PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D20

PROVIDER –
Silverado 2014 Hospice Cap Sequestration

Provider No.: See Appendix A

vs.

MEDICARE CONTRACTOR –
National Government Services

DATE OF HEARING – May 1, 2017

Cost Reporting Period Ended –
October 31, 2014

CASE NO. - 16-1235GC

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ISSUE STATEMENT

Whether National Government Services ("Medicare Contractor"[1] or "NGS") erred in calculating the hospice aggregate cap overpayments when it included, in "the amount of payment made," certain funds that were sequestered and never paid to the Providers.[2]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds the Medicare Contractor properly applied sequestration to the Hospices' aggregate cap payments and calculated the Hospices' aggregate cap overpayments correctly.

INTRODUCTION

This group case involves 3 hospice providers ("Hospices" or Providers")[3] owned by Silverado, Inc. Each Hospice appealed its hospice cap determination for the cap year ending October 31, 2014.[4] The Hospices believe that the Centers for Medicare and Medicaid Services ("CMS") acted inconsistent with the relevant Medicare statutory provisions when CMS included sequestration in calculating the hospice cap. Additionally, the Hospices believe that CMS' sequestration methodology is incorrect and constitutes "double dipping" by requiring hospices to pay back certain funds that they never received.[5]

Each of the Hospices timely appealed the issue and met the jurisdictional requirements for a hearing. Accordingly, the Board held a telephonic hearing on May 1, 2017. The Hospices were represented by Brian Daucher, Esq. of Sheppard, Mullin, Richter & Hampton, LLP. The Medicare Contractor was represented by Bernard Talbert, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

A. HOSPICE PAYMENT METHODOLOGY

In 1982, Congress created the hospice benefit pursuant to § 122 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").[6] The hospice benefit is an election that certain terminally-ill Medicare beneficiaries can make "in lieu of" other Medicare benefits. Congress set the amount of payment for hospice care at 42 U.S.C. § 1395f(i)(1)(A) "based on reasonable

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[1] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[2] Transcript ("Tr.") at 5-6.

[3] *See* Schedule of Providers at Appendix A.

[4] Exhibit P-1 at 10, 16, 22.

[5] Silverado Group's Post-Hearing Brief, 2 (May 8, 2017).

[6] Pub. L. No. 97-248, § 122, 96 Stat. 324, 356 (1982). Initially, Congress made the hospice benefit temporary benefit with a sunset in October 1986 but, in April 1986, Congress made it permanent. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9123(a), 100 Stat. 82, 168 (1986) ("COBRA '85").

costs or such other test of reasonableness as the Secretary shall determine, *subject to a[] . . . limit or **cap***."[7] Congress set this reimbursement or payment cap[8] as a cost containment mechanism: "[t]he intent of the cap was to ensure that payments for hospice care would not exceed what would have been expended by Medicare if the patient had been treated in a conventional setting."[9]

While the TEFRA hospice legislation suggests Congress anticipated that CMS (then known as the Health Care Financing Administration or HCFA) would initially pay hospices on a reasonable cost basis,[10] CMS immediately exercised its discretion under 42 U.S.C. § 1395f(i) to base the initial reimbursement methodology for hospice care on an "other test of reasonableness." Specifically, CMS implemented the hospice benefit using a prospective payment system for hospice care as a proxy for costs.[11] Under this payment methodology, CMS established per-day payment amounts for four categories of hospice care services furnished to Medicare beneficiaries, including routine home care, continuous home care, inpatient respite care, and general inpatient care.[12] Congress has periodically adjusted these payment rates.[13]

Notwithstanding CMS' promulgation of the hospice prospective payment system, Congress has never removed the hospice cap. The hospice cap is set on a per beneficiary basis and is adjusted annually for inflation.[14] The adjusted per-beneficiary cap is then applied to each hospice on an aggregate basis across each relevant 12-month fiscal year. Congress initially set the hospice cap "at 40 percent of the average Medicare per capita expenditure during the last six months of life for Medicare beneficiaries dying of cancer."[15] However, Congress later amended the hospice cap "to correct a technical error" because Congress learned that the data from the Congressional

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[7] H.R. Conf. Rep. No. 97-760, at 428 (1982) *reprinted in* 1982 U.S.C.C.A.N. 1190, 1208. *See also* Staff of H.R. Comm. On Ways and Means, 97th Cong., 2d Sess., Explanation of H.R. 6878, at 17 (Comm. Print 1982) (stating: "Under this provision, reimbursement for hospice providers of services would be an amount equal to the costs which are reasonable and related to the cost of providing hospice care (or which are based on such other tests of reasonableness as the Secretary may prescribe) subject to a 'cap amount'. . . . *The amount of payment* under this provision for hospice care provided by (or under arrangements made by) a hospice program . . . for an accounting year may not exceed the 'cap amount'. . . ." (emphasis added) (*available at*: https://catalog.hathitrust.org/Record/011346136) (hereinafter "Explanation of H.R. 6878").

[8] The hospice cap has been referred to as either a "reimbursement cap" or a "payment cap." *See, e.g.*, H.R. Rep. No. 98-333, at 1 (1983) *reprinted in* 1983 U.S.C.C.A.N. 1043, 1043 ("reimbursement cap") ("the bill . . . to increase the cap amount allowable for reimbursement of hospices under the Medicare program . . ."); Richard L. Fogel, U.S. Gov't Accountability Office, GAO/HRD-83-72, Comments on the Legislative Intent of Medicare's Hospice Care Benefit 1, 5 (1983) (stating: "In authorizing Medicare reimbursement for hospice services, the Congress, in section 122(c)(2)(B) of TEFRA, chose to impose a cap on the average reimbursement which a hospice program could receive for its Medicare patients.") (*available at*: https://www.gao.gov/assets/210/206691.pdf) (hereinafter "GAO Rep. GAO/HRD-83-72").

