PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D26

PROVIDER–
Novus Health Services

HEARING DATE –
April 27, 2017

Provider No.: 67-1710

Cost Reporting Period Ended –
October 31, 2013

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services

CASE NO. – 16-0140

INDEX

ISSUE STATEMENTS

Issue 1
Whether the sequestration amount should be included when calculating the aggregate payment made to Novus Health Services ("Novus" or "Provider") as the reduction in payment through sequestration does not constitute actual Medicare payments made to Novus.[1]

Issue 2
Whether Palmetto GBA c/o National Government Services' ("Medicare Contractor"[2] or "NGS") reopening(s) is/are invalid, as the Medicare Contractor failed to comply with applicable Medicare statutes, regulations, and guidelines when doing so.[3]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that: (1) the Medicare Contractor properly reopened the determination at issue pursuant to 42 C.F.R. § 405.1887(a); and (2) the Medicare Contractor properly applied sequestration to the Provider's aggregate cap payments and calculated the Provider's aggregate cap overpayment correctly.

INTRODUCTION

The Provider is a hospice located in Mesquite, Texas and it appealed two issues to the Board for the cap year ending October 31, 2013. First, the Provider appealed a substantive issue related to whether the sequestration amount should be included in the hospice's payments when determining if the hospice has been paid in excess of its aggregate cap.[4] Second, the Provider appealed a procedural issue claiming the Medicare Contractor failed follow applicable Medicare statutes, regulations, and guidelines when reopening the final cap determination, making the revised determination "void and invalid."[5]

The Provider timely appealed the issues and met the jurisdictional requirements for a hearing. Accordingly, the Board held a telephonic hearing on April 27, 2017. The Provider was represented by Bradley J. Sayles, Esq. of Nelson Mullins Riley & Scarborough LLP. The Medicare Contractor was represented by Bernard Talbert, Esq. of Federal Specialized Services.

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[1] Transcript ("Tr.") at 6.
[2] 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.
[3] Tr. at 7.
[4] Provider's Final Position Paper at 5.
[5] *Id.* at 7.

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 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

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[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").

[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. 56008, 56019 (Dec. 16, 1983).

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

[11] *See* 48 Fed. Reg. at 56008.

Medicare beneficiaries, consisting of 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 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

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[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).
[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).

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 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

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[24] Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 9, § 90.1 (as revised May 8, 2015). *See also* 42 C.F.R. § 418.302(f).
[25] *See* 42 C.F.R. § 405.1803(a)(3) (emphasis added).
[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 at Board Exhibit B6).
[32] A copy of this order was published at 78 Fed. Reg. 14633 (Mar. 6, 2013) (copy at Board Exhibit B5).
[33] *See* 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.") (*available at*: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2013-03-08-standalone.html?DLPage=1&DLEntries=10&DLFilter=2013-03&DLSort=0&DLSortDir=descending); 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

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
>
> - 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.

Significantly, only a portion of the 2013 cap year was subject to sequestration. As sequestration began on April 1, 2013 and the 2013 cap year ran from November 1, 2012 through October 31, 2013, sequestration only impacted the last 7 months of the 2013 cap year (*i.e.*, April 1, 2013 through October 31, 2013).[35] This case focuses on the 2013 cap-year-end reconciliation and accounting process and how CMS accounted for the sequestered payments made during the course of the 2013 cap year in relation to applying the aggregate cap for the Provider.

C. THE PROVIDER'S AGGREGATE CAP CALCULATION FOR CAP YEAR 2013

On July 1, 2014, the Medicare Contractor issued a Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount ("Final Determination") for Provider's 2013 cap year, which calculated an overpayment of $306,809.[36] On May 7, 2015, the Medicare Contractor reopened this Final Determination to "revise the hospice cap determination to reflect the sequestration amount," and also issued a Revised Notice of Review of Hospice Cap Amount ("Revised Final Determination"), which resulted in additional overpayment being assessed in the amount of

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Sequestration.") (*available at*: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2739cp.pdf).

[34] Exhibit I-8 (copy of TDL-150240) (emphasis added).

[35] *See id.* at 2.

[36] Exhibit P-5.

