PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D05

PROVIDER –
Serenity One Hospice & Palliative Care, LLC

HEARING DATE –
July 18, 2023

Provider No. –
14-1694

Fiscal Year –
2019

vs.

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

Case No. –
21-0760

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor used the correct time-period and calculations for determining the Provider's hospice cap amount for the cap year ending on September 30, 2019.[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Medicare Contractor correctly determined the Provider's hospice cap amount for the cap year ending on September 30, 2019.

INTRODUCTION

Serenity One Hospice & Palliative Care ("Provider") is a hospice facility located in Lombard, Illinois[2] and the Medicare contractor[3] assigned to the Provider is Palmetto GBA c/o National Government Services, Inc. (the "Medicare Contractor").

By letter dated September 28, 2020, the Medicare Contractor notified the Provider that its hospice cap amount for the cap year ending on September 30, 2019 was $29,205.44 using the patient-by-patient proportional methodology. Medicare payments to the Provider exceeded the cap amount by $77,895, and the letter served as a First Request for the Provider to repay Medicare the overpayment amount.[4] The Provider timely appealed the Medicare Contractor's hospice cap determination to the Board.

The Board held a video hearing on July 18, 2023. The Provider was represented by Maria Rosario Montalban, RN, the Administrator of the hospice. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

BACKGROUND AND APPLICABLE AUTHORITIES

A. PROCEDURAL HISTORY

The Provider timely filed its initial appeal request with the Board on February 3, 2021, and requested review of the Medicare Contractor's determination of the hospice cap amount for the period from October 1, 2018 through September 30, 2019, from which the Medicare Contractor calculated an overpayment amount of $77,895. The Provider asserted that Medicare Benefit Policy Transmittal 156, dated June 1, 2012, specifies that the cap year is from November 1 of each year to October 31 of the next year, and following that guidance, the cap period should be

[1] Hearing Transcript ("Tr.") at 6.
[2] Exhibit P-2 at 5.
[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 Medicare Contractors, as appropriate.
[4] Exhibit P-2 at 5-6.

from November 1, 2018 through October 31, 2019.[5] The Provider requested that the cap year at issue be changed to the period from November 1, 2018 through October 31, 2019, in accordance with the guidelines of that Medicare Benefit Policy Manual transmittal, and argues that during that period, the beneficiary count is 4.7394, which would reduce the overpayment amount to $49,676.53.[6]

On October 5, 2021, the Provider filed its Preliminary Position Paper ("PPP"). In its PPP, the Provider explained that it was a new hospice provider (established on November 2, 2016), first accredited by the Medicare program for the cap period starting on August 28, 2017.[7] For its first aggregate cap year, the Provider's cap period was initially set from August 28, 2017 to September 30, 2018. The Provider contends that, as a result of the "arbitrary" first cap period set from August 28, 2017 to September 30, 2018, the second cap period ran from October 1, 2018 to September 30, 2019 instead of the cap period as per the Medicare Benefit Policy Manual, CMS Pub. 100-02 ("MBPM"), which should be November 1, 2018 to October 31, 2019.[8]

The Provider further explained that, for their aggregate cap calculation for the cap period of October 1, 2018 to September 30, 2019, there was an overpayment determination in the amount of $77,895.00, which is 69.27 percent of the total aggregate cap amount ($112,446.79) calculated as allowable Medicare payments for that time period. Provider asserts that an overpayment of 69.27 percent for its second year of operation is "highly irregular." The Provider was reimbursed for only 3.8 Medicare beneficiaries for the entire year.[9] The Provider notes that the overpayment for the first year was 71.51 percent, and that these consecutive overpayments of such high percentages has been financially devastating.[10]

On December 5, 2021, the Medicare Contractor filed its PPP and stated, as follows:

> The Provider's first aggregate cap year was calculated using the period 08/28/2017 – 09/30/2018, which equates to 1 year and 4 days. This meets the criteria set in the Medicare Benefit Policy Manual Chapter 90.2.1 (Rev. 246, Issued 09-14-2018, Effective 12-17-18), (Exhibit C-1), which states a new hospice's first aggregate cap year must be more than 12 months, but less than 24 months.[11]