[9] H.R. Rep. 98-333 at 1 (1983). *See also* GAO Rep. GAO/HRD-83-72, at 5-6 (quoting Explanation of H.R. 6878 at 18); 48 Fed. Reg. 56003, 56019 (Dec. 16, 1983).

[10] *See* GAO Rep. GAO/HRD-83-72, at 4-5.

[11] *See* 48 Fed. Reg. at 56003.

[12] 42 C.F.R. § 418.302(c). The payment for inpatient services is limited by an "inpatient care cap" as described in paragraph (f) of this section. The inpatient care cap is not at issue in this appeal.

[13] *See, e.g.*, Pub. L. No. 98-617, 98 Stat. 3294, 3294 (1984); H.R. Rep. No. 98-1100 (1984) *reprinted in* 1984 U.S.C.C.A.N. 5703 (House report that is part of legislative history for Pub. L. No. 98-617); COBRA '85 § 9123(b), 100 Stat. at 168.

[14] 42 C.F.R. § 418.309(a).

[15] H.R. Conf. Rep. No. 97-760, at 428 (1982).

Budget Office ("CBO"), upon which the original hospice cap was based, contained two errors.[16] Specifically, Congress raised the hospice cap to $6,500 per Medicare beneficiary subject to an annual inflation adjustment in order to correct for these errors[17] (which coincidentally occurred between when CMS proposed and finalized the hospice prospective payment system).[18]

Accordingly, hospice care is paid under a unique hybrid reimbursement system involving prospective payments as a proxy for costs subject to an annual cap. Specifically, the total Medicare payments made to a hospice during a 12-month period is limited by a hospice-specific cap amount that is referred to as the "aggregate cap amount."[19] Each hospice's "aggregate cap amount" for a 12-month period is calculated by multiplying the adjusted statutory per-beneficiary cap amount[20] for that period by the number of Medicare beneficiaries served by the hospice during that period.[21] The 12-month period is referred to as the "cap year" and runs from November 1 of each year until October 31 of the following year.[22] Medicare payments made to a hospice during a cap year that exceed the aggregate cap amount are overpayments that the hospice must refund to the Medicare program.[23]

In addition to the aggregate cap, hospices have another limitation imposed on their payments on a cap-year basis referred to as an "inpatient care cap." Specifically, for each cap year for a hospice, "the aggregate number of inpatient days for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate number of days of hospice care provided to all Medicare beneficiaries in that hospice during the same period."[24]

Finally, for every cap year, the Medicare program conducts a hospice-specific cap-year-end reconciliation and accounting process in which it calculates each hospice's aggregate cap amount and determines whether each hospice should be assessed an overpayment based on the total payments made to that hospice for the cap year. Similarly, as part this cap-year-end process, CMS also determines if the hospice exceeded the inpatient care cap. The Medicare program then sends each hospice a "determination of program reimbursement letter, which provides the results of the inpatient ***and*** aggregate cap calculations" for that cap year[25] and, if that calculation

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[16] H.R. Rep. No. 98-333, at 1-2 (1982). *See also* GAO Rep. GAO/HRD-83-72, at 5-6.
[17] Pub. L. No. 98-90, 97 Stat. 606, 606 (1983). *See also* H.R. Rep. No. 98-333, at 2 ("The outcome, therefore, is that the 'cap' amount for 1984, as calculated by the Department of Health and Human Services would be a little over $4,200. This is significantly lower than the $7,600 anticipated, necessitating this technical amendment [to raise the cap to $6,500].").
[18] *See* GAO Rep. GAO/HRD-83-72, at 5-6; 48 Fed. Reg. at 56019.
[19] 42 C.F.R. § 418.308(a).
[20] The adjusted cap amount is determined for each cap year by adjusting $6,500 for inflation or deflation for cap years that end after October 1, 1984 by the percentage change in medical care expenditures category of the consumer price index for urban consumers. *See* 42 C.F.R. § 418.309(a).
[21] 42 C.F.R. § 418.309.
[22] *See, e.g.*, 42 C.F.R. § 418.309(a).
[23] 42 C.F.R. § 418.308(d).
[24] Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 9, § 90.1 (as revised May 8, 2015) (copy included at Exhibit P-16). *See also* 42 C.F.R. § 418.302(f).
[25] *See* 42 C.F.R. § 405.1803(a)(3) (emphasis added).

identifies an overpayment, the determination provides notice of that overpayment amount.[26] If the hospice is dissatisfied with that determination, it may file an appeal with the Board.[27]

B. SEQUESTRATION

In 2011, Congress adopted the Budget Control Act of 2011 ("Act"), which includes a provision commonly known as "sequestration."[28] This sequestration provision requires the President to reduce discretionary spending across the board, including Medicare spending, by certain fixed percentages in the event that budgeted expenditures exceed certain limits. The percentage reduction for the Medicare program is capped at 2 percent for a fiscal year[29] and applies "in the case of [Medicare] parts A and B . . . to individual payments for services. . ."[30]

