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, 2005-Oct. 31, 2006**
vs.	
BlueCross BlueShield Association/ Palmetto Government Benefits Administration	**Review of: PRRB Dec. No. 2012-D15**
Intermediary	**Dated: April 13, 2012**

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. Comments were received from CMS' Office of Financial Management (OFM) and the Center for Medicare (CM) requesting reversal of the Board's decision. 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, 2005 through October 31, 2006.

The Board modified the Intermediary's determination and found that the §1135 waiver applies in this case. The Board denied the Provider's request for a waiver of the entire overpayment but found that a partial waiver of recovery of the overpayment was permitted for the period of time directly related to Hurricane Katrina, which in was November 1, 2005 through January 31, 2006.

COMMENTS

CM submitted comments stating that the Board incorrectly determined that the overpayments determined by the Intermediary are within the scope of §1135. CM points to a similar Administrator Decision Number 2011-D26 which found that the Board neither had the authority or jurisdiction to grant a §1135 waiver, nor did it have the authority to allow for a partial or full waiver of payments.

CM argues that there is no legal option to waive the inpatient cap, which is not subject to waiver under §1135. The §1135 waiver applies to Conditions of Participation, and does not apply to payment rules or regulations. The inpatient cap, as described at 42 C.F.R. §418.302, is a reimbursement limit, and thus a condition for payment rather than a condition of participation. As such, the waiver at issue allowed a hospice to provide hospice care in an inpatient setting over and above the inpatient cap without violating a condition of participation, but it did not waive the payment regulations at 42 C.F.R. §418.302(f); consequently, Medicare could not pay anything over and above the inpatient cap. CM further points out that if Canon Healthcare Hospice had been cited for violating the conditions of participation, it could have used the §1135 waiver as a defense against deficiency, but the remedy would not have been to waive overpayments.

OFM submitted comments stating that the Board lacks the authority to grant the type of waiver at issue and that such authority only resides with the Secretary. According to OFM, the statute states that the Secretary can grant relief during emergency conditions. OFM called attention to the fact that the Secretary did review and consider the Provider's request for retroactive relief from the inpatient Hospice cap and was denied such relief by the CMS Regional Office action on behalf of the Secretary. Furthermore, a review of §1135(c) states that any Authority for Retroactive Waiver is at the Secretary's discretion and, based on the timeline found in the Administrator's prior decision in ADMR Dec. No. 2011-D26, this appears indeed to have been a retroactive request.

OFM stated that it was heavily involved in the Katrina emergency and the implementation of §1135 waivers, and to its recollection, no waiver of Medicare policy for Hospice inpatient caps was considered nor identified. In addition, the CMS Regional Offices were even more involved in the day-to-day scope of the §1135 waiver authority, which is further evidence that the Secretary specifically did not grant relief for Hospice inpatient caps and supports their initial conclusion that this was a retroactive request, since no inquiry or a response would have been necessary if the Secretary had included the waiver notice specific relief for this program policy.

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]
>
> (2) the amount in controversy is $10,000 or more, and
>
> (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)….
>
> (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 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"…

---

[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."

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.
> ….
> (1) For purposes of [405.374][2] concerning claims collection activities, the term does not include an action by CMS with

[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.

> 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.

On April 28, 2008, the Intermediary issued a "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount," advising the Provider that it was overpaid by Medicare because it exceeded the twenty percent limitation on inpatient days for the hospice cap year ended October 31, 2006.[4] The Provider subsequently appealed the Intermediary's adjustments to the Board.

The 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,

---

[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] *See*, Provider's Exhibit P-1.

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

> (b) Incorrect payments [made] on behalf of individuals; payment adjustment
>
> Where -
>
> (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

[5] *See*, 42 C.F.R. §418.302.
[6] *See*, 42 C.F.R. §418.302(f).
[7] *See*, Intermediary's Final Position Paper at 5.
[8] The Administrator notes that the Provider's cap notice for the period ending October 31, 2006 shows days in excess of the allowable days of 1722 days.

