent of the total days of hospice care to Medicare patients, the total payment for inpatient care is determined in accordance with the procedures specified in paragraph (f)(5) of this section. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice. Overall payments to the hospice are subject to the cap amount specified in § 418.309.
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> (5) If a hospice exceeds the number of inpatient care days described in paragraph (f)(4), the total payment for inpatient care is determined as follows:
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> (i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.
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> (ii) Multiply this ratio by the total reimbursement for inpatient care made by the intermediary.
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> (iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.
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> (iv) Add the amounts calculated in paragraphs (f)(5)(ii) and (iii) of this section.

In the preamble to the 1983 final rule that promulgated the regulations to implement the hospice benefit pursuant to TEFRA § 122,[10] CMS included the following discussion on the 20 percent limit:

> Comment: Numerous commenters suggested that we delete the proposed limitation on inpatient care days described in § 418.302(f) of the proposed regulations. That limitation was to be applied to payment for inpatient care days in excess of the percent specified in the statute. The statute (section 1861(dd)(2)(A)(iii) of the Act) specifies that a hospice must assure that it does not exceed 20 percent of the aggregate number of days of hospice care provided to Medicare beneficiaries during any 12 month period.

[10] 48 Fed. Reg. 56008 (Dec. 16, 1983).

> Response: We are not accepting these comments and are retaining this limit because we believe a hospice should not be rewarded through the reimbursement system for exceeding the statutory limit. By making the 20 percent limit a reimbursement limit, the regulations provide an incentive for hospices to remain in compliance with the statutory requirement. We do not believe that costs attributable to excessive inpatient days are necessary in the efficient delivery of hospice services.[11]

Any excess reimbursement is considered an overpayment and must be refunded by the hospice.[12]

MCPM, Chapter 11, § 80.1 also provides the following discussion on the "Limitations on Payments for Inpatient Care":

> Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1-October 31).

In summary there are two limits placed on reimbursement to hospice providers: (1) the 20 percent "Inpatient Day Limitation"; and (2) the "Overall Cap" which is calculated based upon a cap amount per beneficiary. Only the 20 percent "Inpatient Day Limitation" is in controversy in this case.

The intermediary notifies the hospice of the determination of program reimbursement at the end of the cap year.[13] A hospice dissatisfied with an intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of that determination.[14]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Canon Health Care Hospice, LLC ("Provider") became a Medicare-certified hospice on January 3, 2007 and is located in Gulfport, Mississippi. The Provider's designated Medicare intermediary is Palmetto GBA ("Intermediary").

On April 6, 2010, 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

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[11] *Id.* at 56019.
[12] *Id.*at 56034 (promulgating 42 C.F.R. § 418.308(d)).
[13] 42 C.F.R. § 418.308(c) (cross references 42 C.F.R. § 405.1803).
[14] 42 C.F.R. § 418.311; 42 C.F.R. § 405.1835.

exceeded the twenty percent limitation on inpatient days for the period from January 3, 2007 through October 31, 2008.[15]

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., Esq., of Liles Parker, PLLC. The Intermediary was represented by Robin Sanders, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the statutes,[16] regulations,[17] and MCPM[18] provisions limit the period for calculating the Inpatient Day limitation to a 12-month period. The Provider argues that the Intermediary erred in calculating the Inpatient Day Limitation Cap by using a period of greater than 12 months for the Provider's cap year ending October 31, 2008.[19] Provider contends that the Intermediary had no statutory or, regulatory authority for its action.

The Provider states that under the precise language of the statute, the Intermediary can only calculate the inpatient day limitation over a 12-month period running from November 1st of each year and ending on October 31st of the following year.[20] In support of this argument, the Provider cites to the "conditions of participation" language in 42 U.S.C. § 1395(dd)(2)(A)(iii) which requires each Medicare participating hospice to provide: assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G)[21] .....

> provided in any *12-month period* to individual who have an election in effect under section 1395d(d) of this title with respect to that agency or organization does not exceed 20 percent of the aggregate number of days *during that period* on which such elections for such individuals are in effect; . . . .[22]

The Provider argues that this language, along with other regulatory provisions,[23] mandate that the inpatient day limitation can only be calculated on a 12-month period.

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[15] Provider Exhibit P-1; Tr. at 9.
[16] 42 U.S.C. § 1395x(dd)(2)(A)(iii).
[17] 42 C.F.R. §§ 418.98(c), 418.302(f).
[18] MCPM, Ch. 11, § 80.1
[19] Provider's Final Position Paper at 3.
[20] Provider's Final Position Paper, at 2-3.
[21] 42 U.S.C. § 1395x(dd)(1)(G)refers to short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, non-routine, and occasional basis and may not be provided consecutively over longer than five days.
[22] (Footnote and emphasis added.) *See* Provider's Final Position Paper at 4.
[23] *See* Provider's Final Position Paper at 4-6 (citing to 42 C.F.R. §§ 418.98 and 418.302(f) as examples of other regulatory provisions).