The Medicare Contractor continued its position by explaining:

> Per the Medicare Benefit Policy Manual Chapter [9, Section] 90 (Rev. 246, Issued 09-14-2018, Effective 12-17-18) at Exhibit C-1:

---

[5] *See* Provider's Preliminary Position Paper (hereinafter, "Provider's PPP") at 2 (Oct. 5, 2021). Note, the Provider incorrectly referenced transmittal 152 instead of 156. *See also* Exhibit P-1.
[6] *See* Exhibit P-6.
[7] Provider's PPP at 4.
[8] *Id.* at 5.
[9] *See* Provider's PPP at 2. *See also* Exhibit P-3.
[10] Provider's PPP at 2-3.
[11] Medicare Contractor's Preliminary Position Paper (hereinafter, "Contractor's PPP") at 5 (Dec. 10, 2021).

> For the 2016 cap year and earlier, the cap year for the inpatient and aggregate cap runs from November 1st to October 31st. For the 2018 cap year and later, the cap year for both the patient and aggregate cap, as well as the timeframes in which beneficiaries and payments are counted for the purposes of determining each individual hospice's aggregate cap aligns with the federal fiscal year (i.e., October 1st to September 30th).[12]

Thus, the Medicare Contractor contends that the Provider's argument is based upon an outdated version of the relevant guidance materials (MBPM Change Request 7838 dated June 12, 2012), in an attempt "to support their argument of changing their aggregate cap year."[13]

On February 17, 2023, the Provider filed a final position paper. The Provider acknowledged that the instrument or tool used to determine the hospice cap overpayment amount was the Provider's Statistical and Reimbursement System ("PS&R"), which "uses the aggregate amount and the patient-by-patient proportional method when determining the number of beneficiaries allowed for the period and the amount of overpayment or underpayment"[14] (*i.e.*, Medicare payment below the hospice cap amount). The Provider contends that, while the algorithm used for the patient-by-patient proportional method "seems simple," the result "is skewed or deviates toward an overpayment or underpayment of reimbursements at times are in high percentage resulting in large overpayment amounts to be repaid to CMS after hospice care has been provided to CMS beneficiaries."[15] These large overpayments and underpayments are shown in the Provider's PS&R Summary for the last four years as follows:

1) 8/28/17 – 9/30/18 – overpayment of $79,390
2) 10/1/18 – 9/30/19 – overpayment of $77,895
3) 10/1/19 – 9/30/20 –underpayment of $43,397.52
4) 10/1/20 – 9/30/21 –underpayment of $2,893.72[16]

The Provider contends that not all beneficiaries were covered by Medicare in all four periods, and, as a result, these beneficiaries will receive their hospice care, free of charge for those periods. The Provider contends that, in effect, it will ultimately subsidize CMS and will have to allocate $1,407.06 per beneficiary for all expenses, which is not sustainable because the Provider "will keep on borrowing to continue providing hospice care to all unduplicated beneficiaries."[17] The Provider claims that the PS&R "becomes a lucky draw where hospice care provider will always get the short end of the stick[because n]ot all of its patients will be reimbursed with the beneficiary count always less than the [number of] unduplicated patients being served."[18]

---

[12] *Id.* at 5-6.
[13] *Id.* at 6.
[14] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 2 (Feb. 17, 2023).
[15] *Id.*
[16] *Id.* at 3.
[17] *Id.*at 6.
[18] *Id.* at 6-7.

The Provider asserts that the calculations made by the PS&R in terms of beneficiary count are "not clear and transparent"[19] and provides examples of how the calculations do not make sense when considering the beneficiary count in relation to the reimbursement amount. The Provider now asks for the following:

