Published on *The National Law Review* https://natlawreview.com

PRRB Sides With CMS On Hospice Cap Sequestration – Federal Court Next

Article By:

Brian M. Daucher

On Thursday, February 28, 2019, two years after hearing arguments in lead group cases, the Provider Reimbursement Review Board affirmed CMS' approach to counting sequestered funds as part of provider revenue for hospice cap calculations.

In 2012, to address budget deficits, Congress passed the Budget Control Act, providing for, among other things, a 2% reduction in all payments to Medicare providers. Beginning in fiscal year 2013, acting under Executive Order, CMS began reducing payments to Medicare providers by 2% across the board.

Hospices were no exception. A hospice entitled to payment of $100 has since 2013 received just $98; $2 of each $100 have been withheld and never paid.

In addition to facing sequestration, hospice providers also face the hospice cap. An objective creature of statute, the hospice cap provides that if the "amount of payment made" to a provider in a given fiscal year exceeds the total of its cap allowances (a function of the number of patients served), then the hospice must repay the difference. As sequestration began, these two mechanisms came into conflict.

At first, Medicare's contractors continued to calculate the cap simply by looking only at amounts *actually paid* to hospices and comparing these amounts to allowances accrued by each hospice. But in late 2014, CMS called a halt and withdrew prior demands.

Although no public announcement was made, discovery has shown that in early 2015 CMS issued a Technical Direction Letter, instructing its contractors to revise the cap calculation by *adding* the amount of sequestered funds for each provider (i.e., funds *never paid* to the provider) to amounts actually paid for purposes of the "amount of payment made" calculation. Following these secret instructions, Medicare's contractors began issuing cap demands that were inflated by a payment side figure including not only amounts paid but also amounts *never paid*. Any hospice exceeding the cap was first asked to pay back dollars it had never received, such as the $2 withheld in the example above.

Hundreds of hospice providers have appealed cap demands based upon this calculation, asserting

that the demands are overstated because the contractors have failed to measure just “the amount of payment made” in carrying out the calculation. As appeals have dragged on, contractors have continued to apply this practice year after year. This author estimates that, in the last five years, CMS may have overstated hospice cap demands by more than $100 million by including sequestration (amounts never paid) in the payments-made side of the cap equation.

In affirming this practice, the PRRB asserts that CMS is doing nothing wrong in counting funds withheld and not paid as part of the “amount of payment made.” The PRRB claims that this practice is justified because, by virtue of the cap calculation that CMS has specified (to add sequestered funds to actual payments), the sequestered money is in fact “paid” to the provider, even if only in an imaginary (non-remunerative) sort of way. None of us would like to be taxed on income not paid to us, but there you have it.

The PRRB ignores the statutory injunction to count only “payment made,” just as it shuns CMS’ own regulations and policy pronouncements which innocently declare that only “actual” payments count.

Although the PRRB decision is disappointing on an intellectual level, providers are grateful for its issuance as they may now move on to the refreshingly open and public forum of the Federal Courts.

If our government can by sleight of hand count as “payment made” funds never actually paid to providers, then statutory injunctions are no barrier to the whims of our bureaucratic officials. Federal Judges will have to answer this question.

Ashton Massey contributed to this piece.

National Law Review, Volume IX, Number 65