Pursuant to the procedures established by the sequestration provision, on March 1, 2013, the Office of Management and Budget ("OMB") issued a report that triggered sequestration and imposed a 2 percent sequestration reduction to Medicare spending.[31] Consistent with this report and associated Presidential Order,[32] CMS then directed its Medicare contractors to reduce Medicare payments with dates of services or dates of discharge *on or after April 1, 2013* by 2 percent.[33] As part of this implementation, on March 3, 2015 CMS issued a Technical Direction Letter ("TDL") directing Medicare contractors to make sequestration adjustments for hospices subject to the aggregate cap in the following manner:

- The sequestration amount reported on the Provider Statistical and Reimbursement (PS&R) report for each hospice shall be added to the net reimbursement amount reported on the [PS&R].
- The resulting amount shall be compared to the hospice's aggregate cap amount to calculate a *pre-sequester* overpayment; and

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[26] *See* 42 C.F.R. § 405.1803(c).
[27] *See id.*
[28] Pub. L. 112-25, 125 Stat. 240 (2011) (codified at 2 U.S.C. Ch. 20).
[29] 2 U.S.C. § 901a(6)(A).
[30] 2 U.S.C. § 906(d)(1)(A).
[31] Office of Management and Budget, Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013 (2013) (*available at*: https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf) (copy included at Exhibit P-13).
[32] A copy of this order was published at 78 Fed. Reg. 14633 (Mar. 6, 2013).
[33] *See* Exhibit P-14 (copy of CMS Medicare FFS Provider e-News (Mar. 8, 2013) (announcing that "Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment.")); Exhibit P-15 at 2 (copy of Medicare Claims Processing Manual, CMS Pub 100-04, Transmittal 2739 (July 25, 2013) (creating new claim adjustment reason code "to identify claims in which payment is reduced due to Sequestration")).

- The *pre-sequester* overpayment shall be reduced by 2% to reflect the actual amount paid to the hospice. The 2% overpayment reduction cannot be greater than the actual sequestration amount reported on the PS&R report.[34]

Under this methodology, the first two bullets determine whether there would be an overpayment if there had been no sequestration and, if so, what that "pre-sequester" overpayment would have been. To any resulting "pre-sequester" overpayment, the TDL reduced that overpayment by the lesser of the following: (a) 2 percent of the "pre-sequester" overpayment; or (2) the sequestration reported on the PS&R (*i.e.*, the aggregate sequestration amount already collected during the cap year). The resulting amount becomes the overpayment amount assessed for the cap year.

As sequestration began on April 1, 2013, all 12 months of the 2014 cap-year (*i.e.*, November 1, 2013 through October 31, 2014) were impacted by sequestration. This case focuses on the reconciliation and accounting process and how CMS accounted for the sequestered payments, made during the course of the 2014 cap year, in relation to applying the aggregate cap for each of the Hospices.

C. THE HOSPICES' AGGREGATE CAP CALCULATION FOR CAP YEAR 2014

For the 2014 cap year, each of the Hospices received a determination of program reimbursement letter entitled "Final Notice of Review of Hospice Cap" dated December 30, 2015.[35] On September 27, 2016, NGS reopened these determinations, to revise the calculation due to changes in the number of beneficiaries the Hospices served and/or in the amount of interim payment the Hospices received. In these instances, the revised aggregate cap determination resulted in an increase in the amount the Hospices had to refund.[36]

The Hospices have not raised any dispute about the accuracy of the Medicare Beneficiary Count or the adjusted statutory per-beneficiary cap amount. Rather, the Hospices assert that CMS improperly altered the hospice cap calculation by instructing its contractors to include the following "funds" in the amount of payment made to the Hospices: certain funds that were sequestered but never paid to the Hospices.[37] Specifically, the Hospices assert that CMS improperly modified the aggregate cap calculation and that CMS lacked the authority to alter that calculation without Congress first modifying the relevant Medicare statutory provisions governing hospice payment.[38] The Hospices believe that CMS was required to use the net reimbursement (actual amount received by the hospice) in determining how much each of the Hospices exceeded its aggregate cap.[39]

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[34] Exhibit P-5 (copy of TDL-150240) (emphasis added).
[35] *See* Exhibits P-7, P-9, P-11.
[36] Exhibits P-8, P-10, P-12.
[37] Silverado Group's Post-Hearing Brief at 1-2.
[38] *Id.* at 3-5.
[39] *Id.* at 2-3.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Hospices contend that the Medicare statute is clear that, as the Medicare program sequestered hospice payments made during the 2014 cap year, the aggregate cap should simply be measured against the actual net amount of payment received by the hospice provider. Specifically, the Hospices point to 42 U.S.C. § 1395f(i)(2)(A) which states:

> The amount of payment made under this part for hospice care provided by (or under arrangements made by) a hospice program for an accounting year *may not exceed the "cap amount" for the year* (computed under subparagraph (B)) multiplied by the number of medicare beneficiaries in the hospice program in that year (determined under subparagraph (C)).[40]

The Hospices assert that CMS' methodology in the TDL to add the sequestration amount to the "amount of payment made" violates 42 U.S.C. § 1395f(i)(2)(A) because the sequestration amount was never actually paid to the Hospices.[41]

The Hospices point out that the Medicare Statute sets forth precise rules for both the "payment made" and "cap amount" components of the hospice cap. Specifically the Statute sets forth the rate of payment to hospices in §1396f(i)(1) and states that these exact payment rates are to be increased by the market basket percentage for the fiscal year reduced by the productivity adjustment and by 0.3 percentage points for fiscal years 2013 to 2019.[42] The Medicare Statute also sets forth the precise method to determine the hospice cap[43] as well as the number of beneficiaries in a hospice program.[44] The Hospices assert that Congress alone has the power to revise this calculation.[45] The Hospices point out the Congress amended a portion of the aggregate cap calculation in 2014 but did not include an amendment for sequestration.[46]

Additionally, the Hospices assert that the aggregate cap is not a payment but rather a vehicle by which Medicare recovers payments otherwise made. The Hospices argue that CMS violated federal statute by adding the sequestration onto the amount actually paid for hospice stays during the 2014 cap year because this sequestration amount was never actually paid. By adding the sequestration to these payments, the Hospices believe that the Medicare program is "double dipping" by asking them to repay amounts that they never received in the first instance.[47] They argue that the Medicare statutory and regulatory provisions governing hospice payments only require them to repay the difference between the amount actually paid to them (after application of sequestration) and the aggregate cap amount.