> 1. [T]ransparency in the PS&R report that we can verify as to the accuracy in generating the findings when it comes to overpayment. The PS&R should show how the beneficiary count is determined. The beneficiary count has the impact of determining an overpayment.
>
> 2. [A] return of the refund to CMS the amount of $83,000.00. There is an anomaly on the calculations made in the PS&R in terms of reimbursement. Our point of refence [sic] is the more normal calculations [during the period from October 1, 2020 to September 30, 2021] where the deviation between allowable cap and net reimbursement is low at 1.06%, which is the acceptable deviation… although that period only covers 63.29% of the beneficiaries.
>
> 3. In terms of overpayment wherein the provider has to pay back to CMS after providing hospice care, there should be consideration when the PS&R happens to show an underpayment wherein the reimbursement is less than the aggregate cap limit. For now, it is a one-sided relationship, favoring heavily on CMS with declared overpayments…. Having an underpayment means there is less reimbursement than the aggregate cap amount, already set at its minimum amount. The hospice care provider always gets the short end of the stick in both overpayment and underpayment.[20]

On March 17, 2023, the Medicare Contractor filed its final position paper. The Medicare Contractor repeated its arguments that it made in its PPP, specifically that the Provider's argument in its PPP "is unreasonable as they are using outdated versions of regulations . . . to support their argument of changing their aggregate cap year."[21]

B. BACKGROUND ON HOSPICE PAYMENT METHODOLOGY

In 1982, Congress created the hospice benefit pursuant to § 122 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").[22] The hospice benefit is an election that certain terminally-ill Medicare beneficiaries can make "in lieu of" other Medicare benefits. Congress set

---

[19] *Id.* at 7.
[20] *Id.* at 7-8.
[21] On April 13, 2023, the Medicare Contractor filed a jurisdictional challenge to which the Provider responded. On June 20, 2023, the Board determined that it has jurisdiction over this appeal in which the Provider is dissatisfied with the hospice cap overpayment determination.
[22] 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").

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***[.]"[23] Congress set this reimbursement or payment cap[24] 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."[25]

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,[26] CMS immediately exercised its discretion under 42 U.S.C. § 1395f(i) to base the initial reimbursement methodology for hospice care on an "other test of reasonableness." Specifically, CMS implemented the hospice benefit using a prospective payment system for hospice care as a proxy for costs.[27] 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.[28] Congress has periodically adjusted these payment rates.[29]

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.[30] 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."[31] However, Congress later amended the hospice cap "to correct a technical error" because Congress learned that the data from the Congressional

---

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

[24] 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").

[25] 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).

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

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

[28] 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.

[29] *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.

[30] 42 C.F.R. § 418.309(a).

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

Budget Office ("CBO"), upon which the original hospice cap was based, contained two errors.[32] 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[33] (which coincidentally occurred between when CMS proposed and finalized the hospice prospective payment system).[34]

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."[35] Each hospice's "aggregate cap amount" for a 12-month period is calculated by multiplying the adjusted statutory per-beneficiary cap amount[36] for that period by the number of Medicare beneficiaries served by the hospice during that period.[37] The 12-month period is referred to as the "cap year" and, starting in 2018, the cap year is the same period as the federal fiscal year.[38] 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.[39]

In addition to the aggregate cap, hospices have another limitation imposed on their payments on a cap-year basis referred to as the "inpatient care cap." That is, the total number of inpatient days reported for both general inpatient care and inpatient respite care may not exceed 20 percent of the total Medicare days reported by the hospice for a cap year.[40]

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[41] and, if that calculation identifies an overpayment, the determination provides notice of that overpayment amount.[42] If the hospice is dissatisfied with that determination, it may file an appeal with the Board.[43]

---

[32] H.R. Rep. No. 98-333, at 1-2 (1982). *See also* GAO Rep. GAO/HRD-83-72, at 5-6.
[33] 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].").
[34] *See* GAO Rep. GAO/HRD-83-72, at 5-6; 48 Fed. Reg. at 56019.
[35] 42 C.F.R. § 418.308(a).
[36] 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).
[37] 42 C.F.R. § 418.309.
[38] *See, e.g.*, 42 C.F.R. § 418.309(a); MBPM, Ch. 9, § 90 (Dec. 17, 2018).
[39] 42 C.F.R. § 418.308(d).
[40] MBPM, Ch. 9, § 90.1; *See also* 42 C.F.R. § 418.302(f).
[41] *See* 42 C.F.R. § 405.1803(a)(3).
[42] *See* 42 C.F.R. § 405.1803(c).
[43] *See id.*

