

**PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION**

On the Record

2020-D13

PROVIDER–
Good Shepherd Hospice of Mid-America, Inc.

RECORD HEARING DATE –
January 31, 2020

Provider No.: 17-1582

Cost Reporting Period Ending –
December 31, 2013

vs.

MEDICARE CONTRACTOR –
CGS Administrators

Case No. 15-3312

INDEX

	Page No.
Issue Statement	2
Decision.....	2
Introduction.....	2
Statement of Facts	3
Discussion, Findings of Fact, and Conclusions of Law.....	7
Decision and Order	17

ISSUE STATEMENT

Whether the Medicare Contractor's amended hospice cap calculation issued pursuant to the Notice of Reopening properly calculated the Provider's hospice aggregate cap overpayment when it included in "the amount of payment made" certain funds that were sequestered and never paid to the Provider.¹

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly applied sequestration to the Provider's aggregate cap payment and correctly calculated the Provider's aggregate cap overpayment when it reopened the Provider's hospice cap determination for the cap year at issue.

INTRODUCTION

Good Shepherd Hospice of Mid-America, Inc. ("Good Shepherd" or "Provider") is a hospice facility that was certified and approved for Medicare participation as a hospice provider of services effective December 28, 2011.² CGS Administrators (the "Medicare Contractor")³ issued Good Shepherd a hospice cap determination letter on January 8, 2014 which stated the payments made to Provider had not exceeded the statutory cap for the period from December 28, 2011 through October 31, 2013 (the "2013 Cap Year") which was Good Shepard's *first* cap year as a Medicare provider of hospice services.⁴ On July 28, 2015, the Medicare Contractor reopened this hospice cap determination and revised its calculation determining that Good Shepherd was overpaid \$159,494.72.⁵ Good Shepherd disagrees with the revised calculation based on its allegation that the Medicare Contractor included as payment, a portion of the sequestered monies that were never received by the Provider.⁶ As a result, Good Shepherd

¹ Stipulations of Undisputed Facts and Principles of Law, ¶ 12 (Jan. 23, 2020) ("Stipulations").

² *Id.* at ¶ 1.

³ 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.

⁴ Stipulations at ¶ 3. The Board recognizes that: (1) Hospice cap determination are generally calculated on a twelve-month cap year and always end on October 31st (*see* 42 C.F.R. §§ 418.308(c); § 418.309(a); *infra* note 24 and accompanying text); and (2) Good Shepard's 2013 Cap Year began on December 28, 2011 the effective date of Good Shepard participation in the Medicare program as a Medicare provider of hospice services; and (3) Good Shepard's 2013 Cap Year runs for more than 12 months as this cap year runs from December 28, 2011 through October 31, 2013. Rather than having Good Shepard's initial cap year be a period less than 12 months (*i.e.*, from December 28, 2011 through October 31, 2012), Good Shepherd's initial cap year (*i.e.*, the 2013 Cap Year) was extended to run from December 28, 2011 through October 31, 2013. Good Shepherd does not dispute the extended cap year, the number of Medicare beneficiaries, or the calculation of the adjusted statutory per-beneficiary cap amount. As such the Board is addressing the sole issue under appeal which is whether the sequestered funds were handled correctly when the Medicare Contractor reopened Good Shepherd's 2013 Cap determination.

⁵ Stipulations at ¶ 4.

⁶ Provider's Final Position Paper at 2.

believes its 2013 Cap Year overpayment should be reduced to \$143,619.04, a reduction of \$15,875.68.⁷

Good Shepherd timely appealed this issue to the Board and met the jurisdictional requirements for a hearing. The Board granted the parties' request for a record hearing on January 31, 2020. The Provider was represented by Gina Cheatham, Esq. of DeYong & Cheatham, P.A. The Medicare Contractor was represented by Joseph Bauers, 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”).⁸ The hospice benefit is an election that certain terminally-ill Medicare beneficiaries can make “in lieu of” other Medicare benefits. By statute, at 42 U.S.C. § 1395f(i)(1)(A), Congress set the amount of payment for hospice care “based on reasonable costs or such other test of reasonableness as the Secretary shall determine, *subject to a[] . . . limit or cap[.]*”⁹ Congress set this reimbursement or payment cap¹⁰ 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.”¹¹

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,¹² 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

⁷ *Id.* at 6.

⁸ 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”).

⁹ *See also* H.R. Conf. Rep. No. 97-760, at 428 (1982) *reprinted in* 1982 U.S.C.C.A.N. 1190, 1208 (emphasis added). *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”).

¹⁰ 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”).

¹¹ 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).