$804,343.[37] The Provider appealed this Revised Final Determination,[38] and while that appeal was pending, the Medicare Contractor again reopened the Revised Final Determination, assessing an additional overpayment of $115,543.[39]

The Provider has not raised any dispute about the accuracy of the Medicare Beneficiary Count or the adjusted statutory per-beneficiary cap amount.[40] Rather, the Provider asserts that CMS improperly altered the hospice cap calculation by instructing its contractors to include certain funds that were sequestered but never paid to the Provider in the amount of payment made to the Provider.[41] The Provider believes that CMS was required to use the net reimbursement (actual amount received by the hospice) in determining how much it exceeded its aggregate cap.[42] The Provider also believes that the Notice of Reopening was deficient and invalid because it was issued simultaneously with the Revised Final Determination, and did not allow them a "reasonable period of time [to] present any additional evidence or argument in support of their positions" as set forth in 42 C.F.R. § 405.1887(b).[43]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Issue 1 addresses the merits of the case. However, before addressing Issue 1, the Board first addresses Issue 2 because, if the Board were to decide in the Provider's favor on this issue, then the Board would not need to reach Issue 1.

A. ISSUE 2 CONCERNING THE REOPENING OF THE PROVIDER'S HOSPICE CAP DETERMINATION

The Provider contends that the Medicare Contractor improperly reopened its hospice cap determination on two separate occasions because the Medicare Contractor failed to comply with applicable Medicare statutes, regulations, and guidelines when doing so. In particular, the Provider claims that issuing the written notice of a reopening simultaneously with the revised final determination did not give it the "reasonable period of time [to] present any additional evidence or argument in support of their positions" that is permitted under 42 C.F.R. § 405.1887(b).[44] As explained below, the Board disagrees.

The two reopenings referenced by the Provider in its final position paper were the notice of reopening and revised hospice cap determinations simultaneously issued on May 7, 2015 and the notice of reopening and revised hospice cap determination issued simultaneously on January 5,

[37] Exhibits P-3, P-4.
[38] Provider's Final Position Paper at 2.
[39] *Id.*; Exhibits P-1, P-2. The final overpayment totaled $1,226,686, compared to the original $306,809, though the increases were not solely due to sequestration adjustments.
[40] Stipulations (Apr. 25, 2017) ("the parties do not dispute the . . . amounts and calculations used in determining the cap amount, patients, or amounts paid to the provider."); *see also* Tr. at 23.
[41] Tr. at 16-19; *see also* Provider's Final Position Paper at 4-5.
[42] Tr. at 16-19; Provider's Post-Hearing Brief at 3.
[43] Provider's Final Position Paper at 6.
[44] *Id.*

2016.[45] However, the Provider only appealed the May 7, 2015 determination to the Board. As a result, the Board will only review the validity of the May 7, 2015 reopening.

Pursuant to 42 C.F.R. § 405.1885(b)(1), a Medicare Contractor has the authority to reopen a cost report within three years of its issuance.[46] When reopening under § 405.1885, a Medicare contractor must, pursuant to 42 C.F.R. § 405.1887(a), provide a written notice to all parties to the determination. "Upon receipt of the notice," § 405.1887(b) requires that the parties to the determination "must be allowed a reasonable period of time in which to present any additional evidence or argument in support of their positions." During its last revision of § 405.1887, CMS clarified in the Federal Register that an "intermediary or reviewing entity is obliged to provide written notice of the reopening, *allow the parties an opportunity to present additional evidence*, and notify the parties at the conclusion of the reopening of the results, including any revisions."[47] Significantly, the regulations do not require the notice of reopening to include notice of an opportunity to present additional evidence.[48] In this regard, the opportunity to present evidence and argument appears to be related to the provider's due process rights for the proceedings that follow that reopening and do not relate to the validity of the reopening itself.

Federal case law supports the Board's finding. In *Maine Medical Center v. Burwell* ("*Maine Medical*"), the First Circuit Court of Appeals found that 42 C.F.R. § 405.1887 "itself does not require that a notice of reopening include advice about the opportunity to present evidence and arguments. The regulation controls: as we said in an earlier case discussing the PRM, the PRM is nothing more than an interpretive guide . . . ."[49] Further, the Board relies on the *Maine Medical* decision and notes that this decision occurred subsequent to all of the Board decisions cited by the Provider.