The Provider also notes that MCPM, Chapter 11, § 80.2.1, as cited by the Intermediary, indicates only that the Overall Cap (which is not in controversy in this case) may be calculated for more than a 12-month period, specifically for new providers. The Provider argues that this manual section only applies to the overall hospice cap, which is a completely different rule with different statutory and regulatory authority and does not apply to the Inpatient Day Limitation.[24]

Finally, the Provider maintains that the Intermediary assured the Provider that the Inpatient Day Limitation would not apply to the Provider between January 3, 2007 and October 31, 2007 because the Provider had not participated in the program for a full twelve month period.[25] On August 17, 2007, a representative from the Intermediary gave assurance that the Inpatient Day Limitation would not apply until November 1, 2007. Based upon that assurance the Provider did not attempt to adjust its volume of inpatient care to reduce potential overpayments.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends 42 U.S.C. § 1395f(i)(1) gives the Secretary broad authority for calculating the amount of Medicare payment for hospice care. The Intermediary states that the statutes and regulations are silent as to the specific question in this appeal.[26] The Intermediary argues that the Inpatient Day Limitation and the Overall Cap are inextricably intertwined and must be calculated over the same time period.[27] In support of this argument, the Intermediary cites to 42 C.F.R. § 407.1803(a)(3) which instructs intermediaries to provide the results of the calculations for the Inpatient Day Limitation cap and the Overall Cap in a single program payment letter that serves as the NPR.[28]

Further, the Intermediary notes that MCPM, Chapter 11, § 80.2.1 specifically refers to "calculations" in the plural form stating as follows: "the initial cap *calculations* for newly certified hospices must cover a period of at least 12 months but not more than 23 months...."[29] This, the Intermediary argues, makes it clear that they were to use this period when calculating both the Inpatient Day Limitation and the Overall Cap for new providers in the Medicare program.

While the Intermediary states that it agrees with the Provider that 42 U.S.C. § 1395x(dd)(2)(iii) requires that Inpatient Day Limitations should be based on at least a 12-month period, the Intermediary contends that it disagrees with the Provider on whether, as a new hospice provider, the inpatient day limitation should exclude the period from January 3, 2007 through October 31, 2007 as would be the result if the inpatient day limitation was limited to a 12-month period. The Intermediary maintains that there is no authority in the statute or regulations that would allow it to exclude inpatient care days from its calculations if the new Provider's entry into the Medicare

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[24] Tr. at 11.
[25] Provider's Final Position Paper at 8-9.
[26] Tr. at 28.
[27] *Id.*, at 23.
[28] *Id.* Intermediary's counsel cited the regulation as 42 C.F.R § 407.1803(a)(3), however, the correct citation for notice of program reimbursement for hospice caps should be 42 C.F.R.§ 405.1803(a)(3). This regulation was enacted in August 6, 2009 in 74 Fed. Reg. 39384, 39400-01 and not in effect during the applicable cost reporting year.
[29] (Emphasis added). *See* Tr. at 25.

program does not coincide with the beginning of a cap period which runs from November 1st of each year through October 31st of the next year.[30]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and evidence submitted, the Board has set forth below its findings and conclusions.

The question in this case is what period should be used to calculate the Inpatient Day Limitation for new hospices which have a fiscal year that does not coincide with the cap year. 42 U.S.C. § 1395x(dd)(A)(2) specifies the following requirement for hospices as a condition of participation in the Medicare program:

> (2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which--. . .
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> (iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care . . . *provided in any 12-month period* to individuals who have an election . . . with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individual are in effect.[31]

Through its use of the phrase "provided in any 12-month period," the Board finds that the statute does not say the hospice must be open for the entire 12-month period, just that a 12-month period will be used for the calculation of the inpatient day limitation. The Secretary implemented the statutory 12-month period by promulgating the following definition of "cap period" delineated in 42 C.F.R. § 418.3: "*Cap period* means the twelve-month period ending October 31 used in the application of the cap on overall hospice reimbursement specified in § 418.309." The Board finds this regulation consistent with the statute by defining the "cap period" as the 12 months ending October 31.

42 C.F.R. § 418.301 sets out the basic rules for payments for covered hospice care. These rules place two limitations on payment. The first rule, which is the basis for the Inpatient Day Limitation at issue, is found at 42 C.F.R. § 418.301(a) and states: "Medicare payment for covered hospice care is made in accordance with the method set forth in § 418.302." The second is found at 42 C.F.R. § 418.301(b) and specifies the basis for the Overall Cap; however, the second rule is not at issue in this case.

The Secretary specifically promulgated 42 C.F.R. § 418.302(f) to calculate the 20 percent Inpatient Day Limitation on hospice payment. The Board finds that this regulation unambiguously requires the Intermediary to calculate the limitation at the end of a cap period. In this regard, the Board notes that 42 C.F.R. § 418.302(f)(2) specifies that: "*[a]t the end of a cap period*, the intermediary calculates a limitation on payment for inpatient care to ensure that

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[30] Intermediary's Final Position Paper at 8.
[31] (Emphasis added.)

Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients."[32] There is no exception or exemption provided in 42 C.F.R. § 418.302(f) to the application of the cap year.

The Board further finds that the statute through the phrase "days of inpatient care . . . provided in any 12-month period" limits the period for calculating the 20 percent Inpatient Day Limitation to 12 months. Thus, when read together, the statute and the regulation require that the 20 percent inpatient day limitation be applied at the end of each annual 12-month "cap period" ending October 31st without exception or exemption. Pursuant to 42 C.F.R. § 405.1867, the Board "must comply with all provisions of Title XVIII of the Act and regulations issued thereunder."

The Board finds MCPM, Chapter 11, § 80.1 entitled: "Limitation on Payments for Inpatient Care" is consistent with the statute and regulation and supports the Board's finding. In this regard, § 80.1 states:

> Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. *This limitation is applied **once each year**, at the end of the hospices' "cap period" (November 1 – October 31).*[33]

Again, the Board finds no exception/exemption to the 20 percent Inpatient Day Limitation for new providers whose fiscal year does not start on November 1st, the beginning of the cap period in the MCPM. Further, the manual's use of the words "once each year" indicates that there are no exceptions or exemptions to applying the 20 percent Inpatient Day Limitation at the end of *each* "cap period" as defined in 42 C.F.R. § 418.3.

The Board finds that MCPM, Chapter 11, § 80.2.1 cannot be read consistently with the 12-month requirement in the statute for calculating the Inpatient Day Limitation. The Board finds that § 80.2 applies to the "Cap on Overall Hospice Reimbursement" found in 42 C.F.R. § 418.309 not the Inpatient Day Limitation found in 42 C.F.R. § 418.302 and at issue in this case. In this regard, the Board does not agree with the Intermediary's interpretation that the use of the plural "caps" used in one sentence in one paragraph of MCPM, Chapter 11, § 80.2.1 (to wit: "In this situation, the initial cap calculations for newly certified hospices...") was intended to refer to *both* the Overall Cap *and* the Inpatient Day Limitation cap. The Board finds that the use of the plural here simply parallels the drafter's use of the plural of "newly certified hospices" which follows. This conclusion is further supported by the fact that the discussion of Inpatient Day Limitation cap is located in § 80.1 which is a separate manual section (as opposed to § 80.2 or a subsection of § 80.2).

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[32] (Emphasis added.)
[33] (Emphasis added.)

Further, the Board finds that the Inpatient Day Limitation is a separate calculation from the Overall Cap and that, pursuant to the MCPM, it need not be calculated on the same period as the Overall Cap, only that it be calculated first.[34] The Board finds that the Provider's payments as reduced on an annual basis by the Inpatient Day Limitation should be subject to the cap amount specified in 42 C.F.R. § 418.309. In this case, it requires that the two annual Inpatient Day Limitations (cap periods ended October 31, 2008 and October 31, 2007) be compared to the 22 month initial Overall Cap calculations for newly certified hospices made by the Intermediary under MCPM, Chapter 11, § 80.2.1.[35]

In conclusion, the Board finds that the Intermediary erred in calculating the Inpatient Day Limitation over a period greater than 12-months for the Provider's cap year ended October 31, 2008. The Board finds that, pursuant to 42 U.S.C. § 1395x(dd)(A)(2), 42 C.F.R. §§ 418.3 and 418.302(f) and MCPM, Chapter 11, § 80.1, the Inpatient Day Limitation should be calculated separately for the cap periods ended October 31, 2008 (November 1, 2007 through October 31, 2008) and October 31. 2007 (January 3, 2007 through October 31, 2007).

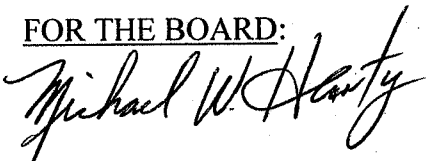
DECISION AND ORDER:

The Intermediary erred in calculating the Inpatient Day Limitation over a period greater than 12 months for the Provider's cap year ended October 31, 2008. The Inpatient Day Limitation should have been calculated separately at the end of the cap periods ended October 31, 2008, and October 31, 2007. The Intermediary's determination is modified.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

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[34] *See* 42 C.F.R. § 418.302(f)(3)&(4) (instructing that the overall payments as reduced by the Inpatient Day Limitation be subject to the Overall Cap amount found in 42 C.F.R. § 418.309). Further, the Board notes that, while MCPM § 80.1 governing the Inpatient Day Limitation contains the limiting language "applied once each year," this limiting language is absent from MCPM §§ 80.2 which governs the Overall Cap. As a result, the Board concludes that the manual provisions have distinguished how a "cap period" is applied for purposes of each of these calculations.

[35] The Board's finding is limited to the issue of the Inpatient Day Limitation. No finding is made on whether MCPM, Chapter 11, § 80.2.1 which states for the overall cap, "the initial cap calculations for newly certified hospices must cover a period of at least 12 months but not more than 23 months," is consistent with the statute and regulations as this manual provision was not at issue in this case.

DATE: APR 08 2014