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[40] (Emphasis added.)
[41] Silverado Group's Post-Hearing Brief at 1-2.
[42] *See id.* at 3-4 (citing 42 U.S.C. § 1395f(i)(1)(C)(iii), (iv)).
[43] *See id.* at 4 (citing 42 U.S.C. § 1395f(i)(2)(B)(i)).
[44] *See id.* at 4 (citing 42 U.S.C. § 1395f(i)(2)(C)).
[45] *Id.* at 5.
[46] Silverado Group's Final Position Paper, 12 (Jan. 31, 2017) (citing Pub. L. No. 113-185, 128 Stat. 1952 (2014)).
[47] *Id.* at 11; Silverado Group's Post-Hearing Brief at 2.

As explained more fully below, the Board finds that CMS did not make any statutory or regulatory changes to the hospice payment when implementing sequestration. Rather, CMS implemented the sequestration order by directing its Medicare contractors to reduce Medicare payments by 2 percent beginning with dates of service or dates of discharge on or after April 1, 2013.[48] Specifically, CMS instructed its contractors on how sequestration should be applied to certain Medicare payments including:

1. Claims payments;[49]
2. Cost report payments including those made to IPPS-exempt hospitals;[50]
3. Electronic health record payments;[51] and
4. Hospice payments.[52]

In connection with hospices, as previously discussed, CMS issued the March 3, 2015 TDL directing Medicare contractors on how to implement sequestration when reconciling a hospice's interim payments made during the cap year to the aggregate cap determined at the end of the cap year.

With respect to the TDL, it is important to clarify what is in dispute. The Hospices' dispute arises from the TDL's cap-year-end reconciliation and accounting process and, as laid out in the TDL, this process involves the following inputs and factors:

1. The net prospective payments received during the 2014 cap year as listed on the Hospices' PS&R for the 2014 cap year;
2. The sequestered amounts deducted during the 2014 cap year as listed on the Hospices' PS&R for the 2014 cap year;
3. The number of beneficiaries served during the 2014 cap year;
4. The adjusted per-beneficiary statutory cap for the 2014 cap year; and
5. Each Hospices' aggregate cap for the 2014 as determined by ## 3 and 4.

The Hospices' do not dispute ## 3 to 5. Nevertheless, the Board did review these items and finds that the Medicare Contractor did not modify the Hospices' 2014 aggregate caps as they were all calculated by multiplying the adjusted per-beneficiary statutory cap by the number of beneficiaries each hospice served during the 2014 cap year.[53] Therefore, sequestration has no impact on how the aggregate caps for the Hospices for the 2014 cap year were calculated as they

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[48] Exhibit P-14.
[49] Exhibit P-15.
[50] Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), Ch. 40, Transmittal 4 (Sept. 2013) (instructions for Form CMS-2552-10) (*available at*: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R4P240.pdf).
[51] Mandated Sequestration Payment Reductions Beginning for Medicare HER Incentive Program (Apr. 11, 2013) (*available at*: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ListServ_SequestrationUpdate_EHR_Program.pdf).
[52] Exhibit P-5.
[53] The Board notes that a hospice's aggregate cap for a cap year is calculated by multiplying the number of beneficiaries the hospice serviced in that cap year by the adjusted per-beneficiary statutory cap. 42 U.S.C. § 1395(f)(i)(2)(A-C). The statutory Cap for the 2014 cap year is $26,725.79. 79 Fed. Reg. 50451, 50485 (Aug. 22, 2014).

were in exactly the same manner as before sequestration.[54] The dispute then centers on how the aggregate caps are applied to and interface with the Hospices' interim payments under the hospice prospective payment system and sequestration.

The Hospices assert that the TDL violates the Medicare statute and regulations by adding the sequestered funds to the net reimbursement for the 2014 cap year[55] because 42 C.F.R. § 418.308 states "the total Medicare payment to a hospice . . . is limited by the hospice cap amount" and "total Medicare payment" cannot include the sequestered funds because the sequestered funds were never paid.[56] The Board disagrees because it finds nothing in the Medicare statutory or regulatory provisions governing hospice payment that identifies a hospice's "total Medicare payment" as the *net* reimbursement to the hospice.[57] Rather, the Board finds these provisions establish payment *rates* for the various hospice services, direct how these payment *rates* will be updated,[58] and require payment be made to the hospice for each day during which a beneficiary is eligible and under the care of the hospice.[59] Contrary to the Hospices' assertion, it is a hospice's gross payment that reflects these established rates, not the hospice's net reimbursement.

The Hospices believe that the TDL direction to the Medicare Contractor to use the full payment amount rather than the net reimbursement results in the Hospices having to repay amounts they never received in the first instance.[60] The Board reviewed the Medicare Contractor's calculation and disagrees that the Hospices have to pay back amount they never received as explained below.

