PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2021-D22

PROVIDER–
Serenity One Hospice & Palliative Care

Provider No.: 14-1694

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

LIVE HEARING DATE –
January 27, 2021

Cap Year Ending –
September 30, 2018

Case No. – 19-2078

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor used the correct number of Medicare beneficiaries in calculating the Cap Year 2018 Hospice Cap.[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that, based on the statute, regulations, and Manual requirements, the Medicare Contractor: (a) properly determined the number of Medicare beneficiaries eligible to be included in the aggregate cap calculation for Serenity One Hospice & Palliative Care ("Serenity One" or "Provider") for Cap Year 2018; and (b) correctly calculated Serenity One's Hospice Cap and the associated aggregate cap overpayment for the Cap Year 2018.

INTRODUCTION

Serenity One is a hospice facility located in Lombard, Illinois and the Medicare contractor[2] assigned to Serenity One is Palmetto GBA c/o National Government Services, Inc. (the "Medicare Contractor"). Serenity One claims that the Medicare Contractor miscalculated the aggregate cap amount for Cap Year 2018 as it does not reflect the correct number of beneficiaries.[3]

On April 11, 2019, the Medicare Contractor issued its Hospice Cap determination advising that Serenity One's aggregate cap amount for Cap Year 2018 was $28,664.84 using the patient-by-patient proportional methodology.[4] As a result of that review, the Medicare Contractor determined that Serenity One was overpaid by an amount totaling $67,577.[5] Serenity One alleges that the overpayment is beyond the margin of error, and that three (3) additional Medicare beneficiaries were cared for during the Cap Year 2018, but that the Medicare beneficiaries had died before Medicare reimbursements could be claimed, a fact that Serenity One alleges improperly skewed the cap amount calculation for Cap Year 2018.[6]

On May 31, 2019, Serenity One submitted an Individual Appeal Request to appeal from the hospice cap determination issued by the Medicare Contractor on April 11, 2019 regarding Cap Year 2018.[7]

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[1] Transcript ("Tr.") at 5.
[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] *See* Provider's Final Position Paper at 8 (noting "[f]or the first cap year 08/28/2017 to 09/30/2018 there will [*sic*] only two surviving hospice beneficiaries that survived, enabling their claims for reimbursement to be processed for payment. The net effect using the proportional method of benefit count was reduced to 1.04 because the two surviving hospice beneficiaries has [*sic*] survived into the next cap year 2019.").
[4] Exhibit C-2.
[5] *Id*.
[6] Provider's Final Position Paper at 8, 10.
[7] Provider's Request for Hearing, Case No. 19-2078 (May 31, 2019).

Serenity One timely appealed this issue to the Board and met the jurisdictional requirements for a hearing. A video hearing was held on January 27, 2021. Serenity One was represented by Maria Rosario Montalbon, the Administrator for Serenity One Hospice & Palliative Care. The Medicare Contractor was represented by Bianca Smith, Esq. and 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. 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***."[9] Congress set this reimbursement or payment cap[10] 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 reasonableness." Specifically, CMS implemented the hospice benefit using a prospective

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[8] Pub. L. No. 97-248, § 122, 96 Stat. 324, 356 (1982). Initially, Congress made the hospice benefit a 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.

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 errors[19] (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 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 amount[22] 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 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]

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[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. § 418.309(a).
[25] 42 C.F.R. § 418.308(d).

In addition to the aggregate cap, hospices have another limitation imposed on their payments on a cap-year basis, referred to as an "inpatient care cap." Specifically, for each cap year for a hospice, "the total inpatient days reported 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 year[27] and, if that calculation identifies an overpayment, the determination provides notice of that overpayment amount.[28] If the hospice is dissatisfied with that determination, it may file an appeal with the Board.[29]

B. HOSPICE ELECTION AND HOSPICE BENEFICIARY PAYMENT

42 C.F.R. § 418.24(a) (2018)[30] specifies the requirements for filing an election of hospice benefits:

> (1) *General*. An individual who meets the eligibility requirement of § 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in § 418.3) may file the election statement.
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> (2) *Notice of election*. The hospice chosen by the eligible individual (or his or her representative) must file the Notice of Election (NOE) with its Medicare contractor within 5 calendar days after the effective date of the election statement.
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> (3) *Consequences of failure to submit a timely notice of election*. When a hospice does not file the required Notice of Election for its Medicare patients within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the notice of election. These days are a provider liability, and the provider may not bill the beneficiary for them.