¹² *See* GAO Rep. GAO/HRD-83-72, at 4-5.

reasonableness.” Specifically, CMS implemented the hospice benefit using a prospective payment system for hospice care as a proxy for costs.¹³ Under this payment methodology, CMS established per-day payment amounts for four categories of hospice care services furnished to Medicare beneficiaries, consisting of routine home care, continuous home care, inpatient respite care, and general inpatient care.¹⁴ Congress has periodically adjusted these payment rates.¹⁵

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.¹⁶ 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.”¹⁷ 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.¹⁸ Specifically, Congress raised the hospice cap to \$6,500 per Medicare beneficiary, subject to an annual inflation adjustment, in order to correct for these errors¹⁹ (which coincidentally occurred between when CMS proposed and finalized the hospice prospective payment system).²⁰

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 given 12-month period is limited by a hospice-specific cap amount that is referred to as the “aggregate cap amount.”²¹ Each hospice’s “aggregate cap amount” for a 12-month period is calculated by multiplying the adjusted statutory per-beneficiary cap amount²² for that period by the number of Medicare beneficiaries served by the hospice during that period.²³ 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.²⁴ Medicare payments

¹³ See 48 Fed. Reg. at 56008.

¹⁴ 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.

¹⁵ 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.

¹⁶ 42 C.F.R. § 418.309(a).

¹⁷ H.R. Conf. Rep. No. 97-760, at 428 (1982).

¹⁸ H.R. Rep. No. 98-333, at 1-2 (1982). See also GAO Rep. GAO/HRD-83-72, at 5-6.

¹⁹ 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].”).

²⁰ See GAO Rep. GAO/HRD-83-72, at 5-6; 48 Fed. Reg. at 56019.

²¹ 42 C.F.R. § 418.308(a).

²² 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).

²³ 42 C.F.R. § 418.309.

²⁴ See, e.g., 42 C.F.R. § 418.3 (2012). The cap period was later changed to October 1 through September 30. See 83 Fed. Reg. 38655, 38634 (Aug. 6, 2018).

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.²⁵

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, “the total inpatient days reported [by a hospice] for both general inpatient care and inpatient respite care may not exceed 20% of the total Medicare days reported by the hospice for a cap year.”²⁶

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 of 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 year²⁷ and, if that calculation identifies an overpayment, the determination provides notice of that overpayment amount.²⁸ If a hospice is dissatisfied with that determination, it may file an appeal with the Board.²⁹

B. SEQUESTRATION

In 2011, Congress adopted the Budget Control Act of 2011, which includes a provision commonly known as “sequestration.”³⁰ 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,³¹ and applies “in the case of [Medicare] parts A and B . . . to individual payments for services. . . .”³²

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.³³ Consistent with this report and associated Presidential Order,³⁴ 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

²⁵ 42 C.F.R. § 418.308(d).

²⁶ Medicare Benefit Policy Manual, CMS Pub. 100-02 (“MBPM”), Ch. 9, § 90.1 (in effect prior to the May 8, 2015 revisions). *See also* 42 C.F.R. § 418.302(f); MBPM, Ch. 9, § 90.1 (in effect after the May 8, 2015 revisions).

²⁷ *See* 42 C.F.R. § 405.1803(a)(3) (emphasis added).

²⁸ *See* 42 C.F.R. § 405.1803(c).

²⁹ *See id.*

³⁰ Pub. L. 112-25, 125 Stat. 240 (2011) (codified at 2 U.S.C. Ch. 20).

³¹ 2 U.S.C. § 901a(6)(A).

³² 2 U.S.C. § 906(d)(1)(A).

³³ 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/fy13ombjsequestrationreport.pdf).

³⁴ A copy of this order was published at 78 Fed. Reg. 14633 (Mar. 6, 2013).

percent.³⁵ 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
- 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.³⁶

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 cap year under appeal was subject to sequestration. As sequestration began on April 1, 2013 and the cap year under appeal ran from December 28, 2011 through October 31, 2013, sequestration only impacted the last seven months of this period (*i.e.*, April 1, 2013 through October 31, 2013). This case focuses on the cap-year-end reconciliation and accounting process and how CMS accounted for the sequestered payments made during the course of the affected portion of cap year in relation to applying the aggregate cap to the Provider’s Medicare payments.

³⁵ 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 Sequestration.”) (*available at*: <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2739cp.pdf>).

³⁶ See Exhibits P-8 & C-4 (emphasis added).

C. THE PROVIDER'S AGGREGATE CAP CALCULATION

The Medicare Contractor issued a single cap determination for the period December 28, 2011 through October 31, 2013 showing no overpayment to the Provider.³⁷ On July 28, 2015, the Medicare Contractor revised that hospice cap determination, recalculating Good Shepherd's cap liability using updated payment and beneficiary count information and using a revised methodology that included sequestered funds in the amount of payments made to the Provider.³⁸ The Provider appealed this revised cap determination because it disagrees with the Medicare Contractor's treatment of sequestered funds.