At the outset, how the hospice cap interacts with sequestration is key. In this regard, the Board rejects the Hospices' assertion that the hospice cap is not an integral part of determining "the [Medicare] amount paid"[61] to hospices to which sequestration must be applied. Rather, as explained below, the Board finds that, for hospices that exceed their aggregate cap (and all the Hospices in these cases exceeded their aggregate cap), their aggregate cap then becomes the Medicare allowable payment for the 2014 cap year and, therefore, sequestration must be applied to the resulting Medicare allowable payment.

Through the operation of 42 U.S.C. § 1395f(i)(1)(A) and the hospice regulations at 42 C.F.R. Part 418, Subpart G, hospices are reimbursed for "costs" over a 12 month period (*i.e.*, the cap year) subject to a cap or cost ceiling where the hospice prospective payment system serves as a proxy for those "costs." In this regard, 42 U.S.C. § 1395f(i)(1)(A) specifies that "[s]ubject to the limitation under paragraph (2) [*i.e.*, the hospice cap] . . ., the amount paid to a hospice . . . shall

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[54] The aggregate cap is identified in Line 3 - Allowable Medicare payments in the section Cap on overall Medicare payment. *See* Exhibits P-7, 9 & 11. Further, note that the aggregate cap calculations were reopened to adjust the number of beneficiaries but this adjustment was not related to sequestration. *See* Exhibits P-8, 10 & 12.
[55] *See* Silverado Group's Final Position Paper at 10 (citing 42 U.S.C. §1395f(i)(2)(A); 42 C.F.R. § 418.308(a)).
[56] *Id.* at 7-9.
[57] Net reimbursement refers to the interim payment amount following sequestration. In the Hospices' terms it is the "cash" actually received during the cap year.
[58] 42 U.S.C. § 1395f(i)(1)(B); 42 C.F.R. § 418.302(c).
[59] 42 C.F.R. § 418.302(e)(1).
[60] Silverado Group's Final Position Paper at 11.
[61] 42 U.S.C. § 1395f(i)(1)(A).

be an amount equal to the ***costs*** *which* are reasonable and related to the cost of providing hospice care ***or*** *which* are based on such other tests of reasonableness as the Secretary may prescribe in regulations[.]"[62] Essentially, this statutory provision specifies that, *for each hospice cap year*, hospices are to receive "an amount equal to" either their reasonable costs or the "***costs*** . . . which are based on such other test of reasonableness" "subject to the [hospice cap] limitation." As previously discussed, the Secretary opted to exercise her discretion under § 1395f(i)(1)(A) to establish an "other test of reasonableness" for determining "costs" – the hospice prospective payment system. Accordingly, for each hospice cap year, the "amount paid to a hospice . . . shall be equal to . . . ***costs*** . . . which are based on such other test of reasonableness [*i.e.*, the hospice prospective payment system]" "subject to the [hospice cap] limitation." More simply, a hospice's reimbursable "costs" for a cap year are "based on" the hospice prospective payment system as a proxy for those "costs" "subject to" the hospice cap on those "costs" (*i.e.*, cost ceiling).[63] Accordingly, the Board concludes that the "amount paid" or the "amount of payment" to a hospice must be viewed on a cap year basis and it is to that amount which sequestration applies. Similarly, the Board finds that payments made to hospices during a cap year are effectively *interim* payments for "costs" that must be accounted and reconciled at cap-year-end with the aggregate cap amount (*i.e.*, the hospice's cost ceiling) which is the maximum Medicare allowable payment that can be made for the cap year. Thus, following that process, the Medicare program issues a "determination of program reimbursement letter"[64] to, in essence, confirm the total Medicare allowable amount for the hospice's "costs" for that cap year.

The fact that the payments made during the year are *interim* is further reinforced by the fact that payments made during the year are subject to not just the aggregate cap but also a cap related to inpatient care. As previously discussed, *for each cap year* for a hospice, "the aggregate number of inpatient days for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate number of days of hospice care provided to all Medicare beneficiaries in that hospice during the same period."[65]

The concept that Medicare payments to hospices must be viewed on a cap-year basis is reinforced by the facts that: (1) for every cap year, the Medicare program sends each hospice a "determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations" for that cap year;[66] (2) if the hospice is dissatisfied with that final determination for the cap year, it may file an appeal with the Board.[67] Finally, the Board notes that the Medicare statutes establish a similar reimbursement structure for hospitals exempt from the inpatient prospective payment system ("IPPS") where reimbursement is viewed on a fiscal

[62] (Emphasis added).
[63] This conclusion is consistent with the *supra* discussion on the legislative history for the hospice benefit.
[64] 42 C.F.R. § 405.1803(a)(3), (c).
[65] Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 9, § 90.1 (as revised May 8, 2015) (copy included at Exhibit P-16). *See also* 42 C.F.R. § 418.302(f).
[66] *See* 42 C.F.R. § 405.1803(a)(3).
[67] *See id. See also* 42 C.F.R. § 405.1811(a).

year basis with a cost ceiling,[68] and these IPPS-exempt hospitals are subject to sequestration in a manner similar to hospices.[69]