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[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] 42 C.F.R. § 405.1803(a)(3) (emphasis added).
[28] 42 C.F.R. § 405.1803(c).
[29] *Id.*
[30] All citations to 42 C.F.R. Part 418 are to the 2018 version(s) unless otherwise noted.

> (4) *Exception to the consequences for filing the NOE late*. CMS may waive the consequences of failure to submit a timely-filed NOE specified in paragraph (a)(2) of this section. CMS will determine if a circumstance encountered by a hospice is exceptional and qualifies for waiver of the consequence specified in paragraph (a)(3) of this section. A hospice must fully document and furnish any requested documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to the following:
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> (i) Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the hospice's ability to operate.
>
> (ii) A CMS or Medicare contractor systems issue that is beyond the control of the hospice.
>
> (iii) A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.
>
> (iv) Other situations determined by CMS to be beyond the control of the hospice.

For Medicare beneficiaries who ***elect*** hospice care, a daily benefit is paid depending upon the level of care needed.[31] The process for "electing" hospice care is explained in the Medicare Benefits Policy Manual, CMS Pub. 100-02 ("MBPM"), Ch. 9, § 10 (Rev. 188):

> An individual (or his authorized representative) ***must*** *elect hospice care to receive it*. The first election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods, and an unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, *he or she must file an election statement with a particular hospice*. *Hospices* obtain election statements from the individual and ***file a Notice of Election with the Medicare contractor****, which transmits them to the Common Working File (CWF) in electronic format*. Once the initial election is processed, CWF maintains the beneficiary in hospice status until a final claim indicates a discharge (alive or due to death) or until an election termination is received.[32]

There is a maximum amount or CAP that will be paid for any beneficiary who has elected to receive hospice care.[33] During the payment period, which runs from November 1st to October

[31] 42 C.F.R. § 418.302.
[32] Copy at Exhibit C-6 (emphasis added).
[33] 42 C.F.R. § 418.309.

31st of the next year, daily benefits are paid irrespective of whether the individual beneficiary has exceeded his/her CAP.[34] There is a year-end reconciliation in which the CAP maximum (beneficiaries times the CAP) is compared to total payments, and if payments exceed the CAP, an overpayment is determined and collected.[35]

In general, as governed by 42 U.S.C. § 1395f(i), Medicare pays hospice care providers on a per diem basis. The total payment to a hospice in an accounting year (November 1 to October 31, also known as the Cap Year) is limited by a statutory cap.[36] Payments made in excess of the statutory cap are considered overpayments and must be refunded by the hospice care provider.[37] The statutory cap is calculated by multiplying the applicable cap amount by the number of Medicare beneficiaries in the hospice program that year.[38] The statute states:

> [T]he number of Medicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election [to receive hospice care] and have been provided hospice care by (or under arrangements made by) the hospice program under this part in the accounting year, such number reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year or under a plan of care established by another hospice program.[39]

In 1983, the Department of Health and Human Services ("HHS") adopted a rule that allocates hospice care on an aggregate basis by allocating each beneficiary entirely to the cap year in which he or she would be likely to receive the preponderance of his or her care.[40] The original 1983 regulation calculated the number of hospice beneficiaries as follows:

> Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with § 418.24, from the hospice during the period beginning on September 28 (35 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).[41]

In April 2011, CMS issued CMS Ruling 1355-R, as a result of provider appeals challenging the accuracy of the methodology used to calculate the number of beneficiaries in the hospice cap calculation. This Ruling addressed CMS' determination to grant relief to any hospice provider that had a properly pending appeal in any administrative appeal tribunal that sought review of an overpayment determination for any hospice cap year (*i.e.*, the period November 1 to October 31)

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[34] 42 C.F.R. § 418.302(e)(1)
[35] 42 C.F.R. § 418.308.
[36] 42 U.S.C. § 1395f(i)(2)(A)-(B).
[37] 42 C.F.R. § 418.308(d).
[38] 42 U.S.C. § 1395f(i)(2)(A).
[39] 42 C.F.R. § 1395f(i)(2)(C).
[40] 48 Fed. Reg. 56008, 56022 (Dec. 16, 1983).
[41] *Id.* at 56034; 42 C.F.R. § 418.309(b)(1) (1984).