Accordingly, consistent with *Maine Medical*, the Board first reviewed whether the reopening itself was proper. Pursuant to 42 C.F.R. § 405.1885(b)(1), a Medicare Contractor has the authority to reopen a cost report within three years of its issuance. Further, 42 C.F.R. § 405.1885(c)(1) specifies that the "CMS may direct a [Medicare] contractor . . . to reopen and revise any matter . . . by providing explicit direction to the contractor . . . to reopen and revise" as long as the reopening is not prohibited and within the three-year period for reopening. The reopening at issue was within the three-year period and essentially was initiated to effectuate the directive from the President to sequester Medicare payments as suggested by the following issue statement included in the notice of reopening:

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[45] Exhibits P-1, P-2, P-3, P-4.
[46] A Cost Report may also be reopened if CMS provides explicit notice to the Medicare Contractor to do so. 42 C.F.R. § 405.1885(c)(1).
[47] 73 Fed. Reg. 30189, 30230 (May 23, 2008) (emphasis added).
[48] The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2932(A) states that if a provider's final determination is reopened, the notice of reopening will advise them of the "opportunity to comment, object, or submit evidence in rebuttal." However, the PRM 15-1 is not binding and does not affect the Board's conclusion that the opportunity to comment, object or submit additional evidence is a due process right flowing after the reopening and does not impact the reopening itself.
[49] 841 F.3d 10, 18 (1st Cir. 2016).

> To revise the hospice cap determination to reflect the sequestration amount. The sequestration amount reported on the Provider Statistical and Reimbursement (PS&R) report has been added to the net reimbursement amount reported on the PS&R. The resulting amount was compared to the hospice's aggregate cap amount to calculate a pre-sequester overpayment. The pre-sequester overpayment was 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.)[50]

This issue statement put the Provider on notice as to the nature of the reopening. Further, the issue statement does not fall within a "prohibited reopening" which is defined in § 405.1885(c)(2) to include "[a] change of legal interpretation or policy by CMS in a regulation, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS, whether made in response to judicial precedent or otherwise." There is no evidence that there is a change in CMS legal interpretation or policy and, in particular, the March 3, 2015 TDL appears to be a statement to ensure both the correct *and* consistent application of the March 1, 2013 sequestration order to Medicare payments. Based on the above, the Board concludes the reopening at issue was proper. Indeed, at the hearing, the Provider appeared to only dispute whether the notice of reopening needed to give the Provider an opportunity submit evidence and argument and appeared to concede that the notice of reopening was *otherwise* proper and did not *otherwise* dispute the notice itself.[51]

With regard to the regulatory requirement that the provider be allowed the opportunity to present additional evidence and argument, the Board finds there is no evidence to suggest that the Provider has been prejudiced. In this regard, it is important to first recognize that CMS directed the Medicare Contractor to reopen the Provider's original hospice cap determination along with all other hospices and "send a listserv to [hospice] providers explaining the sequestration impact on the hospice cap calculation and may post information regarding this issue on its website."[52] Accordingly, the Provider should have been aware that the reopening at issue was going to occur and could have contacted the Medicare Contractor in advance of that reopening.

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[50] Exhibit P-3.

[51] *See generally* Tr. at 49-54. During the hearing, the Board recognized that the notice of reopening and notice of revised determination were issued separately but concurrently and asked the Provider whether they were disputing the notice of reopening itself. *Id.* at 49. In response, the Provider stated that "We do dispute the notice itself. I understand the distinction you're making, but I don't think you can segregate the two. The process is what the requirement is supposed to be, and the notice becomes deficient when it does not follow that process. It does not matter whether the Provider itself suffered any actual harm from it, what matters is in reopening the claims, this is the process that happened. And when you issue notice not in compliance with that process, it is deficient, it's invalid and void." *Id.* at 50. Upon further questioning by the Board and whether the content of the notice of reopening met the regulatory requirements, the Provider stated that "Other than in not providing the opportunity to respond, which is part of the content, because we were not given that opportunity, and it is not included in there because they knew as in sending this they did not have to include that opportunity to respond because it was already . . . moot at that point. So the content does not contain that, and it is a requirement of the content. So yes, it is deficient in that regard, but *otherwise, we do not dispute the content,* if that makes sense." *Id.* at 52-53 (emphasis added).

[52] Exhibit I-8 at 2.

More importantly, there is no evidence that the Provider has been harmed or prejudiced by not having an opportunity to present evidence between the reopening and the issuance of the determination. In particular, the Provider did not argue that it was specifically harmed by the failure to provide an opportunity to submit evidence and argument (*e.g.*, explain what would have actually been accomplished if they were given a chance to reply).[53] Moreover, the Board notes that the merits of this case do not involve any factual dispute. Rather, it is a legal dispute. Further, the Provider has had two different opportunities to present evidence and argument: (1) it had, but opted not to pursue, an opportunity to request that Medicare Contractor reopen the determination at issue "to correct the amount reflected" in the determination; and (2) it has had the opportunity to present any evidence and argument in this case through its appeal to the Board.