This case then becomes a matter of how CMS executed and accounted for sequestration when it applied sequestration to the Hospices' Medicare "amount paid" for the 2014 cap year under operation of 42 U.S.C. § 1395f(a)(1)(A). The simplest way to analyze sequestration is to apply it to a *full* cap year and to wait to apply it *until the cap year has ended*. In this situation, the 2 percent sequestration would be applied to the resulting "amount paid" *after* the hospice aggregate cap itself has been applied. More specifically, if the hospice were under its aggregate cap, then the 2 percent would be applied to all the interim hospice payments received for that cap year's "costs." However, if that same hospice exceeded its aggregate cap, then the full amount in excess of its aggregate cap would be an overpayment and the resulting "amount paid" for "costs" for the cap year would be its aggregate cap amount (*i.e.*, the cost ceiling for that hospice). This resulting "amount paid" for "costs" for the cap year (*i.e.*, the aggregate cap *amount*) would then be subject to sequestration of 2 percent. The following Table 1 illustrates how sequestration would work if applied to a *full* cap year for 3 hypothetical hospices *following the end of that cap year* where they each have an aggregate cap of $200,000[70] for the cap year but: (1) the total payments for the hypothetical hospice 1 ("HH1") during the cap year is under the aggregate cap by $20,000; (2) the total payments for hypothetical hospice 2 ("HH2") for the cap year exceeds its aggregate cap by $50,000; and (3) the total payments for the hypothetical hospice 3 ("HH3") for the cap year grossly exceeds the aggregate cap by $250,000:

[68] The hospice cap functions in the same way as the ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital (also known as the "TEFRA target amount") functions for IPPS exempt hospitals (*i.e.*, hospitals that are paid based on reasonable cost basis). *See* TEFRA, § 101, 96 Stat. at 332 (codified at 42 U.S.C. §1395ww(b)). Indeed, Congress enacted both the hospice cap and the TEFRA target amount in the same legislation. *Compare* TEFRA § 122 (establishing hospice cap), *with* TEFRA § 101 (establishing TEFRA target amount for hospitals). The TEFRA target amount for certain IPPS-exempt hospitals functions as a reimbursement cap and is set using a base year adjusted for inflation. Unless an exception or an exemption applies, the Medicare program will reimburse the IPPS-exempt hospital its reasonable costs for a fiscal year up to the TEFRA target amount for that fiscal year.

[69] CMS has imposed sequestration on hospitals subject to the TEFRA target amount in a similar fashion to hospices. *See* PRM 15-2, Ch. 40, Transmittal 4 (Sept. 2013) (instructions for Form CMS-2552-10) (*available at*: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R4P240.pdf).

[70] As there is no dispute as to how the aggregate cap itself was calculated for the Hospices, *see* Silverado Group's Final Position Papers at n.1, the Board examples use a flat aggregate cap in order to focus on the elements of the calculation that are in dispute.

	TABLE 1	HH1 (< aggregate cap)	HH2 (> aggregate cap)	HH3 (>> aggregate cap)
A	Aggregate cap for the cap year	$200,000	$200,000	$200,000
B	Total payments received for hospice care during the cap year *with no sequestration applied*.	$180,000	$250,000	$450,000
C	Payments in excess of aggregate cap (Amount Line B exceeds Line A)	$ 0	$ 50,000	$250,000
D	Amount to be recouped as an overpayment by operation of the aggregate cap alone. (Line C)	$ 0	$ 50,000	$250,000
E	Resulting "amount paid" for the cap year per 42 U.S.C. § 1395f(i). (Line B – Line D)	$180,000	$200,000	$200,000
F	Amount to be deducted by sequestration. (2 percent of Line E)	$ 3,600	$ 4,000	$ 4,000
G	Net amount paid for the cap year after application of the aggregate cap and sequestration. (Line B – Line D – Line F)	$176,400	$196,000	$196,000

Table 1 represents an ideal world in which the full cap year is subject to sequestration and sequestration is applied to hospice reimbursement *after* the cap year ends when the end-of-cap-year reconciliation and accounting occurs. It is the purest way to see how the cap is applied separately from sequestration.

Not surprisingly, CMS does not want to knowingly overpay providers, so it does not wait until the close of the cap year to apply sequestration to the Medicare allowable amount determined as part of the cap-year-end reconciliation and accounting process for the cap year. Rather, CMS applies sequestration up front throughout the cap year to any hospice payments made prior to the cap-year end. This up-front application of sequestration is practical given that most hospices will not exceed their aggregate cap (similar to HH1 in Table 2 below) and, thus, have no overpayment at the cap-year end.[71] Indeed, if CMS did not apply sequestration up front but rather waited until the cap-year-end reconciliation and accounting process as outlined in Table 1, then CMS would be assessing and collecting overpayments on ***all*** Medicare-participating hospices which would not be administratively practical. The hospices in Table 1 would be assessed an overpayment that equals the sum of Line D and Line F.

[71] This assumes that these hospices did not exceed the inpatient care cap or have any other adjustments.

As a result of its choice to apply sequestration up front, CMS has to go through a more complex end-of-cap-year reconciliation and accounting process than the simplified approach laid out in Table 1. More specifically, because CMS applied sequestration to the interim payment rather than waiting until the final Medicare allowable amount is determined, CMS had to develop a cap-year end reconciliation and accounting process that simulated the proper process reflected in Table 1. Contrary to the Hospices' allegations, the Board finds that this process does *not* "double dip" from any hospices. In particular, the TDL's methodology reverses and adds back any sequestration amounts already deducted during the year (*i.e.*, to restate payment to total "pre-sequester" payments) to ensure that the aggregate cap is applied separately from sequestration to prevent sequestration from affecting or interfering with or otherwise altering application of the aggregate cap in the first instance. The Medicare program then effectively reapplies sequestration after the aggregate cap has been applied so that both the overpayment amount and the amount of Medicare payment are properly stated. This does not run afoul of the Medicare statutory provisions in 42 U.S.C. §§ 1395f(i)(1)(A) governing overall hospice payment and 1395f(i)(2)(A) governing the hospice cap. As noted in the Medicare Benefit Policy Manual, CMS Pub 100-02, Ch. 9, § 90.2.1 (as revised May 8, 2015), the hospice cap applies to "[t]otal actual Medicare payments for services . . . regardless of when payment is actually made."[72] The fact that payment is made on paper (*i.e.*, reverse sequestration to pre-sequester amounts) and then, in the same process, is taken away as an overpayment as part of the end-of-cap year reconciliation and accounting process does not in any way alter its validity. This is illustrated by comparing Table 1 above, to Table 2 below.