C. TIME-PERIOD AND CALCULATION METHODOLOGY TO USE FOR DETERMINING HOSPICE CAP

The Medicare Benefit Policy Manual (MBPM), Chapter 9, § 90,[44] provides guidance on "Caps and Limitations on Hospice Payments," and states, in pertinent part:

> For the 2016 cap year and earlier, the cap year for the inpatient and aggregate cap runs from November 1st to October 31st. For the 2018 cap year and later, the cap year for both the inpatient and aggregate cap, as well as the timeframes in which beneficiaries and payments are counted for the purposes of determining each individual hospice's aggregate cap aligns with the federal fiscal year (i.e., October 1st to September 30th).
>
> In the year of transition (2017 cap year), for the inpatient cap, the Medicare contractors will calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care and respite care) from November 1, 2016 through September 30, 2017 (11 months). For the 2017 cap year, hospices using the patient-by-patient proportional method for their aggregate cap determinations should count beneficiaries from November 1, 2016 to September 30, 2017. For those hospices using the streamlined method for their aggregate cap determinations, hospices should count beneficiaries from September 28, 2016 to September 30, 2017, which is 12 months plus 3 days, in that cap year's calculation. For the counting of hospice payments, hospices using either the streamlined method or the patient-by-patient proportional method, hospices should count 11 months of payments from November 1, 2016 to September 30, 2017 for the 2017 cap year. For the 2018 cap year and later, hospices should count both beneficiaries and payments, regardless of whether the streamlined or the patient-by-patient proportional methods are used, from October 1 to September 30.

While this version of the MBPM was not effective until December 17, 2018, the preamble to the regulations governing hospice payments, for example 42 C.F.R. §§ 418.308 and 418.309, was published on August 6, 2015, and addressed these changes, as follows:

> In FY [fiscal year] 2012, we decided not to finalize changing the cap accounting year to the FY, partly because of a concern that a large portion of providers could still be using the streamlined method. As stated earlier, the streamlined method has a different timeframe for counting the number of beneficiaries than the cap accounting year, allowing those beneficiaries who elected hospice near the end of the cap year to be counted in the year when most of the services were provided. However, for the 2013 cap year, only 486 hospices used

[44] The version issued on September 14, 2018, effective December 17, 2018.

the streamlined method to calculate the number of Medicare hospice patients and the remaining providers used the patient-by-patient proportional method. Since the majority of providers now use the patient-by-patient proportional method, we believe there is no longer an advantage to defining the cap accounting year differently from the hospice rate update year; maintaining a cap accounting year (as well as the period for counting beneficiaries under the streamlined method) that is different from the federal fiscal year creates an added layer of complexity that can lead to hospices unintentionally calculating their aggregate cap determinations incorrectly. In addition, shifting the cap accounting year timeframes to coincide with the hospice rate update year (the federal fiscal year) will better align with the intent of the new cap calculation methodology required by the IMPACT Act of 2014, as discussed in section III.C.4. Therefore, we are aligning the cap accounting year for both the inpatient [care] cap and the hospice aggregate cap with the federal fiscal year for FYs 2017 and later. In addition to aligning the cap accounting year with the federal fiscal year, we will also align the timeframe for counting the number of beneficiaries with the federal fiscal year. This will eliminate timeframe complexities associating with counting payments and beneficiaries differently from the federal fiscal year and will help hospices avoid mistakes in calculating their aggregate cap determinations.

****

In shifting the cap year to match the federal fiscal year, we are aligning the timeframes in which beneficiaries and payments are counted for the purposes of determining each individual hospice's aggregate cap amount . . . as well as the timeframes in which days of hospice care are counted for the purposes of determining whether a given hospice exceeded the inpatient [care] cap. In the year of transition (2017 cap year), for the inpatient [care] cap, we will calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care and respite care) from November 1, 2016 through September 30, 2017 (11 months). For those hospices using the patient-by-patient proportional method for their aggregate cap determinations, for the 2017 cap year, we will count beneficiaries from November 1, 2016 to September 30, 2017. For those hospices using the streamlined method for their aggregate cap determinations, we will allow 3 extra days to count beneficiaries in the year of transition. Specifically, for the 2017 cap year (October 1, 2016 to September 30, 2017), we will count beneficiaries from September 28, 2016 to September 30, 2017, which is 12 months plus 3 days, in that cap year's calculation. For hospices using either the streamlined method or the patient-by-patient proportional method, we will count 11 months of payments from November 1, 2016 to September 30,

