

## HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### CMS Proposes A Cure For The Hospice Cap: Watch For Side Effects

July 18, 2011

After losing numerous court cases challenging its system for computing the hospice cap and facing dozens of additional claims, the Centers for Medicare & Medicaid Services (CMS) has issued an administrative ruling and a proposed rule providing a new methodology for computing the hospice cap. However, while offering the potential for greater reimbursement, the new methodology appears to be significantly more cumbersome and labor-intensive than the previous hospice cap calculation.

#### **Background and Basis of Dispute**

In 1982, the statutory law governing Medicare expanded to cover hospice services.<sup>1</sup> The revised statute included a provision subjecting payments to each hospice to an annual cap. Congress' intent in implementing the cap was to guarantee that the costs to Medicare of treating a patient on hospice would not exceed the amount spent in treating the same patient in the traditional setting.<sup>2</sup> Any payment in excess of the statutory cap is considered an overpayment and requires refund by the hospice to CMS.<sup>3</sup> The cap is calculated based on the number of Medicare beneficiaries that receive services at the individual hospice and the total payments that Medicare makes to the individual hospice provider in a single year, as calculated from November 1 to October 31.<sup>4</sup> More specifically, the statute offers the following definition:

the "number of [M]edicare beneficiaries" in a hospice program in an accounting year is equal to the number of individuals who have made an election under subsection (d) of this section with respect to the hospice program 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 account year** or under a plan of care established by another hospice program [emphasis supplied].<sup>5</sup>

<sup>1</sup> See The Tax Equity Fiscal Responsibility Act of 1982, Pub. L. No. 97-248.

<sup>2</sup> H.R. Rep. 98-333, at 1, as described in Hospice of New Mexico, LLC v. Sebelius, 2010 U.S. Dist. LEXIS 26444, (March 5, 2010) at 4. See also Medicare Payment Advisory Commission (MedPAC) Report to the Congress, Medicare Payment Policy, March 2010, available at [http://www.medpac.gov/documents/Mar10\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar10_EntireReport.pdf), at p. 144.

<sup>3</sup> *Id.*

<sup>4</sup> 42 U.S.C. § 1395f(i)(2)(A).

<sup>5</sup> *Id.* at § 1395f(i)(2)(C) (bold added).

In 1983, the Department of Health and Human Services (HHS) issued regulations implementing the statute that included definitions and calculations surrounding the cap. The regulation calculates each hospice's cap amount 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."<sup>6</sup> The number of beneficiaries in a given year is defined differently in the regulations than in the statute. The regulatory definition is:

[t]hose 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...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).<sup>7</sup>

As can be seen, the regulatory definition does not track the statutory language providing for allocation of a beneficiary's treatment across the years in which that treatment is received. Historically, this difference has not created much controversy because the number of hospices exceeding the cap has been low. However, in recent years more hospices are exceeding the cap due to increases in the number of hospices and increases in very long hospice stays for some patients.<sup>8</sup>

### **Litigation**

While the regulation remains unchanged since 1983, hospices began challenging CMS' hospice cap calculation in federal court in recent years, asserting that the regulation used to calculate the hospice cap is invalid because it fails to follow the statutory requirement to allocate cap allowances for each patient proportionally across years of treatment. The cases claim that the failure to account for hospice patients' treatment across more than one cap year results in overstated allowances in prior years and devalued allowances and therefore higher demands for repayment to CMS in later years. For example, if someone enrolled in hospice on September 20, 2008, and lived one hundred eighty days, the hospice cap allowance for that patient would be attributed to the 2008 cap year, despite the fact that the majority of Medicare payments received by the hospice for that patient would occur in 2009. Within the past two years, numerous federal district courts have issued rulings in favor of the hospices, finding the regulation to be inconsistent with the statutory language and therefore invalid. However, rather than eliminating any cap liability, the courts have remanded the matter back to the Provider Reimbursement Review Board (PRRB) for a re-determination of the provider's cap liability based on the statutory language rather than the regulation.<sup>9</sup>

### **Administrative Ruling and Proposed Rule**

On May 9, 2011, CMS released a proposed rule providing an alternative method of calculating the hospice cap.<sup>10</sup> Referred to as the "patient-by-patient proportional methodology" or

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<sup>6</sup> 42 C.F.R. § 418.309(b).

<sup>7</sup> 42 C.F.R. § 418.309(b)(1).

<sup>8</sup> Medicare Payment Advisory Commission (MedPAC) Report to the Congress, Medicare Payment Policy, March 2010, available at [http://www.medpac.gov/documents/Mar10\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar10_EntireReport.pdf), at p. 145. According to MedPAC, 10.4% of hospices exceeded the annual payment cap in 2007, compared to 2.6% in 2002; the percentage steadily grew each year between 2002 and 2007. The increase may partially be the result of increased enrollment of patients with non-cancer diagnoses, who tend to have longer hospice stays and provide more challenge in predicting life expectancy. In addition, hospices exceeding the cap tend to be for-profit, free standing facilities with smaller patient loads and a greater share of patients with Alzheimer's and other neurological disorders.

<sup>9</sup> For example, see Russell-Murray Hospice, Inc. v. Sebelius, 724 F.Supp.2d 43 (D.D.C. July 20, 2010); see also Autumn Light Hospice v. Sebelius, No. 2011 WL 102525 (W.D. Ok. Jan. 12, 2011). To our knowledge, the PRRB has yet to issue any such re-determination.

<sup>10</sup> 76 Fed. Reg. 26806 (May 9, 2011).

"proportional methodology," the calculation will prorate beneficiaries' hospice care across the years in which the beneficiary received the care. Simultaneously with this proposed rule, CMS gave notice of Ruling CMS-1355-R (Ruling), effective April 14, 2011.<sup>11</sup> Under the Ruling, CMS will grant relief to any hospice that currently has a proper hospice cap appeal pending in the administrative system (either with the PRRB or CMS). The relief shall consist of sending the case back to the appropriate Medicare contractor to have the hospice cap recalculated using the proportional methodology as opposed to the prior cap calculation.

### **What Are The Side Effects?**

While the current methodology varies from the statutory requirements, the new proportional methodology as proposed adds complexity to the calculation. Instead of counting total Medicare beneficiaries enrolled in the hospice as of a certain start date, the proportional methodology calculates Medicare beneficiaries using a fraction representing the portion of a patient's total days of care (in *all* hospices in *all* years) that were spent in that particular hospice in that particular cap year. Presumably in recognition of the fact that hospices may not possess all information about a patient's days of care in other hospices in other years, CMS notes that hospices will have to use the best data available at the time of the calculation. However, the data could be open to recalculation by the CMS intermediary or otherwise in the future when better or more comprehensive data becomes available. As a result, many hospices may be looking at a protracted reimbursement process.

### **Implications**

Under the proposed rule, hospices will be able to choose whether to use the old system (the "streamlined methodology") or the new proposed proportional methodology. However, under the rule as proposed, once a hospice uses the proportional methodology, either to re-calculate the amount due under a currently pending challenge or to calculate a hospice cap for 2012 or in the future, the hospice cannot switch back to using the streamlined methodology. Hospices should carefully analyze which method would best serve them, both in terms of hospice cap calculation and resources necessary to calculate and submit the documentation required under the methodologies. For hospices currently facing repayment to CMS for a cap violation this year, the hospice might consider filing a claim with the PRRB if the period of appeal is still open and if the proposed proportional methodology would considerably influence the amount owed.

If you have any questions, please do not hesitate to contact any of the attorneys in our Healthcare Practice Group listed below.

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<sup>11</sup> 76 Fed. Reg. 26731 (May 9, 2011).

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