CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Canon Healthcare Hospice	**Reimbursement Determination for Period:**
Provider	**Nov. 1, 2004 – Oct. 31, 2005**
vs.	
Blue Cross Blue Shield Association/ Palmetto Government Benefits Administration	**Review of: PRRB Dec. No. 2011-D26**
Intermediary	**Dated: April 15, 2011**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. No comments were received from either party in this case. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether a full or partial waiver is permissible for the Provider's hospice inpatient day limitation overpayment for the cap year November 1, 2004 through October 31, 2005.

The Board held that the §1135 waiver issued by the Secretary applies in this case and found that a partial waiver of recovery of the overpayment is permitted from August 29, 2005 through October 31, 2005, the end of the cap year. The Board however denied the Provider's arguments that a full waiver is appropriate pursuant to: "extraordinary circumstances"; equitable principles; Section 1870 of the Social Security Act, or Section 1135 of the Social Security Act.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision and finds that the Board's decision should be modified. The Board lacks jurisdiction and / or the authority to render a decision on the applicability of the Secretary's §1135 waiver in this case.

Pursuant to § 1878(a)(1) of the Act, a provider has a right to a hearing before the Board, if such provider:

> (a) (1) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report….[1]
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> (2) the amount in controversy is $10,000 or more, and
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> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i)….
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> (b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matter in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is in the aggregate, $50,000 or more. (Emphasis added).

In addition, Section 1878(d) of the Act provides that: "The Board shall have the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report and to make such other revisions on matters covered by such cost reports…" Consistent with section 1878(d), the regulation at 42 C.F.R

[1] Section 1878(a)(1)(A)(ii) provides that a provider may also appeal if such a provider "is dissatisfied with a final determination of the Secretary with the amount of payment under subsection (b) [TEFRA] or (d) [IPPS] of section 1886."

405.1869 explains that the "Board shall have the power to affirm, modify or reverse a determination of an intermediary with respect to a cost report"…

The regulation at 42 C.F.R §418.311 provides that:

> A hospice that believes its payments have not been properly determined in accordance with these regulations may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least $1,000 or $10,000, respectively. In such a case, the procedure in 42 C.F.R Part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under §405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the payment rates by CMS are not subject to appeal.

The appeal procedures of 42 C.F.R Part 405, Subpart R, consistent with the statutory language of § 1878 of the Act, provide at 42 C.F.R. § 405.1835(a) that a provider has a right to a hearing before the Board, if:

(1) the provider has preserved the right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by either-

   (i) including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(2) The amount in controversy… is $10,000or more; and…

   (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; ….

Related to this case, according to 42 C.F.R. §405.1801(a)(2008), an "intermediary determination" is defined as:

> (1) [A] determination of the amount of total reimbursement due the provider, pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.
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> ….

> (1) For purposes of [405.374][2] concerning claims collection activities, the term does not include an action by CMS with respect to a compromise of a Medicare overpayment claim or termination or suspension of collection action on an overpayment claim against a provider or physician or other supplier.

With respect to the determination of the intermediary, the regulation at 42 C.F.R. §405.1803 specifically requires an intermediary determination to be made pursuant to notice of amount of program reimbursement or "NPR" and also allows the use of the notice as a basis for recovery of overpayments.[3] In addition, section 405.1803(a)(3) states that:

> (3) Hospice caps. With respect to a hospice, the reporting period for the cap calculation is the cap year; and the intermediaries' determination of a program reimbursement letter, which provides the results of the inpatient and aggregate cap calculation, shall serve as a notice of program reimbursement. The time period for filling cap appeals begins with receipt of the determination of program reimbursement letter.

By letter dated December 5, 2007, the Provider timely appealed its "Notice of Effect of Inpatient Day Limitation and Hospice Cap" amount dated June 11, 2007.[4]

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[2] This provision of 42 C.F.R 405.1801 was unchanged from the pre-2008 language which referred to 42 C.F.R 405.374.

[3] Subsection (c) states:

> The intermediary's determination contained in its notice is the basis for making the retroactive adjustment…to any program payments made to the provider during the period to which the determination applies, including recoupment under § 405.373 from ongoing payments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under §§ 405.1811 or 405.1835.