Table 2 illustrates how the TDL would apply to sequestration for a *full* cap year (*i.e.*, how the TDL would apply sequestration to all 12 months of the 2014 cap year) using the same cap-year-end reconciliation and the same three hypothetical hospices as in Table 1. Rather than applying sequestration following the cap year end as done in Table 1, Table 2 illustrates how sequestration was applied to the hospices' payments as they were issued throughout the 2014 cap year and how applying the TDL results in the same end points as Table 1 (it does so by reverse engineering the process). HH1 represents the majority of hospices which will not exceed their aggregate cap and, as a result, their interim payments made during the year represent in the aggregate their final payment amount for the cap year with sequestration already applied. HH2 and HH3 represent the situations where sequestration had to be reversed and reapplied because the hospice exceeded its aggregate cap.

[72] Exhibit P-16 at 7.

	TABLE 2	HH1 (< aggregate cap)	HH2 (> aggregate cap)	HH3 (>> aggregate cap)
A	Aggregate cap for the cap year	$200,000	$200,000	$200,000
B	Sequestration amount reported on PS&R for cap year. (Line D x .02)	$ 3,600	$ 5,000	$ 9,000
C	Net reimbursement received per PS&R for cap year. (Line D-Line B)	$176,400	$245,000	$441,000
D	Gross pre-sequester payments where sequestration is reversed. (Line B + Line C)	$180,000	$250,000	$450,000
E	Pre-sequester overpayment. (Amount Line D exceeds Line A)	$ 0	$ 50,000	$250,000
F	Pre-sequester overpayment reduced by 2 percent. (Line E – (Line E x 0.02))). NOTE—This result is the net overpayment that should be assessed. The sequestration is credited and backed out of the overpayment since CMS need not pay it out and then collect it back as an overpayment.	$ 0	$ 49,000	$245,000
G	Net amount paid for the cap year after recoupment of net overpayment. (Line C – Line F)	$176,400	$196,000	$196,000

As Table 2 illustrates, for hospices that do not exceed their aggregate cap (similar to HH1), there is no overpayment as sequestration was withheld during the cap year. For hospices that exceed their aggregate cap (similar to HH2 and HH3), the overpayment amount to be refunded on Table 2 (Line F) will be smaller than the overpayment amount had their interim payments not been sequestered throughout the cap year as represented in Table 1. Specifically, a comparison of the overpayment amount in Table 1 to Table 2 confirms that:

1. Hospices receive the ***same*** net reimbursement regardless of whether interim payments were sequestered throughout the cap year (confirmed by comparing Line G in both tables).

2. The overpayment amount to be refunded is less if interim payments are sequestered throughout the cap year (confirmed by comparing the sum of Lines D and F in Table 1 to Line F in Table 2).

The easiest way to grasp how the TDL applies is to think about the applicable cap year for a hospice as a jar with a line marked on it to represent that hospice's aggregate cap for that cap year (*i.e*, any additional payment added to the jar above that line for the hospice would be an overpayment for that hospice). The TDL instructions approach the hospice's jar from the cap-year end (*i.e*, after the jar is already filled with all of the hospice payments for that hospice for the cap year).

However, if one first thinks about the jar from the front end, *as it is being filled*, it is easier to understand the sequestration applied for a particular cap year. In order to view the jar as it is being filled for a hospice, one first has to assume for the sake of illustration that CMS could know in advance what an individual hospice's aggregate cap was when the applicable cap year began and that there is a line on the jar for this aggregate cap. As payments are made to the hospice during the course of the cap year, CMS places equivalent green chips into the jar for what is paid out on an interim basis to the provider (*i.e.*, the net amount) and, for any amount sequestered, it puts the equivalent red chips into the jar. CMS needs to put red chips representing the sequestered amounts because it is the ***full*** payment rate (*i.e.*, pre-sequester rate) that is the proxy *for the hospice's costs* for that service and it is the hospice's aggregate *costs* for the year that are capped at the hospice's aggregate cap (*i.e.*, the maximum Medicare allowable amount). Once the green and red chips hit the hospice cap line, then the Medicare program would make no more payments regardless of how many additional services the hospice furnishes the remainder of the cap year. The red chips below the line would represent the amount appropriately sequestered for the cap year.

Keeping with the jar analogy for the 2014 cap year, we know that CMS cannot know in advance what the aggregate cap is for a hospice until after the cap-year end ***or****, for that matter, cannot know in advance whether a hospice will actually exceed its aggregate cap for the cap year*. Accordingly, the methodology laid out in the TDL reverse engineers this process by starting with a filled jar consisting of all the green and red chips from payments made *in sequence* for the entire 2014 cap year. CMS must calculate the aggregate cap and mark the jar with a line for the aggregate cap for 2014 after the jar is already filled.