ending on or before October 31, 2011 that challenged the validity of the beneficiary counting methodology.[42] In 2011, CMS also issued a proposed and final rule revising 42 C.F.R. § 418.309(b)(1) to provide for application of a patient-by-patient proportional methodology for cap years 2012 and beyond, or for qualifying providers, the continued application of the streamlined methodology at the provider's election.[43] Serenity One's initial hospice cap computation in this appeal was calculated using the patient-by-patient proportional methodology.[44]

C. SERENITY ONE'S CAP CALCULATIONS, BENEFICIARY COUNT, AND PAYMENT LIMITS

Hospice payments are required by statute to be limited by an inpatient cap and by an aggregate cap with the total hospice cap amount adjusted annually.[45] The total actual Medicare payments made for services furnished to Medicare beneficiaries during the cap year (November 1st to October 31st) are compared to the aggregate cap for this period.[46] Any actual Medicare payments in excess of the aggregate cap must be refunded by the hospice.[47] The regulation at 42 C.F.R. § 418.302(f) describes Medicare payment limitations for inpatient hospice care.

The Medicare beneficiary count is determined using either the proportional method or the streamlined method.[48] Serenity One's initial hospice cap determination was calculated using the proportional methodology, and this methodology is not in dispute in this appeal.[49] In accordance with 42 C.F.R. § 418.309(c)(1), under the patient-by-patient methodology, only the fraction which represents the portion of a Medicare beneficiary's total days of ***hospice*** care in all hospices and all years that were spent in a hospice in that cap year (November 1st to October 31st) is included in the respective hospice calculation, based on the best available data at the time of calculation. Specifically, 42 C.F.R. § 418.309(c) defines the patient-by-patient proportional methodology as follows:

> A hospice's aggregate cap is calculated by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries as described in paragraphs (c)(1) and (2) of this section. For the purposes of the patient-by-patient proportional methodology -
>
> (1) A hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in

[42] CMS Ruling 1355-R (Apr. 14, 2011).
[43] 76 Fed. Reg. 47302, 47332 (Aug. 4, 2011)
[44] Exhibit C-2. S*ee also* 42 C.F.R. § 418.309.
[45] 42 U.S.C. § 1395f(i)(2)(A); 42 C.F.R. § 418.309(a).
[46] 42 C.F.R. § 418.308.
[47] 42 C.F.R. § 418.308(d).
[48] 42 C.F.R. § 418.309.
[49] Provider's Final Position Paper at 8 (noting "[f]or the first cap year 08/28/2017 to 09/30/2018 there will [*sic*] only two surviving hospice beneficiaries that survived, enabling their claims for reimbursement to be processed for payment. The net effect using the proportional method of benefit count was reduced to 1.04 because the two surviving hospice beneficiaries has [*sic*] survived into the next cap year 2019.").

> that cap year, using the best data available at the time of the calculation. The total number of Medicare beneficiaries for a given hospice's cap year is determined by summing the whole or fractional share of each Medicare beneficiary *that received* ***hospice*** *care during the cap year, from that hospice*.
>
> (2) The aggregate cap calculation for a given cap year may be adjusted after the calculation for that year based on updated data.[50]

Serenity One claims that the regulations at 42 C.F.R. § 418.21 and 42 C.F.R. § 418.309 create a potential risk to a hospice of exceeding the hospice cap by more than 50 percent if a beneficiary under hospice care survives more than six months.[51]

D. THE PROVIDER STATISTICAL & REIMBURSEMENT SYSTEM

In accordance with the MBPM, Ch. 9, § 90.2.5, the computation and application of the aggregate cap is made by the Medicare Contractor after the cap year ends. The Provider Statistical & Reimbursement ("PS&R") system as updated in 2011 is used by each hospice's Medicare contractor to determine proportional allocations. For the 2012 cap year and beyond, hospices no longer need to report the number of Medicare beneficiaries electing hospice care during the period to the Medicare contractor in order to be counted in the aggregate cap calculation due to the updated PS&R system.[52]

In the FY 2015 IPPS final rule published on August 22, 2014, the Secretary explains what occurred:

> In response to concerns from hospices, we redesigned the Provider Statistical and Reimbursement (PS&R) system in 2011, so that hospices can now easily manage their inpatient and aggregate caps. The redesigned PS&R enables hospices to calculate estimated caps to monitor their cap status at different points during the cap year, and also enables them to calculate their caps after the cap year ends.[53]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Serenity One is contesting the Medicare Contractor's calculation of the number of Medicare beneficiaries used to determine its hospice aggregate cap for Cap Year 2018.[54] The Medicare Contractor contends Serenity One "did not claim three additional beneficiaries of their own admission[,]" and that the Medicare Contractor utilized the most recent PS&R report to calculate

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[50] (Emphasis added.)
[51] Provider's Final Position Paper at 10 (noting "Maximum reimbursement for each beneficiary is 6 months which is the statutory cap. However, 42 CFR § 418.21 and 42 CFR § 418.249(c) Duration of hospice the Medicare beneficiary can remain on hospice care beyond six months if they remain eligible.").
[52] MBPM, Ch. 9, § 90.2.5.
[53] 79 Fed. Reg. 50452, 50472 (Aug. 22, 2014).
[54] Provider's Final Position Paper at 10.