[4] Initially, the Provider characterized its appeal as: Issue No. 1, whether the Intermediary should be able to recover all or part of the 2005 overpayment because "extraordinary circumstances" prevented it from complying with the inpatient day limitation at 42 CFR 418.302(f) or even mitigate the effect of non-compliance; and Issue No. 2, whether the Intermediary should be prevented from collecting the alleged overpayment because the Provider relied, to its detriment, on the Intermediary's prior determination of compliance for the 2003 and 2004 cap years

The core issue in this case stems from the Medicare program's provision of coverage for terminally ill beneficiaries who elect to receive care from a participating hospice. The Medicare program reimburses hospices for 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. The hospice implementing regulations provide for payment in one of four prospectively determined categories, routine home care, continuous home care, inpatient respite care, and general inpatient care, based on each day a qualified Medicare beneficiary is under a hospice election.[5] The Medicare program also limits total reimbursement to a hospice for a fiscal year. Under that limit, the cap amount, is generally calculated by multiplying the cap amount by the number of Medicare beneficiaries allocated to the hospice program for that year according to CMS rules. The intention of the cap was to ensure that payments for hospice care would not exceed the amount that would have been spent by Medicare had the patient been treated in a traditional setting. The regulations also impose a limitation on payment for inpatient care days, which is "subject to a limitation that total inpatient care days for Medicare patients not exceed 20 percent of the total days for which these patients had elected hospice care."[6]

The parties agree that there is no dispute that the overpayment amount is correct and that the Provider was properly notified, of the overpayment.[7]

The Provider makes four arguments to suggest waiver of the collection of the overpayment that occurred as a result of the inpatient day limitation determination. The arguments respectively involve: extraordinary circumstances, equity, Section 1870 of the Social Security Act; and Section 1135 of the Social Security Act, which the Provider claims all prohibit the recoupment of the overpayment. The Administrator finds, that the Board properly determined that equitable relief is not available in this case and that 42 C.F.R 418.302(f) does not provide an exception

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and absent those erroneous determinations, the Provider would have discovered any deficiencies in its inpatient percentages, monitoring procedures and been able to correct an overages of inpatient care in the cap year in 2005. In the final position paper, dated August 1, 2008, the Provider added two further arguments (or issues): Issue No. 3, whether the Intermediary was prevented from recouping any overpayments under Section 1870 of the Act; and Issue No. 4, whether the Intermediary is prevented from recouping any overpayment because the Secretary waived any non-compliance when he issued a Katrina-related wavier under Section 1135 of the Social Security Act.

[5] *See*, 42 C.F.R. §418.302.
[6] *See*, 42 C.F.R. §418.302(f).
[7] Transcript of Oral Hearing at 36.

for "extraordinary circumstances."[8] The provider argues that Section 1870 of the Social Security Act allows for waiver of recovery of overpayments in certain circumstances. That section of the Act states:

> (b) Incorrect payments [made] on behalf of individuals; payment adjustment
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> Where –
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> (1) More than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount…

However, the Administrator finds that the Board properly determined that Section 1870 is not applicable to the facts of this case.

Finally, the Provider also relies on the provision of section 1135 of the Social Security Act, stating that Congress authorized the Secretary to waive certain Medicare requirements during national emergencies.[9] Section 1135 of the Social Security Act states, in pertinent part that:

> (a) Purpose.
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> The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1) –

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[8] The Administrator notes that the Provider's cap notice for the period ending October 31, 2005 shows days in excess of the allowable days of 2012 days. The days in excess of allowable days for the cap year 2005 at issue was 1748 days. The record shows that even if the days for September and October 2005 are removed from the day limitation calculation, the Provider was still operating significantly over the 20 percent limitation for th preceding 10 months of the 2005 cap year.

[9] See, Provider's Exhibit P-5.

> (1) that sufficient health care items and services are available to meet the needs of individuals in such area enrolled in the programs under subchapters XVIII, XIX, and XXI; and
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> (2) that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) Secretarial authority.

To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to –

(1) (A) conditions of participation or other certification requirements for an individual health care provider or types of providers,

(B) program participation and similar requirements for an individual health care provider or types of providers, and

(C) pre-approval requirements;

> (2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

Among other things, the Provider claims that application of the §1135 waiver would allow the Provider's aggregate overpayments to be properly waived in this case.

