PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2025-D45

PROVIDER –
Partners In Care Hospice, LLC

PROVIDER NO. –
A0-1712

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
August 13, 2024

FEDERAL FISCAL YEAR –
2023

CASE NO. –
23-0312

INDEX

ISSUE STATEMENT

Whether the imposition of a two (2) percentage point reduction to Partners in Care Hospice, LLC's Federal Fiscal Year ("FFY") 2023 Annual Payment Update ("APU") under the Hospice Quality Reporting Program ("QRP") was proper.[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that CMS' decision to reduce Partners in Care Hospice, LLC's APU by two (2) percentage points for FFY 2023 was proper.

INTRODUCTION

Partners in Care Hospice, LLC, dba PIC Comfort Care ("PIC" or "Provider") is a Medicare certified hospice provider located in Auburn, California.[2] PIC's assigned Medicare contractor[3] is National Government Services, Inc. ("Medicare Contractor").[4]

By letter dated July 6, 2022, the Medicare Contractor notified PIC that its APU would be reduced by two (2) percentage points for FFY 2023 due to non-compliance with the Affordable Care Act (ACA) requirement for hospices to submit quality data.[5] Specifically, the Notice stated that PIC was noncompliant with the quality data reporting requirements for the timely submission of Hospice Item Set ("HIS") data.[6]

On August 4, 2022, PIC submitted a reconsideration request to CMS.[7] By letter dated September 20, 2022, CMS notified PIC that it was upholding the two (2) percentage point reduction to PIC's FFY 2023 APU, citing a finding that "this hospice did not provide evidence that it submitted required quality measure data during the required timeframes."[8] On November 28, 2022, PIC timely appealed CMS' reconsideration determination to the Board and met the jurisdictional requirements for a hearing.[9]

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[1] Revised and Supplemented Joint Stipulations of Undisputed Facts and Principles of Law (hereinafter, "Stip.") at ¶ 3 (Jul. 18, 2024).
[2] *Id.* at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted to organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs as appropriate and relevant.
[4] Stip. at ¶ 2.
[5] *Id.* at ¶ 4. *See also,* Exhibit (hereinafter, "Ex.") P-10 at P028 (NGS Letter of Non-Compliance – July 6, 2022).
[6] Ex. P-10.
[7] Stip. at ¶ 5. *See also,* Ex. P-11 (Request for Reconsideration FY 2023 – August 4, 2022).
[8] Ex. P-12 (CMS Denial of Reconsideration - September 20, 2022).
[9] Provider's Appeal Request at 1 (Nov. 28, 2022).

The Board granted a record hearing on August 13, 2024. PIC was represented by Burt Wilson, CEO of Partners in Care Hospice, LLC. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS

Per PIC, it received its hospice accreditation on February 28, 2020.[10] The COVID-19 pandemic began shortly thereafter, causing PIC to reallocate resources. PIC's FY 2023 Reconsideration Request identified the following issues:

- leadership staff have been out in the field seeing patients due to our staffing shortages
- limited staff that we have are periodically required to quarantine for COVID-19 exposure or positive tests, etc., adding another layer of stress and uncertainty around our operations
- additional workloads relating to the numerous COVID compliance requirements and ongoing refinements and revisions coming from CMS, CDC, CDPH, CDDS, OSHA, Cal OSHA, CDSS and county and local health departments.
- set up and administer ongoing a COVID-19 testing program for our staff and patients
- set out to source limited COVID-19 testing options, source limited PPE (personal protective equipment) etc.[11]

Fiscal Year 2022

Calendar year 2020 Hospice QRP HIS and CAHPS reporting requirements/submissions impacted the annual payment update for FY 2022.[12] PIC was not compliant with FY 2020 reporting[13] and attributes its FY 2022 noncompliance to a CCN number entry issue and confusion about the exemption process/period and changes during the pandemic regarding due dates.[14] Consequently, CMS re-opened the reconsideration period for the FY 2022 Hospice QRP, citing "[t]he hospice may have been directly impacted in its timely submission of Calendar Year (CY) 2020 quality data due to staffing shortages or other unexpected issues due to