Serenity One's 2018 Hospice Cap.[55] Serenity One, in its Final Position Paper, acknowledged it did not submit bills to the Medicare program for the three (3) beneficiaries at issue "because there was [*sic*] no claims being made and thus there was no reimbursement."[56] Per the Medicare Contractor's initial 2018 hospice cap determination, it used 1.4675 Medicare beneficiaries based on the most recent PS&R.[57]

The Medicare Contractor states that, as explained in the FY 2015 IPPS final rule, the Secretary has directed the Medicare contractors to use the information on the most recent PS&R *unless* the provider furnishes proof that inaccuracies exist in the PS&R System.[58] The Medicare Contractor notes that this policy applies to Cap Years 2012 and forward and is memorialized in the MBPM, Ch. 9, § 90.2.5.[59] The PS&R System, which accumulates statistical and reimbursement data applicable to *processed **and** finalized* Medicare Part A claims, submitted by providers on the Form UB-04, is a key tool for institutional healthcare providers, Medicare contractors, and CMS.[60] This data is summarized in various reports, which are used by providers to prepare Medicare cost reports and by Medicare contractors during the audit and settlement process, including hospice cap determinations.[61] The providers must use the reports in preparing cost reports and must be able to explain any variances between the most recent PS&R report and the cost report.[62]

The Medicare Contractor asserts that the PS&R System's reliance on data from *processed **and** finalized* Medicare Part A claims is critical for achieving complete and accurate data to prepare a Medicare cost report and/or a hospice cap determination. The accuracy of the system-generated reports is, in relevant part, dependent on whether or not a provider timely files its Medicare claims.[63]

Medicare's requirements for timely filing claims are located at 42 C.F.R. § 424.44 (2018), which states in relevant part:

> (a) *Time limits*. (1) Except as provided in paragraphs (b) and (e) of this section, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.
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> . . . .

[55] Medicare Contractor's Final Position Paper at 8.
[56] Provider's Final Position Paper at 10 (". . . three (3) Medicare beneficiaries are not included in the Providers Statistical Reimbursement (PS&R) because there was [*sic*] no claims being made and thus there was no reimbursement. These three (3) Medicare beneficiaries we provided hospice care and should be included to have an aggregate count.")).
[57] Medicare Contractor's Final Position Paper at 8 (citing Exhibit C-2).
[58] *Id*. at 8-9 (citing to 79 Fed. Reg. 50452, 50472 (Aug. 22, 2014)).
[59] *Id*.
[60] *Id*.
[61] *Id*.
[62] *Id*.
[63] *Id*.

> (b) *Exceptions to time limits.* Exceptions to the time limits for filing claims include the following:
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> (1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority.[64]

The Medicare Contractor uses the standard Remittance Advice ("RA"), along with the PS&R Summary Report, as a means to communicate to providers claim processing decisions such as payments, adjustments, and denials.[65] The RA is a notice of payments and adjustments sent to providers, billers, and suppliers. After a claim has been received and processed, a Medicare contractor produces the RA, which may serve as a companion to a claim payment(s) or as an explanation when there is no payment.[66] The purpose of an RA is to provide detailed payment information relative to health care claims and, if applicable, to describe why the total original charges have not been paid in full. This remittance information is provided as justification for the payment, as well as input to the payee's patient accounting system/accounts receivable and general ledger applications.[67] The codes listed on the RA help the provider identify any additional action that may be necessary. For example, some RA codes may indicate a need to resubmit a claim with corrected information, while other RA codes may indicate whether the payment decision can be appealed.[68]

The Medicare Contractor generates the RA and sends it to the provider.[69] If a claim does not meet coverage, medical necessity, or policy requirements, providers may have the right to appeal the claim with additional information for redetermination based on RA guidance. Providers can use the RA, which contains detailed and specific claim decision information, to post payments and to review claim adjustments.[70] An adjustment may be made for any number of reasons, which are identified on the RA through standardized code sets, which include Group Codes, Claim Adjustment Reason Codes, and RA Remark Codes.[71]

When a claim is denied, the hospice has the right to challenge that decision and file an appeal. Currently, there are five levels to the Medicare claims appeals process: (1) redetermination, (2) reconsideration, (3) administrative law judge hearing, (4) Medicare Appeals Council review, and (5) judicial review by a federal court.[72] If the hospice receives a denial at one level, it can proceed to the next, until it receives a favorable decision, or a federal court finds against it.