The record shows that Secretary Michael Levitt signed the §1135 Waiver on September 4, 2005, due to the effects from Hurricane Katrina.[10] The Provider apparently unsuccessfully requested approval to waive the conditions of participation patient day limitation at 42 CFR 418.98(c)[11] and, thus, indirectly to also waive repayment of its aggregate overpayments for hospice services pursuant to the waiver.[12] On April 26, 2006, CMS responded to the Honorable Louisiana Congressman, Bobby Jindal, whom submitted a request to the Secretary on behalf of Dr. Shiva K. Akula, the Provider's President (of Canon Health Care) requesting the Secretary's application of the §1135 waiver to the 42 C.F.R 418.98(c), the Inpatient Care Limitation, due to decreasing population in the New Orleans area of Louisiana. The Secretary, through the CMS Regional Office, responded as follows:

> This is in response to your inquiry on behalf of Dr. Shira K. Akula, president of Canon Healthcare…. Dr. Akula is requesting a waiver for the requirement at 42 C.F.R 418.98(c), inpatient care limitation, due to the decreasing population of the New Orleans area of Louisiana. The regulation at 42 C.F.R 418.98(c) states the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in any 12-month period preceding a certification survey in a particular hospice may not exceed 20 percent of the total number of hospice days for this group of beneficiaries. While this 20% requirement is listed in the Medicare conditions of participation, enforcement and payment of this requirement falls under policy.
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> ….
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> Dr. Akula believes [that] these regulations refer[s] to the number of patients, i.e. you must have 80 outpatients for every 20 inpatients. He states he cannot meet this requirement due to the decreasing population in the New Orleans area of Louisiana. Both regulations

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[10] *See*, Provider's Exhibit P-5.

[11] The Provider's letter requesting the waiver is not part of the record.

[12] A Secretary declaration of a waiver or modifications of the requirements under Section 1135 of the Social Security Act generally means a provider may submit a request to operate under that authority and does not provide an automatic blanket application to classes of providers unless specifically so designated. See e.g. Requests for §1135 Waiver (Revised November 4, 2009) ("Once an 1135 Waiver is authorized, health care providers can submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office with a copy to the State Survey Agency." …. Information on your facility and justification for requesting the waiver will be required.)

> [i.e., 42 CFR 418.98(c) and 42 CFR 418.302(f)] refer to the number of patient days, not number of patients. Therefore, the rationale for the need to waive this regulation, as provided by Canon Health Care, does not conform with the regulatory requirement.[13]

The Provider exercised its opportunity to seek and acquire the Secretary's approval to apply the §1135 waiver by having its Congressman inquire to the Secretary on its behalf. CMS, and thus, the Secretary, denied the Provider's request as inappropriate and unnecessary. In contrast, the scope of the Board authority and jurisdiction is limited to matters in dispute with respect to the Intermediary determination as to the amount of payment. The Administrator finds that the Board has no authority or jurisdiction to grant a §1135 waiver under section 1878 of the Act or the regulations at part 405 subpart R. Moreover, the Secretary's authority in this regard is of the Secretary's sole discretion and has already been decided adverse to the Provider. Accordingly, as the Board does not have jurisdiction or authority over the Secretary's waiver authority determinations, the decision of the Board is modified as to whether the Provider is eligible for a full or partial wavier for its hospice inpatient day limitation overpayment for the cap year November 1, 2004 through October 31, 2005.

In sum, the Administrator finds that there is no authority to allow a partial or full waiver of the overpayment.[14] The Administrator finds that Board properly determined that the inpatient day limitation at 42 C.F.R §418.302(f) does not provide an exception for "extraordinary circumstances." The Board also properly determined that the Provider's argument, that equity prevents the recoupment of overpayments, is not supportable under the law and is outside the scope of authority of the statutorily created board and the controlling statute and regulations. In addition, the Board properly determined that Section 1870 of the Social Security Act does not apply in this case as it is intended for individual beneficiary claims. Finally, the Board incorrectly determined that the provider was properly granted a §1135 waiver for the period August 29, 2005 through October 31, 2005.

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[13] Intermediary Exhibit I-2. *See* also Transcript of Oral Hearing at 104-110 referring to other Provider communications with CMS and the CMS distinction between conditions of participation and payment policy. (Provider Witness: "[T]he response we got was that this is a payment regulation and it is not covered by the §1135 waiver." Tr. At 109)

[14] Finally, generally the regulation at 42 C.F.R 405.374 and 405.376 control the scope and procedures for the compromise of, or suspension or termination of collection action on, claims for overpayment against a provider and is adopted pursuant to the Federal Claims Collection Act which is separate and distinct authority from the Board review authority authorized by Section 1878 of the Social Security Act and the regulations over intermediary payment determinations.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion,.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 6/13/11 /s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services