

## **Court in Texas Rules on Hospice Caps**

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On February 22, 2010, a federal court in Texas ruled that regulations of the U.S. Department of Health and Human Services (DHHS) imposing a statutory cap on Medicare payments for hospice care are arbitrary and capricious and cannot be implemented. The judge granted summary judgment to the hospice, which means that the Court decided that both the law and the facts are in favor of the hospice or plaintiff [*Lion Health Services, Inc. v. Sebelius*, No. 4:09-CV-493-A (N.D. Tex. Feb. 22, 2010)].

Previously, on July 13, 2009, a federal court in California ruled in favor of Los Angeles Haven Hospice, Inc. and said that the statutory cap on Medicare payments for hospice payments is invalid [*Los Angeles Haven Hospice, Inc. v. Sebelius*, No. CV-08-4469 (C.D. Cal. July 13, 2009)]. The U.S. District Court for the Western District of Oklahoma also previously decided on July 10, 2009 that Compassionate Care Hospice could challenge statutory caps on Medicare payments [*Compassionate Care Hospice v. Sebelius*, No. 5:09-cv-00028-C (W.D. Okla. July 10, 2009)].

Like the Court in California, the U.S. District Court for the Northern District of Texas decided that caps on payments to hospices under the Medicare hospice benefit conflict with a clear Congressional directive for calculating the annual provider cap. Consequently, the Court ruled that DHHS cannot collect overpayments from the hospice that initiated the suit. The Court also decided that DHHS cannot use the regulation to calculate the hospice's payment cap for past, present, or future accounting years. The Court further ordered DHHS to refund all monies repaid to the Medicare Program by the hospice for the accounting years 2006 and 2007 in the amounts of \$1,137,113 and \$1,124,637, respectively.

After the Provider Reimbursement Review Board decided it did not have the authority to decide the legal question of whether Section 418.209(b) is valid, the hospice filed suit claiming that the regulation is contrary to the language of the governing statute. According to the statute, the amount paid for hospice care for an accounting year is limited to a "cap amount" for the year "multiplied by the number of Medicare beneficiaries in the hospice program in that year." The statute provides that the number of Medicare beneficiaries for purposes of this calculation should be "reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year..."

The implementing regulation, Section 418.309(b), however, calculates each hospice's cap amount using "the number of Medicare beneficiaries who elected to receive hospice care during the cap period." The hospice argued that the regulation was invalid because it includes an individual in a single accounting year depending on when the individual filed an election to receive hospice care, rather than requiring a proportional adjustment as specified by the statute.

The Court stated that Congress clearly indicated in the statute how the number of beneficiaries should be calculated.

By its plain language, the statutory requirement that the number be 'reduced to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent accounting year' can only be accomplished in one way: each such individual who was also provided care in other accounting years must be counted toward the 'number of beneficiaries' in that year as a fraction...

Section 418.309(b)(1) clearly does not follow the method described in §1395f(i)(2)(C)...rather than merely to 'reduce' the number of individuals who were provided care in a particular accounting year, the regulation completely excludes individuals who did not elect benefits in that accounting year...

Hospice providers will surely want to stay up-to-date on developments in these cases.