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[64] 42 C.F.R. § 424.44.
[65] Medicare Contractor's Final Position Paper at 10.
[66] *Id*.
[67] *Id*.
[68] *Id*.
[69] *Id*. at 11.
[70] *Id*.
[71] *Id*.
[72] *Id*.

There are time limits and requirements for filing a redetermination as outlined in 42 C.F.R. § 405.942. Following the appeal process for the denial of claims is important as it allows the data to be captured and to properly flow through the PS&R report.[73]

The Medicare Contractor contends it properly calculated Serenity One's Hospice Cap calculation for the 2018 cap year using the correct data from the PS&R System. It asserts that Serenity One received its Initial Hospice Cap Determination along with the PS&R Summary Reports and was given sufficient time to explain and/or appeal why the additional beneficiaries should be included on the PS&R and in the hospice cap determination.[74] As Serenity One did not seek to correct the PS&R data, the Medicare Contractor omitted the beneficiaries in question from the PS&R.[75]

Serenity One argues that, for the first cap year, August 28, 2017 to September 30, 2018, there were only two (2) hospice beneficiaries that survived, with survival being the criterion enabling their claims for reimbursement to be processed for payment.[76] Serenity One argues that the net effect of using the proportional method of beneficiary count reduced the count to 1.04 because only two (2) hospice beneficiaries had survived into the 2018 Cap Year.[77] Serenity One argued that without using the aggregated hospice beneficiary count, the statistical distribution has skewed towards over-payment 77.42 percent beyond the normal statistical distribution.[78]

Serenity One argues that, without the aggregate cap, hospice care was provided to Medicare beneficiaries for a total of 339 days during the first cap year covering the periods from October 27, 2017 to September 30, 2018. However, the claims were limited to $44.66 (30,012.09 / (339 x 2)) instead of the set reimbursement claim of $160.47 (108,800.92 / (339 x 2)) average for each hospice Medicare beneficiary.[79] Further, during the accreditation process, Serenity One provided Hospice care services for Medicare beneficiaries who already died before the accreditation process was completed, and the claims could not be submitted.[80]

Serenity One's arguments focus on a statistical distribution analysis of the aggregate cap and reimbursement, as well as administrative difficulties incurred by Serenity One in establishing themselves *initially* as a Medicare-accredited hospice provider. Serenity One notes that during the accreditation process, they had furnished care to three (3) additional Medicare beneficiaries, whose claims could not be processed because the beneficiaries passed away before the accreditation period ended (*i.e.*, before the effective date of their Medicare accreditation as a hospice provider), and this fact contributed in large part to the overpayment.[81] The inclusion of

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[73] *Id*.
[74] *Id*.
[75] *Id*.
[76] Provider's Final Position Paper at 8.
[77] *Id*. *See also* Exhibit P-2.
[78] *Id*. *See also* Tr. at 7 (stating "the deviat[ion] towards an overpayment of 72.42 percent. It's way beyond the margin of error.").
[79] Provider's Final Position Paper at 8.
[80] *Id*. at 9.
[81] *Id*. (Beneficiaries expired before accreditation period completed, and hospice was not eligible for reimbursement). *See also* Exhibit P-4.

the three additional beneficiaries would have increased the aggregate count to 4.074 (3 + 1.047) using the proportional method for the first cap year ending September 30, 2018, and would have changed the 77.42 percent deviation of the PS&R to 6.74 percent.[82] With the three (3) additional beneficiaries included in the beneficiary count, Serenity One proposes the following calculations:[83]

Lines	Description	Amount
a.	Medicare Beneficiary count (3 + 1.047) Proportional Method	4.07
b.	Statutory Cap Amount for 09/30/2018	$28,664.84
c.	Aggregate Cap Amount Allowable (c = a x b)	$116,665.90
d.	Net Reimbursement for the cap year	108,801.36
e.	Difference between Aggregate Cap Amount and Reimbursement	$7,864.54
f.	Percent Deviation	6.74%