Based on the above, the Board concludes that the reopening at issue is valid. The Board further finds that any failure to give the Provider an opportunity to present evidence or argument between the date of the reopening and the date of the revised determination did not prejudice or harm the Provider and, consistent with the decision in *Maine Medical*, did not otherwise invalidate the reopening itself.

B. ISSUE 1 CONCERNING THE APPLICATION OF SEQUESTRATION TO PROVIDER'S PAYMENTS

The Provider contends that, under the Medicare statute, since the Medicare program sequestered hospice payments made during the 2013 cap year, the aggregate cap should simply be measured against the actual net amount of payment received by the hospice provider.[54] Specifically, the Provider points 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)).[55]

The Provider asserts that CMS' methodology in adding the sequestration amount to the "amount of payment made" violates 42 U.S.C. § 1395f(i)(2)(A) and 42 C.F.R. § 418.308 because the sequestration amount was never actually paid to the Provider.[56]

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[53] *See generally* Tr. at 143-148. *See also* Tr. at 146 ("What is really the issue is was it done right, and it wasn't."); Tr. at 147 ("But the question is, was it done right here, and it wasn't."). When the Board inquired as to what demonstrable harm was caused, the Provider Representative did not articulate any specific harm or prejudice, arguing that there is an implied harm in being denied the opportunity to respond because "[i]f there was no harm from [being denied] the procedure, we wouldn't have it." Tr. at 148. *See also* Tr. at 50 ("It does not matter whether the Provider itself suffered any actual harm from it . . . .").

[54] Tr. at 16-19; Provider Post-Hearing Brief at 3.

[55] (Emphasis added.)

[56] Tr. at 16-19; *see also* Provider's Final Position Paper at 4-5.

The Provider points out that the Medicare Statute sets forth precise rules for both the "payment made" and "cap amount" components of the hospice cap.[57] The Provider argues that CMS violated federal statute by adding the sequestration onto the amount actually paid for hospice stays during the 2013 cap year because this sequestration amount was never actually paid.[58] Indeed, they state that the statute and regulations make clear that for the cap, "only the actual Medicare payments made to the provider should be calculated when determining the amounts in excess of the aggregate cap."[59] The Provider asserts that the aggregate cap is an upper limit of potential payment to hospices, and that while individual payments may be reduced by sequestration, the cap remains the same.[60]

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.[61] Specifically, CMS instructed its contractors on how sequestration should be applied to certain Medicare payments including:

1. Claims payments;[62]
2. Cost report payments including those made to IPPS-exempt hospitals;[63]
3. Electronic health record payments;[64] and
4. Hospice payments.[65]

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.

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[57] *See* Tr. at 16-21, 80-82.
[58] *Id.* at 16-19.
[59] Provider's Final Position Paper at 5.
[60] *Id.*; Tr. at 141-142.
[61] *See* 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.") (*available at*: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2013-03-08-standalone.html?DLPage=1&DLEntries=10&DLFilter=2013-03&DLSort=0&DLSortDir=descending).
[62] 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") (*available at*: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2739cp.pdf).
[63] 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).
[64] 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).
[65] Exhibit I-8 (copy of TDL-150240).

With respect to the TDL, it is important to clarify what is in dispute. The Provider's 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 2013 cap year as listed on the Provider's PS&R for the 2013 cap year;
2. The sequestered amounts deducted during the 2013 cap year as listed on the Provider's PS&R for the 2013 cap year;
3. The number of beneficiaries served during the 2013 cap year;
4. The adjusted per-beneficiary statutory cap for the 2013 cap year; and
5. The Provider's aggregate cap for the 2013 as determined by ## 3 and 4.

The Provider does not dispute ## 3 to 5.[66] Therefore, sequestration has no impact on how the aggregate cap for the Provider for the 2013 cap year was calculated as it was in exactly the same manner as before sequestration.[67] The dispute then centers on how the aggregate cap is applied to and interfaces with the Provider's interim payments under the hospice prospective payment system and sequestration.

The Provider asserts that CMS' methodology violates the Medicare statute and regulations by adding the sequestered funds to the net reimbursement for the 2013 cap year 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.[68] 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.[69] Rather, the Board finds these provisions establish payment *rates* for the various hospice services, direct how these payment *rates* will be updated,[70] and require payment be made to the hospice for each day during which a beneficiary is eligible and under the care of the hospice.[71] Contrary to the Provider's assertion, it is a hospice's gross payment that reflects these established rates, not the hospice's net reimbursement.