The Provider does not dispute the extended cap period of December 28, 2011 through October 31, 2013, the accuracy of the Medicare Beneficiary Counts, or the adjusted statutory per-beneficiary cap amount.³⁹ Rather, the Provider asserts that, pursuant to 42 U.S.C. § 1395f(i)(2)(A) and 42 C.F.R. § 418.308, only *payments* made to a hospice can be assessed as a cap overpayment.⁴⁰ Similarly, the Provider argues that the CMS System Manual used to calculate the cap amount references "total *actual* Medicare payments made."⁴¹ Based on the foregoing, the Provider concludes that CMS's methodology outlined in its March 3, 2015 TDL⁴² resulted in the Provider being improperly required to refund a cap overpayment that includes monies never received by the Provider due to Congress' sequestration order.⁴³ Good Shepherd maintains that CMS was required to use the net reimbursement (actual amount received by the hospice) in determining how much it exceeded its aggregate cap.⁴⁴

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

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 applicable cap year, the aggregate cap should simply be measured against the actual net amount of payment received by the hospice provider.⁴⁵ 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

³⁷ Hospice cap determinations are generally calculated on a twelve-month cap period. See 42 C.F.R. §§ 418.308(c), 418.309(a). Good Shepherd's 2013 hospice cap determination covered the period December 28, 2011 through October 31, 2013. See discussion at *supra* note 4; Provider's Final Position Paper at 2; Exhibit C-2.

³⁸ See Exhibits C-2, C-3.

³⁹ See Provider's Final Position Paper at 4 (noting "[t]he sole issue before the Board is whether the hospice cap amount should have been calculated using the actual reimbursements received . . . rather than the reimbursement amount . . . which included a portion of the sequestration amounts not paid to the Provider."). See also Stipulations at ¶ 12; discussion at *supra* note 4.

⁴⁰ Provider's Final Position Paper at 4.

⁴¹ *Id.* at 5.

⁴² Exhibit C-4.

⁴³ Provider's Final Position Paper at 5.

⁴⁴ *Id.* at 6.

⁴⁵ *Id.*

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)).

The Provider asserts that CMS’ methodology that adds 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.

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 properly 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, 2013.⁴⁶ Specifically, CMS instructed its contractors on how sequestration should be applied to certain Medicare payments, including:

1. Claims payments;⁴⁷
2. Cost report payments, including those made to IPPS-exempt hospitals;⁴⁸
3. Electronic health record payments;⁴⁹ and
4. Hospice payments.⁵⁰

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 Provider’s dispute arises from the TDL’s cap-year-end reconciliation and accounting process. As laid out in the TDL, this process involves the following inputs and factors:

1. The net prospective payments received during a cap year as listed on the Provider’s PS&R for that cap year;

⁴⁶ 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>).

⁴⁷ 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>).

⁴⁸ 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>).

⁴⁹ 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).

⁵⁰ Exhibits P-8 & C-4.

2. The sequestered amounts deducted during a cap year as listed on the Provider's PS&R for that cap year;
3. The number of beneficiaries served during the cap year;
4. The adjusted per-beneficiary statutory cap for the cap year; and
5. The Provider's aggregate cap for the cap year as determined by factors 3 and 4.

The Provider does not dispute factors 3 to 5 relating to the calculation of the aggregate cap.⁵¹ Indeed, sequestration has no impact on how the aggregate cap itself was calculated because it was calculated in exactly the same manner as before sequestration.⁵² Rather, the dispute in this appeal 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 Board finds nothing in the Medicare statutory or regulatory provisions governing hospice payments that identifies a hospice's "total Medicare payment" as the *net* reimbursement to the hospice.⁵³ Rather, the Board finds these provisions establish payment *rates* for the various hospice services, direct how these payment *rates* will be updated,⁵⁴ and require payment be made to the hospice for each day during which a beneficiary is eligible and under the care of the hospice.⁵⁵ 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 the Providers having to repay amounts they never received in the first instance.⁵⁶ The Board reviewed the Medicare Contractor's calculation and disagrees that the Provider has to pay back an amount they never received as explained below.

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"⁵⁷ 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 for the 2013 Cap Year), the aggregate cap then becomes the Medicare allowable payment for the applicable 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 twelve 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

⁵¹ See Provider's Final Position Paper at 4 (noting "[t]he sole issue before the Board is whether the hospice cap amount should have been calculated using the actual reimbursements received . . . rather than the reimbursement amount . . . which included a portion of the sequestration amounts not paid to the Provider.").

⁵² The aggregate cap is identified in Line 19 – Cap Amount. See Exhibit P-4.

⁵³ Net reimbursement refers to the interim payment amount following sequestration.

⁵⁴ 42 U.S.C. § 1395f(i)(1)(B); 42 C.F.R. § 418.302(c).

⁵⁵ 42 C.F.R. § 418.302(e)(1).