> 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. Section 1135 of the Social Security Act states, in pertinent part that:

> (a) Purpose.
>
> 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) -
>
> > (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
> >
> > (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 full or alternatively, in part 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.[9] The Administrator finds that the Secretary's issuance of the September 5, 2005 §1135 waiver is not a "blanket" waiver for Louisiana health care institutions to become "non-compliant" with aspects of the Medicare reimbursement system that was not contemplated by the Secretary. The Board's assertion that the Secretary's issuance of the September 5, 2005 §1135 waiver effectively exempts providers in Louisiana from having to submit individual or formal waiver requests to waive certain aspects of Medicare requirements is improper. Quite opposite, the Secretary's §1135 waiver issuance provides an opportunity for the Secretary to use his or her statutory discretion to decide on which aspects of Medicare requirements should be waived to assure public safety and the delivery of health care to the Louisiana population given the circumstances presented by Hurricane Katrina. The Secretary never waived the obligation to recoup overpayments made to providers or allowed providers to keep Medicare dollars as profit in the face of a decrease in patient utilization caused by Hurricane Katrina. Issuance of an §1135 waiver is not an excuse for non-compliance that falls outside the scope of the Secretary's intent or subsequent disapproval (as is the case for this particular Provider) through requests made to the Secretary.[10]

---

[9] *See*, Provider's Final Position Paper at 12; Exhibit P-7.

[10] *See*, Canon Health Care Hospice, LLC, ADM. Dec. No 2011-D26 (April 15, 2011) where the Administrator addressed the same issue presented in the current case but impacted the 2005 Cap year. In that case, the Provider exercised its

Furthermore, other than the date of issuance, nothing in the record, the plain language of the statutory authority, nor the history of the Secretary's issuance of the §1135 waiver indicates that the Secretary intended to retroactively apply the §1135 waiver to Medicare requirements other than Conditions of Participation. The Secretary's §1135 waiver of certain aspects of the Medicare Conditions of Participation does not automatically and retroactively apply to waive the payment regulations such as those found in 42 C.F.R §418.302(f) for the inpatient cap. In fact, the Secretary's November 4, 2009 publication "Requesting an 1135 Waiver" is an indication that the Secretary's issuance of an §1135 waiver in the time of crisis is intended to preserve public safety in emergency situations such as Hurricane Katrina while at the same time preserving the fiscal integrity of the Medicare Trust Fund.

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, 2005 through October 31, 2006.[11] In sum, the Administrator finds that there is no authority to allow a partial or full waiver of the overpayment.[12] The Board properly determined that the Provider's argument that equity prevents the recoupment of overpayments

---

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. The CMS and, thus, the Secretary, denied the Provider's request as inappropriate and unnecessary. As such, the Secretary has already exercised its discretionary authority and rendered a decision specifically adverse to this Provider. Neither the Provider nor Secretary acted as if the Secretary's §1135 Waiver, dated September 4, 2005, was a blanket exemption as the Board found in its decision. The Administrator's Decision in that case is herein incorporated by reference.

[11] The Board concurs with the Administrator's ruling that the Board does not have the authority jurisdiction to grant a §1135 under Section 1878 of the Act, however it attempts to distinguish its inability to "grant" a waiver as opposed to "addressing whether the waiver is applicable."See, Canon Health Care Hospice, LLC, PRRB Dec. 2012-D15, page 8. The Administrator finds that there is no such distinction since the end result would allow the Board to make a decision that is reserved solely for the discretion of the Secretary.

[12] 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 from appeals allowed under the procedures authorized by Section 1878 of the Social Security Act.

is not supportable under the law and outside the scope of authority of the statutorily created board. 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. Further, the Administrator finds that the inpatient day limitation at 42 C.F.R §418.302(f) also does not provide an exception for "extraordinary circumstances."

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: 6/6/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services