> 2017 for the 2017 cap year. For the 2018 cap year (October 1, 2017 to September 30, 2018), we will count both beneficiaries and payments for hospices using the streamlined or the patient-by-patient proportional methods from October 1, 2017 to September 30, 2018. Likewise, for the 2018 cap year, we will calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care or respite care) from October 1, 2017 to September 30, 2018.
>
> ****
>
> We note that the [Medicare contractors] currently send a reminder notice to hospices no later than 30 days prior to the due date of the self-determined cap. We encourage hospices to visit their respective MAC Web site regularly for announcements and updates regarding the hospice program. Please contact your [Medicare contractor] if you need information regarding the cap calculation or additional information.
>
> ****
>
> Final Action: We are finalizing the proposal and proposed methodology to align the inpatient and aggregate cap accounting year, as well as the timeframe for counting the number of beneficiaries, with the federal fiscal year. We are also finalizing the proposed changes to § 418.308(c).[45]

For ***new*** hospices, MBPM, Ch. 9, § 90.2.1 states the following:

> The hospice aggregate cap is calculated in a different manner for new hospices entering the Medicare program if the hospice has not participated in the program for an entire cap year. In this situation, the initial cap calculations for newly certified hospices must cover a period of at least 12 months but less than 24 months.
>
> Hospices and Medicare contractors shall use the proportional method when calculating the aggregate cap for all hospices which are Medicare-certified on or after October 1, 2011.

The MBPM also provides guidance on counting beneficiaries for calculation, and provides, in pertinent part:

> Each hospice's cap amount is calculated by multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period.

[45] 80 Fed. Reg. 47142, 47184-86 (Aug. 6, 2015).

> The two methods for counting beneficiaries are the streamlined method and the proportional method, and [relevant here, the proportional method is] explained below.
>
> **Proportional Method:** Under the proportional method, each hospice shall include 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 that cap year, using the best data available at the time of the calculation (subject to revision at a later time based on updated data). The whole and fractional shares of Medicare beneficiaries' time in a given cap year are then summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year.
>
> The fractional share for any given beneficiary counted using the proportional method shall be calculated as follows:
>
> Proportion = Beneficiary's Hospice Days in Cap Year in a Distinct Hospice / Beneficiary's Total Hospice Days for all Years
>
> When a hospice's cap is calculated using the proportional method, and a beneficiary included in that calculation survives into another cap year, the Medicare contractor may need to make adjustments to prior cap determinations. Reopening is allowed for up to 3 years from the date of the cap determination notice, except in the case of fraud, where reopening is unlimited. A revised cap determination letter issued as a result of a reopening may itself be reopened, subject to the 3 year limitation on reopening.[46]

The MBPM also provides beneficiary counting examples for illustrative purposes.[47]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

At the onset of the hearing, the Provider's representative indicated that she is now focusing her arguments in this appeal on the calculations for the hospice cap determination and the summary of the PS&R. She confirmed that the Provider is *no longer challenging* the time-period in which the hospice cap was determined for 2019 because she now understands that the cap period set by the Medicare Contractor is correct under the authorities in effect for that fiscal year.[48]

While the Provider indicated that it is no longer challenging the time-period used to calculate the 2019 hospice cap, to be clear, the Board will briefly address it here. The guidance in the Medicare transmittal dated June 1, 2012 (initially relied upon by the Provider in its initial appeal request)

---

[46] MBPM, Ch. 9, § 90.2.2 (Dec. 2018).
[47] The current version of the MBPM, chapter 9, is available online at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf (last accessed Sept. 26, 2023).
[48] Hearing Transcript (hereinafter "Tr.") at 6-7, 16-21, 48, 56-61, 68-69 (July 18, 2023).

was in effect and applied to the determination of aggregate caps through the cap year of 2016. However, CMS changed the period in which the hospice cap is calculated to the federal fiscal year starting in cap year 2018, as thoroughly discussed in the August 6, 2015 Federal Register, quoted above. While this change in policy was not published in MBPM, Ch. 9, § 90 until September 14, 2018, and became effective on December 17, 2018, the August 6, 2015 Federal Register explicitly described such information in great detail, and indicated that providers could find such information on their respective Medicare Contractor Websites.