According to Serenity One, it provided "care" to five (5) total Medicare beneficiaries during and through their accreditation period (*i.e.*, before the effective date of their accreditation as a Medicare hospice provider).[84] Three (3) of their five (5) Medicare beneficiaries had passed away before the end of the accreditation period, with the result that Serenity One was only able to submit claims for the 2 remaining Medicare beneficiaries.[85] The MBPM states that a Medicare beneficiary must make an election for Medicare hospice care ***on or after*** the date that the hospice provider is Medicare certified (*i.e.*, on or after the effective date of the accreditation as a Medicare hospice provider).[86] Even though the three (3) expired Medicare beneficiaries were provided "care" during the accreditation period, Serenity One was unable to submit claims for reimbursement of ***hospice*** care for these Medicare beneficiaries because of Medicare's beneficiary hospice election and claims submission timing rules.[87] To this point, Serenity One presented testimony that it did, in fact, submit a claim for one (1) of the three (3) Medicare beneficiaries at issue, but that this claim was rejected by the Medicare Contractor because the Medicare beneficiary had not made a proper election for hospice care and, thus, the Medicare beneficiary was not included in the cap calculation.[88]

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[82] Provider's Final Position Paper at 11.
[83] *Id.*
[84] Tr. at 8.
[85] *Id.*
[86] MBPM, Ch. 9, § 20.2.1 (Rev. 209) (copy at Exhibit C-6).
[87] *See* Tr. at 25.
[88] *Id.* at 32:9-13 ("[Question:] Did I understand correctly that you did, in fact, try to submit a claim for, example, that patient three on P-4, and it was rejected? [Answer:]Yes.")

A Medicare beneficiary, or authorized representative, must elect to receive hospice care benefits from a hospice provider prior to actually receiving any hospice care.[89] Specifically, a Medicare beneficiary may elect to receive Medicare coverage for two 90-day periods, and an unlimited number of 60-day periods.[90] If the Medicare beneficiary or authorized representative elects to receive hospice care, he or she must file an election statement *with a particular hospice*.[91] The hospices receiving an election statement from a Medicare beneficiary must then file a Notice of Election with the Medicare contractor for that Medicare beneficiary, and the Medicare Contractor, in turn, transmits them to the Common Working File ("CWF") in electronic format.[92] Once the initial election is processed, the CWF maintains the Medicare beneficiary in "hospice" status until a final claim indicates a discharge or until an election termination is received.[93]

MBPM, Ch. 9, § 20.2.1 clearly states: "*For Medicare payment purposes*, an election for Medicare hospice care must be made ***on or after*** *the date that the hospice provider is Medicare-certified*."[94] Specifically, once a provider receives that certification from the Medicare program, a Medicare beneficiary may then "elect" to receive hospice care from that provider and in turn receive "hospice" care from that provider. However, in order for that hospice care to be billable, the provider must file the beneficiary's "Notice of Election" with the Medicare contractor within five (5) calendar days after the effective date of election unless an exception applies. Further, as with any election, the hospice ***must*** fulfill all other admission requirements, such as certification or recertification, any required face-to-face encounters, or Conditions of Participation ("CoP") assessments.[95]

As noted above, the MBPM allows the hospice to file a Notice of Election beyond the five-day window in certain limited circumstances.[96] Specifically, there are four exceptional circumstances listed in the MBPM as follows which essentially paraphrases 42 C.F.R. § 418.24(a)(4):

> 1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;
>
> 2. An event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice;
>
> 3. ***A newly Medicare-certified hospice that is notified of certification after the Medicare certification date, or is awaiting its user ID from its Medicare contractor***; or,

[89] *See* MBPM, Ch. 9, § 10 (Rev. 209, May 8, 2015).
[90] *Id*.
[91] *Id*.
[92] *Id*.
[93] *Id*.
[94] (Emphasis added.)
[95] MBPM, Ch. 9, § 20.2.1. *See also* Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 11, § 20.1.1.
[96] MBPM, Ch. 9, § 20.2.1.