⁵⁶ Provider's Final Position Paper at 2.

⁵⁷ 42 U.S.C. § 1395f(i)(1)(A).

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[.]”⁵⁸ 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).⁵⁹ Thus, 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 for 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”⁶⁰ 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* payments 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 total inpatient days reported for both general inpatient and inpatient respite care may not exceed 20% of the total Medicare days reported by the hospice for a cap year.”⁶¹

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;⁶² and (2) if the hospice is dissatisfied with that final determination for the cap year, it may file an appeal with the Board.⁶³ 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

⁵⁸ (Emphasis added).

⁵⁹ This conclusion is consistent with the discussion, *supra*, on the legislative history for the hospice benefit.

⁶⁰ 42 C.F.R. § 405.1803(a)(3), (c).

⁶¹ MBPM, Ch. 9, § 90.1 (in effect prior to the May 8, 2015 revisions). *See also* 42 C.F.R. § 418.302(f); MBPM, Ch. 9, § 90.1 (in effect after the May 8, 2015 revisions).

⁶² *See* 42 C.F.R. § 405.1803(a)(3).

⁶³ *See id.* *See also* 42 C.F.R. § 405.1835(a).

year basis with a cost ceiling.⁶⁴ Importantly, these IPPS-exempt hospitals are subject to sequestration in a manner similar to hospices.⁶⁵

This case then is best reviewed as a dispute over the manner in which CMS executed and accounted for sequestration when it applied sequestration to the Provider's Medicare "amount paid" for the applicable 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 wait to apply it *until the cap year has ended*. More specifically, if the hospice were under its aggregate cap, then the 2 percent 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 \$200,000⁶⁶ for the cap year but: (1) the total payments for 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 hypothetical hospice 3 ("HH3") for the cap year grossly exceeds the aggregate cap by \$250,000:

⁶⁴ 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.

⁶⁵ 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>).

⁶⁶ As there is no dispute as to how the aggregate cap itself was calculated for the Providers (*See supra* note 39), 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 <i>with no sequestration applied.</i>	\$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 cap-year-end 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 and reasonable, 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.⁶⁷ 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 Lines D and F.

⁶⁷ This assumes that these hospices did not exceed the inpatient care cap or have any other adjustments.

As a result of its decision to apply sequestration up front, CMS has to go through a more complex cap-year-end reconciliation and accounting process than the simplified approach laid out in Table 1. More specifically, because CMS applies sequestration to the interim payments 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.

Even though it is more complex, 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 or § 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, 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. This is illustrated by comparing Table 1 above, to Table 2 below.

To illustrate that the results of applying sequestration after the cap-year-end and during the cap year, 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 twelve 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 hospice payments as they were issued throughout a full cap year and how applying the TDL methodology produces 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 because sequestration was withheld throughout the cap year. For hospices that exceed their aggregate cap (similar to HH2 and HH3), the overpayment amount to be refunded in 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 or sequestration took place *after* the cap year ends, when the cap-year-end reconciliation and accounting occurs (confirmed by comparing Line G from 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 a result of sequestration beginning 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 the 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 that caveat to 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 aggregate 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 seven months from April 1, 2013 through October 31, 2013). The facts in Table 3 otherwise stay the same except that the PS&R for each of 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 five 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

A simple 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 that cap year. In this visual, any 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 to 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 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).

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.⁶⁸ 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 furnished during the remainder of the 2013 cap year (this is HH3 in Table 3). In the alternative, if green chips from the first five 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).

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 represent that amount that has been properly sequestered during the course of the cap year.⁶⁹

⁶⁸ Again, this appears to be an extremely rare or improbable possibility for which CMS needed to account.

⁶⁹ 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 Medicare Statute establishes precise rules for determining all aspects of a hospice's aggregate cap. However, as the above Tables illustrate, neither the sequestration order nor the CMS TDL altered *any* aspect of the calculation of the aggregate cap. Rather, the Board concludes that 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 Provider in this appeal exceeded its aggregate cap for the 2013 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 simply been their aggregate cap (*i.e.*, cost ceiling). While the Provider in this appeal would like the Medicare Contractor to reduce its debts by the full sequestered amount, the Board disagrees because sequestration applies to the amount paid as determined by the applicable cap-year-end reconciliation and accounting process. If the Medicare Contractor reduced the Provider's debt by the full sequestered amount (such that it would be considered a payment), then the Provider's final Medicare payment for its "costs" would be its full aggregate cap amount, and no portion of that payment would have been sequestered. This outcome clearly 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, 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 payment sequestered, even though that payment was determined based on its aggregate cap.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly applied sequestration to the Provider's aggregate cap payment and correctly calculated the Provider's aggregate cap overpayment when it reopened the Provider's hospice cap determination for the cap year at issue.

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For the Board:

7/31/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair

Signed by: Clayton J. Nix -A