The Provider believes that the practice of the Medicare Contractor to use the full payment amount rather than the net reimbursement results in it having to repay amounts they never received in the first instance.[72] The Board reviewed the Medicare Contractor's calculation and disagrees that the Provider has to pay back amount they never received as explained below.

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[66] Stipulations (July 18, 2017) ("the parties do not dispute the . . . amounts and calculations used in determining the cap amount, patients, or amounts paid to the provider."); *see also* Tr. at 23.
[67] The aggregate cap is identified in Line 3 – Aggregate Cap Amount / Allowable Medicare payments. *See* Exhibit P-6.
[68] Tr. at 16-19; Provider's Final Position Paper at 3-4.
[69] Net reimbursement refers to the interim payment amount following sequestration.
[70] 42 U.S.C. § 1395f(i)(1)(B); 42 C.F.R. § 418.302(c).
[71] 42 C.F.R. § 418.302(e)(1).
[72] *See, e.g.*, Tr. at 16-19.

At the outset, how the hospice cap interacts with sequestration is key to understanding the issue in this case. In this regard, the Board notes that the hospice cap is an integral part of determining "the [Medicare] amount paid"[73] to hospices to which sequestration must be applied. As explained below, the Board finds that, for hospices that exceed their aggregate cap (the Provider in this case exceeded its aggregate cap), the aggregate cap then becomes the Medicare allowable payment for the 2013 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 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[.]"[74] 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).[75] 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 that amount to 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"[76] 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

[73] 42 U.S.C. § 1395f(i)(1)(A).
[74] (Emphasis added).
[75] This conclusion is consistent with the *supra* discussion on the legislative history for the hospice benefit.
[76] 42 C.F.R. § 405.1803(a)(3), (c).

of the aggregate number of days of hospice care provided to all Medicare beneficiaries in that hospice during the same period."[77]

The concept that Medicare payments to hospices must be viewed on a cap-year basis is also 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;[78] (2) if the hospice is dissatisfied with that final determination for the cap year, it may file an appeal with the Board.[79] 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 year basis with a cost ceiling,[80] and these IPPS-exempt hospitals are subject to sequestration in a manner similar to hospices.[81]

This case then becomes a matter of how CMS executed and accounted for sequestration when it applied sequestration to the Provider's Medicare "amount paid" for the 2013 cap year under operation of 42 U.S.C. § 1395f(a)(1)(A). As sequestration began during the middle of the 2013 cap year, the Board first analyzed a simpler situation, namely how sequestration would work if sequestration were applied to a *full* cap year.

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

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[77] Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 9, § 90.1 (as revised May 8, 2015). *See also* 42 C.F.R. § 418.302(f).

[78] *See* 42 C.F.R. § 405.1803(a)(3).

[79] *See id. See also* 42 C.F.R. § 405.1835(a).

[80] 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.

[81] 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).

aggregate cap of $200,000[82] 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:

	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 interim 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.[83] 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,

[82] As there is no dispute as to how the aggregate cap itself was calculated for the Provider (*See* Stipulations (Apr. 25, 2017); *see also* Tr. at 23), the Board examples use a flat aggregate cap in order to focus on the elements of the calculation that are in dispute.

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

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.

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. 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." 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. Tables 2 to 3 illustrate the basis for this finding.

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) 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 2013 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.

	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).

As the sequestration began on April 1, 2013 near the midpoint of the 2013 cap year, CMS had to refine the TDL to ensure that the reconciliation consistently treated those payments made prior to sequestration as not being subject to sequestration. The only scenario that CMS needed to address (which also appears extremely rare or improbable) is when a hospice's total interim payments for the five months prior to the sequestration alone surpass its aggregate cap for the 2013 cap year. It is ***only*** in this situation when the following caveat in the third bullet of the TDL would apply: "The 2% overpayment reduction cannot be greater than the actual sequestration amount reported on the PS&R report." Applying the caveat for this situation

ensures that the hospice would ***not*** be subject to sequestration for cap year 2013 because the hospice would have already hit the 2013 aggregated cap ***before*** sequestration had begun on April 1, 2013, thereby, obviating the need to apply sequestration. In other words, based on the hospice's aggregate cap for the 2013 cap year, there would have been no additional payments following April 1, 2013 to which sequestration could have been applied for the 2013 cap year and, as a result, the hospice would have its payments simply reduced to the aggregate cap amount as if there were no sequestration.