> 4. Other circumstances determined by CMS to be beyond the control of the hospice.[97]

If one of the four circumstances described above prevents a hospice from timely-filing its Notice of Election, the hospice must document the circumstance to support a request for an exception, which would waive the consequences of filing the Notice of Election late.[98] Using that documentation, the hospice's Medicare contractor will determine if a circumstance encountered by a hospice qualifies for an exception to the consequences for filing a Notice of Election more than five (5) calendar days after the effective date of election.[99]

In instances where a Notice of Election for a Medicare beneficiary is not timely-filed (or an exception is not established), the Medicare program will ***not*** cover and pay for any days of hospice care from the hospice admission date to the date the Notice of Election is submitted to, and accepted by, the Medicare contractor.[100] Rather, the hospice provider is liable for the days, and may not bill the Medicare beneficiary for them.[101]

In this case, Serenity One received Medicare accreditation as a hospice provider *effective* August 28, 2017 but did not receive their Submitter's ID until over 8 months later, on May 14, 2018.[102] As a result, Serenity One qualifies for the third exception listed above. However, *in order for this exception to be applicable to a Medicare beneficiary*, Serenity One had to first obtain an election from that beneficiary and, for the Cap Year 2018, Serenity One obtained timely elections for only two (2) Medicare beneficiaries and, as a result, could only bill the Medicare program for those 2 Medicare beneficiaries. As set forth below, Serenity One's hospice cap calculation was only based on those two (2) Medicare beneficiaries because Serenity One failed to obtain the pre-requisite election from the three (3) Medicare beneficiaries it is seeking to include in the hospice cap calculation as part of this appeal and, thereby, could not bill for those three (3) Medicare beneficiaries.

42 C.F.R. § 418.309(d)(2) specifies that, for cap years 2012 and beyond, a hospice's aggregate cap is calculated using the patient-by-patient proportional methodology (unless the hospice qualifies for an exception). Serenity One's initial hospice cap computation in this appeal was calculated using the proportional methodology, as defined at § 418.309(c), and the Medicare Contractor's use of this methodology is not in dispute or being challenged.[103] Rather, Serenity One is challenging whether the Medicare Contractor used the correct data in calculating the cap using the proportional methodology.

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[97] *Id*. (emphasis added).
[98] *Id*.
[99] *Id*. (stating: "If the request for an exception is denied, the Medicare contractor will retain the decision of the denial. Hospices retain their usual appeal rights on the claim for payment. *See* Pub. 100-04, Medicare Claims Processing Manual, Chapter 11, "Processing Hospice Claims" for requirements for [Notice of Election] submission, reporting provider-liable days, and qualifying circumstances for a request for exception.")
[100] *See id*. § 20.2.1.1.
[101] *Id*.
[102] Tr. at 17.
[103] Exhibit C-2.

Significantly, § 418.309(c)(1) specifies that a hospice only uses Medicare beneficiaries "that *received* ***hospice*** *care* during the cap year, from that hospice."[104] MBPM, Ch. 9, §§ 90.1 and 90.2.5 direct the Medicare contractor to use the most recent PS&R for the relevant cap year to identify these Medicare beneficiaries for purposes of the aggregate cap calculation for that cap year. This information is available to hospices to reference and monitor as noted in the August 22, 2014 final rule:

> In response to concerns from hospices, we redesigned the Provider Statistical and Reimbursement (PS&R) system in 2011, so that hospices can now easily manage their inpatient and aggregate caps. The redesigned PS&R enables hospices to calculate estimated caps to monitor their cap status at different points during the cap year, and also enables them to calculate their caps after the cap year ends
>
> . . . .
>
> We proposed that hospices would be provided a pro-forma spreadsheet that they would use to calculate their caps to remit any overpayments. The redesigned PS&R system provides the inpatient days, total days, beneficiary counts, and Medicare payments that are needed to calculate any inpatient or aggregate cap overpayments. The redesigned system can provide needed data whether a hospice uses the streamlined method or the patient-by-patient proportional method for its aggregate cap calculation. *All hospices are required to register in Individuals Authorized Access to CMS Computer Services (IACS) and obtain their PS&R report from the PS&R system.* Hospices experiencing difficulties can request a copy of their PS&R report from their MAC.[105]

The Board finds that the Medicare Contractor properly calculated Serenity One's Hospice Cap calculation for the 2018 cap year using data from the applicable PS&R report. It is undisputed that the PS&R report shows only two (2) Medicare beneficiaries having received hospice care from Serenity One during the cap year at issue. Serenity One received its Initial Hospice Cap Determination along with the PS&R Summary Reports and was given sufficient time to explain why the three (3) additional Medicare beneficiaries at issue in this appeal should be included on the PS&R report and in the hospice cap determination. As Serenity One did not adequately explain or appeal the exclusion of these three (3) additional Medicare beneficiaries, the Medicare Contractor used only the two (2) Medicare beneficiaries reported on the PS&R report in the hospice cap determination.