If the jar is filled *in sequence*, then the excess green and red chips above the aggregate cap line, would represent the gross overpayment amount. The excess green chips themselves represent the overpayment amount that should be assessed, while the excess red chips are credited as amounts previously sequestered and are not part of the overpayment.[73] Similarly, the green chips below the aggregate cap line represent the hospices' net reimbursement and the red chips below the aggregate line, represent that amount that has been properly sequestered during the course of the cap year.[74]

[73] CMS makes the credit for the previously sequestered amounts that it had just reversed on paper (*i.e.*, converted to pre-sequestered amounts) because CMS would not pay out this amount only to then turn around and collect it as an overpayment. That is why it handled administratively on paper.

[74] Again, CMS makes the credit for the previously sequestered amount that it had just reversed on paper *(i.e.*, converted to pre-sequestered amount) because CMS would not pay out this amount only to then turn around and collect again as a sequestered amount. That is why it is handled administratively on paper.

The Board agrees that the Medicare Statute establishes precise rules for determining all aspects of a hospice's aggregate cap. However, the Board points out that, as the above Tables illustrate, neither the sequestration order nor the CMS TDL altered *any* aspect of the calculation of the aggregate cap. Rather, CMS implemented sequestration in a manner to ensure that no aspect of those cap calculations was altered by sequestration and that sequestration is effectively applied after the aggregate cap.

The Hospices point out that CMS has handled overpayments identified from audits by Zone Program Integrity Contractors ("ZPICs") differently because the ZPICs offset any ZPIC debts by the full aggregate hospice cap overpayment amount to ensure there was no over collection.[75] In other words, if a hospice exceeded its aggregate cap and the resulting overpayment was collected prior to a ZPIC audit, the ZPICs give credit for the cap overpayment collection and will assume that any ZPIC debts resulting from that audit up to the amount of the cap overpayment have already been collected. The Board understands that this full reduction or credit was necessary because ZPIC audits deny entire services and sometimes all the services *for a particular beneficiary*.[76] Moreover, there is no evidence in the record to suggest that the ZPIC process did not account for sequestration when crediting the cap overpayment amount to ZPIC debts to ensure it was applying apples to apples (*e.g.*, ZPIC debts based on net payments offset by net cap overpayment amount).

Unlike the ZPIC audits, sequestration did not deny or eliminate any service. Rather sequestration *reduced* the payment for all services in the sequestration period *by 2 percent*. This reduction was applied up front to amounts paid for services that were part of the overpayment amount as well as to amounts paid for services as part of the cap (and are not part of the overpayment). Similar to the ZPIC methodology, CMS instructed the Medicare Contractor to reduce the Hospices' aggregate cap overpayments for sequestration withheld, but limited that reduction to 2 percent of the overpayment amount (up to the total sequestration withheld). It would be inappropriate to reduce the overpayment amount by more than 2 percent as any amount sequestered that is over 2 percent of the overpayment clearly does not apply to the overpayment as previously discussed.

All of the Hospices in this appeal exceed their aggregate cap for the 2014 cap year and, but for sequestration, the total amount of Medicare payment for their "costs" under 42 U.S.C. § 1395f(i)(1)(A) would have been simply their 2014 aggregate cap (*i.e.*, cost ceiling). While the Hospices would like the Medicare Contractor to reduce their debts by the full sequestered amount, the Board disagrees because sequestration applies to the amount paid as determined by the 2014 cap-year-end reconciliation and accounting process. If the Medicare Contractor reduced the Hospices' debts by the full sequestered amount (such that it would be considered a payment), then each of the Hospices' final Medicare payment for their "costs" would simply be their full 2014 aggregate cap and no portion of that payment would have been sequestered. This outcome clearly would violate the President's sequestration order.

In summary, although the Hospices in these appeals would like to be paid their entire aggregate cap amounts despite the sequestration order, the Board finds that the sequestration order requires

[75] *See* Exhibit P-24.
[76] *See* Exhibit P-26 (denying services).

that all Medicare payments, without exception, be reduced. Therefore, the Board concludes that the Hospices must have their final Medicare payments sequestered, even though those payments were determined based on the aggregate cap.

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds the Medicare Contractor properly applied sequestration to the Hospices' aggregate cap payments and calculated the Hospices' aggregate cap overpayments correctly.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A, CPC-A
Robert A. Evarts, Esq.

FOR THE BOARD:

3/27/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Model Form G: Final Schedule of Providers in Group (Summary Page)

Group Name Representative: Silverado 2014 Hospice Cap Sequestration CIRP Group
Brian M. Daucher
Sheppard Mullin Richter & Hampton LLP (bdaucher@smrh.com)

Page 1 of 1

Date: June 30, 2016

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Case No. 16-1235GC

Issue _Validity of Hospice Cap Repayment Demand Regulation

Lead Intermediary: National Government Services

#	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days[1]	D Audit Adj. No.	E Amount in Controversy	F Original Case No.	G Date(s) of Add/ Transfer
1.	55-1534	Silverado Hospice – Los Angeles Los Angeles – Los Angeles - CA	2014	NGS	12/30/15	3/16/16	77	NA	$ 118,320.79	NA	3/16/16
2.	05-1786	Silverado Hospice – Ventura Ventura – Ventura - CA	2014	NGS	12/30/15	3/16/16	77	NA	$ 36,730.85	NA	3/16/16
3.	05-1771	Silverado Hospice – Orange County Irvine – Orange - CA	2014	NGS	12/30/15	3/16/16	77	NA	$ 131,209.98	NA	3/16/16
								TOTAL:	**$286,261.62**		

[1] Must be within 185 days, inclusive of 5 day extension for receipt.