Moreover, the applicable guidance in the MBPM was in effect on the date the Provider filed its appeal request in the instant case (February 3, 2021), and remains in effect. It is also available online at https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms *as well as* via a direct link provided on CMS's website for hospice services, available at https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice. The MBPM guidance is clear that the federal fiscal year is used for the 2018, and subsequent years, cap determinations. Accordingly, the Board finds that the Medicare Contractor used the correct time-period (the federal fiscal year) to calculate the Provider's 2019 hospice cap, as the Provider now acknowledges. Again, as noted above, the Provider concedes that the Medicare Contractor used the correct time-period.

With regard to the Provider's challenge to the calculation of the hospice cap, and the summary of the PS&R, the Provider argues that the calculations of the hospice cap were unfair for the 4 years in which it has been calculated for the Provider. Accordingly, the Provider seeks remedies that include a refund payment in the amount of $83,000, as well as more transparency in the PS&R report – specifically more information demonstrating how the beneficiary count is determined.[49] The Provider requests these remedies only because the Provider does not think the methodology used to calculate the hospice aggregate cap is fair, particularly to a new, small hospice provider such as itself.[50]

The Board is sympathetic to how a small hospice may potentially be hurt by the methodologies and calculations in the Medicare regulation; especially one that is new. However, the Medicare Contractor (as well as the Board) is *required* to apply the regulations and similar authorities governing the hospice cap calculation. On review of the administrative record, the Board finds that the Medicare Contractor complied with the statute and regulations and calculated the 2019 hospice cap and overpayment determination properly. Moreover, the Provider has not provided any information or documentation to support a finding that any of the calculations were wrong or how the Provider's beneficiary counts were different from that of the Medicare Contractor's beneficiary counts.[51] Further, the administrative record does not show any discrepancies such as would call the PS&R into question.

The crux of the Provider's appeal was to share with the Board its dissatisfaction with the hospice cap determination methodologies, particularly with respect to small hospice providers.[52] However,

---

[49] The Board notes that this methodology and process is available to the Provider in the regulation at 42 C.F.R. § 418.309 and is further described in the MBPM with examples, as discussed in the above Authorities section of the decision.
[50] *See* Tr. at 56-60.
[51] *Id.* at 48-50.
[52] *Id.* at 16-18, 19-21, 39-42, 48-50, 64, 68-69.

notwithstanding the fact that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue,"[53] the Provider presented no evidence or argument alleging that the methodology and calculations used by the Medicare Contractor to determine the hospice cap were based on an error under the applicable regulations. The Provider's representative asked at the hearing whether "[b]ecause our census was low at the time, as a startup, is there a way that this overpayment can be waived?"[54] Essentially, the Provider is seeking an equitable remedy, which the Board does not have the authority to offer. The regulation at 42 C.F.R. § 405.1867 limits the scope of the Board's authority as follows:

> [T]he Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

The Board does not have the power to provide equitable remedies[55] and is bound by the applicable regulations. In this matter, 42 C.F.R. § 418.309 sets forth the hospice aggregate cap calculation methods that are required to be used by the Medicare Contractor (and that the Board is required to follow per 42 C.F.R. § 405.1867).[56] The Board must also afford great weight to the applicable policies and rules, procedures and practices established by CMS per § 405.1867. In this case, the procedures outlined in the MBPM are applicable, as described herein. Accordingly, the Board finds the Medicare Contractor used the correct time-period and calculations in determining the Provider's hospice cap and overpayment amount for the hospice cap year ending on September 30, 2019.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor correctly determined the Provider's hospice cap amount for the period ending on September 30, 2019.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

12/22/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[53] 42 C.F.R. § 405.1871(a)(3).
[54] *Id.* at 69.
[55] *Sebelius v. Auburn Regional Medical Center*, 568 U.S. 145 (2013).
[56] 42 C.F.R. § 405.1867.