In this appeal, Serenity One asks for leniency based on its status as a new Medicare hospice provider, who furnished care for the three (3) additional Medicare beneficiaries at issue during its accreditation period without the ability to obtain reimbursement for "hospice" care. While the Board empathizes with Serenity One's situation, the Board is not a body of equity, but rather it is

[104] (Emphasis added.)
[105] 79 Fed. Reg. 50451, 50472 (Aug. 22, 2014) (emphasis added).

bound by Medicare statutes and regulations and must give great weight to policy pronouncements as published in the Medicare manuals.[106] Rather, the Board finds that the Medicare statute and regulations are clear regarding the requirements for reimbursement of "hospice" care furnished to Medicare beneficiaries and, unfortunately, ***any*** *care* that Serenity One furnished to the three (3) additional Medicare beneficiaries at issue *prior to* the effective date of certification as a Medicare hospice provider *categorically* cannot qualify as "***hospice***" care for Medicare program purposes.

In this regard, the Board notes that 42 C.F.R. § 418.24(a) and MBPM, Ch. 9, § 20.2.1 (as both quoted above) make clear that a Medicare beneficiary can ***only*** elect the hospice benefit with a provider if that provider is a "hospice" provider, *i.e.*, a Medicare-certified hospice provider. The facts established in the parties' position papers, exhibits, and testimony at hearing demonstrate that August 28, 2017 is the effective date of Serenity One's certification by the Medicare program as a Medicare ***hospice*** provider. As result, *for Medicare program purposes*, Serenity One could ***not*** furnish "hospice" services to Medicare beneficiaries *prior to* August 28, 2017 and necessarily Serenity One's *Medicare* patients could ***not*** elect to receive "hospice" services from Serenity One ***prior to*** August 28, 2017.[107] None of the three (3) additional Medicare beneficiaries at issue that Serenity One seeks to have included in their hospice cap calculation made the prerequisite election to receive hospice care from Serenity One *on or after* August 28, 2017, the date when Serenity One could furnish "hospice" care *for Medicare program purposes*. Indeed, two (2) of those Medicare beneficiaries died ***prior to*** the August 28, 2017 date and there was no possibility for these two (2) Medicare beneficiaries to have made a proper election to receive hospice care from Serenity One (much less be included in the cap year calculation since the cap year began on August 28, 2017, the effective date of Serenity One's Medicare certification as a hospice provider). The third Medicare beneficiary died on September 13, 2017 and, while Serenity One had 16 days (*i.e.*, from August 28, 2017 to September 13, 2017) to obtain an election from this Medicare beneficiary, it failed to do so *prior to* the beneficiary's death. As a result of its failure to obtain that election, consistent with 42 C.F.R. § 418.24, Serenity One was unable to bill for the third Medicare beneficiary and was unable to include that beneficiary in the hospice cap calculation. This is why the PS&R report at issue was correct and did not include any of the three (3) Medicare beneficiaries at issue.

In contrast, there were two (2) Medicare beneficiaries that Serenity One was able to include in its hospice cap calculation. These beneficiaries also had been receiving services from Serenity One prior to the August 28, 2017 certification date. While Serenity One had the opportunity to obtain a hospice benefits election from these 2 Medicare as early as August 28, 2017, Serenity One did not obtain such an election until October 2017 (roughly two (2) months after Medicare certification was obtained). Accordingly, once these elections were made, Serenity One could (and did) begin to bill the Medicare program for hospice services. The post-election ***hospice*** services for these two (2) Medicare beneficiaries are reflected in the PS&R report at issue consistent with the mandate in 42 C.F.R. § 418.309(c), which specifies that only Medicare beneficiaries "that *received* ***hospice*** *care* during the cap year, from that hospice" are included in the aggregate cap calculation.[108]

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[106] 42 C.F.R. § 405.1867.
[107] Via the Notice of Election.
[108] (Emphasis added.)

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that, based on the statute, regulations and Manual requirements, the Medicare Contractor: (a) properly determined the number of Medicare beneficiaries eligible to be included in Serenity One's aggregate cap calculation for Cap Year 2018; and (b) correctly calculated Serenity One's Hospice Cap and associated aggregate cap overpayment for Cap Year 2018.

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