Table 3 illustrates how the TDL works *for the 2013 cap year* where there is a ***partial*** year of sequestration (*i.e.*, sequestration for 7 months from April 1, 2013 to October 31, 2013). The facts in Table 3 otherwise stay the same except that the PS&R for the hypothetical hospices breaks out the pre-sequester payments, the net reimbursement and sequestration amounts for the 2013 cap year as follows: (1) HH1 has $178,800 in net reimbursement with $1,200 as the associated sequestration amount; (2) HH2 has $247,400 in net reimbursement with $2,600 as the associated sequestration amount; and (3) HH3 has $446,400 in net reimbursement with $3,600 as the associated sequestration amount. Note that HH3 illustrates how the caveat in the third bullet of the TDL would apply where the hospice payments received from the first 5 months of the 2013 cap year alone exceed the aggregate cap.

	TABLE 3	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.	$ 1,200	$ 2,600	$ 3,600
C	Net reimbursement received per PS&R for cap year.	$178,800	$247,400	$446,400
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 unless the 2 percent reduction exceeds Line B, then the reduction is capped at Line B. (Line E – (Line E x 0.02 or line B))). NOTE—This result is the net overpayment that should be assessed. The sequestration is backed out of the overpayment since CMS need not pay it out and then collect it back as an overpayment.	$ 0	$ 49,000	$246,400 (as 2 percent of Line E exceeded Line B, then Line E must be reduced by Line B)
G	Net amount paid for the cap year after recoupment of net overpayment is accounted. (Line C – Line F)	$178,800	$198,400	$200,000

The easiest way to grasp how the TDL applies is to think about the 2013 cap year for a hospice as a jar with a line marked on it to represent that hospice's aggregate cap for the 2013 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 2013 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 2013 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).

The first five months of the 2013 cap year were not subject to sequestration (sequestration did not begin until April 1, 2013). So, if the hospice's payments issued *prior to sequestration* resulted in the green chips hitting the aggregate cap line, then at that point the Medicare program would stop making payments and, as such, there would be no additional payments for the cap year to which sequestration could be applied.[84] As a result, the hospice's total Medicare payment for the 2013 cap year would be the aggregate cap itself regardless of how many additional services the hospice furnishes the remainder of the 2013 cap year (this is HH3 in Table 3). In the alternative, if green chips from the first 5 months did *not* hit the aggregate cap but come close (for example, within exactly $20,000 gross), then all subsequent payments up to $20,000 gross would be subject to sequestration as represented by $19,600 green chips and $400 red chips going into the jar. However, once the $20,000 mark was reached, the Medicare program would make no more payments regardless of how many additional services the hospice furnishes the remainder of the year and $400 would be the amount sequestered for the cap year (this is similar to HH2 in Table 3).

Keeping with the jar analogy for the 2013 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 cap year (and in this illustration it is the 2013 cap year). CMS must calculate the aggregate cap and mark the jar with a line for the aggregate cap for 2013 after the jar is already filled.

[84] Again this appears to be an extremely rare or improbable possibility for which CMS needed to account.

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. Similarly, the green chips below the aggregate cap line represent the hospice's net reimbursement and the red chips below the aggregate line (*i.e.*, to the extent there is not a situation like HH3 from Table 3 where the services from October 2012 through March 2013 alone exceeded the cap), then they would represent that amount that has been properly sequestered during the course of the cap year.[85]

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.

While the Provider in this appeal would like the Medicare Contractor to reduce its debts by the full sequestered amount, the Board disagrees because the sequestration withheld applies not only to the overpayment amount, but to the extent services paid for by the aggregate cap (and not included in the overpayment amount) occurred after April 1, 2013, the sequestration withheld applies to those services also. If the entire sequestration amount withheld was actually credited to the Provider's debts (such that it could be considered a payment) then no portion of the aggregate cap payments would be sequestered which would violate the President's sequestration order.

Finally, although the Provider in this appeal would like to be paid its entire aggregate cap amount despite the sequestration order,[86] the Board finds that the sequestration order requires that all Medicare payments, without exception, be reduced. Therefore, the Board concludes that the Provider must have its 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 that: (1) the Medicare Contractor properly reopened the determination at issue pursuant to 42 C.F.R. § 405.1887(a); and (2) the Medicare Contractor properly applied sequestration to the Provider's aggregate cap payments and calculated the Provider's aggregate cap overpayment correctly.

[85] 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.
[86] *See* Tr. at 113-119, 121-122, 161-165.

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5/20/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
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