[10] *See* Ex. P-11 (Provider's FY 2023 Reconsideration Request) at P031 (Aug. 4, 2022).
[11] *Id. See also* Ex. P-7 at P017 (Provider's FY 2022 Reconsideration Request) (May 13, 2022).
[12] *See* Ex. C-2 at C-0011 (Hospice Quality Reporting Program Requirements for the Fiscal Year (FY) 2021 and Future FY Reporting Years (Last Updated October 2019)).
[13] *See* Ex. P-1 at P001 (CMS Notification of Non-Compliance with the Hospice Quality Reporting (QRP) Data) (July, 8, 2021 – for FFY 2022).
[14] *See* Ex. P-7 at P017.

circumstances surrounding the COVID-19 Public Health Emergency (PHE)."[15] In a determination dated July 21, 2022, **CMS reversed its FY 2022 noncompliance decision**.[16]

Fiscal Year 2023
Calendar year 2021 Hospice QRP HIS and CAHPS reporting requirements/submissions impacted the annual payment update for FY 2023.[17] For this determination period, at least "90% of all HIS assessments must be submitted within 30 days of the event date (admission or discharge)" to avoid the payment reduction.[18] On July 6, 2022, CMS, through National Government Services, notified PIC that it was not compliant for meeting the quality requirements and that its Medicare payment for FY 2023 would be reduced by 2 percentage points.[19] On August 4, 2022, PIC requested reconsideration, citing the continuing impact of COVID-19 on its organization, creating staff shortages, and the need to redirect resources.[20] PIC also reported to CMS that it had instituted a performance improvement plan and would be "sending in HIS twice a month to make sure to meet the 30-day mark."[21] In a determination dated September 20, 2022, **CMS upheld its FY 2023 noncompliance decision**.[22]

STATEMENT OF RELEVANT LAW

A. Form, Manner, and Time

The data submission requirements for the Hospice Quality Reporting Program are set forth in 42 C.F.R. § 418.312 (Oct. 1, 2021), which states, in pertinent part:

> (a) General rule. Except as provided in paragraph (g) of this section, Medicare-certified hospices must submit to CMS data on measures selected under section 1814(i)(5)(C) of the Act in a form and manner, and at a time, specified by the Secretary.
>
> (b) Submission of Hospice Quality Reporting Program data.
>
> (1) Standardized set of admission and discharge items Hospices are required to complete and submit an admission Hospice Item Set (HIS) and a discharge HIS for each patient to capture patient-level

[15] Ex. P-4 (Re-Opening of the Reconsideration Period for the Fiscal Year (FY) 2022 Hospice Quality Reporting Program (HQRP) Annual Payment Update (APU) (Dec. 9, 2021).
[16] *See* Ex. P-8 at P025 (Final Notice of Quality Reporting Program Noncompliance Decision – Reversed) (July 21, 2022).
[17] *See* Ex. C-2 at C-0011.
[18] *Id*. at C-0006-0007 (Hospice Quality Reporting Program (HQRP) Quick Reference Guide). Also available at https://www.cms.gov/files/document/hqrp-quickreferenceguide-fy-2023-and-all-future-yearsseptember2021.pdf (accessed Sept. 16, 2025).
[19] *See* Ex. P-10 at P028 (CMS/NGS FY 2023 Notification of Reduction in Payment) (July 6, 2022).
[20] *See* Ex. P-11 at P031.
[21] *Id.* at P032.
[22] *See* Ex. P-12 at P042 (Fiscal Year 2023 Annual Payment Update for the Hospice Quality Reporting Program Determination) (Sept. 20, 2022).

data, regardless of payer or patient age. The HIS is a standardized set of items intended to capture patient-level data.

(2) Administrative data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay, are required and fulfill the HQRP requirements for § 418.306(b).

(3) CMS may remove a quality measure from the Hospice QRP based on one or more of the following factors:

(i) Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better patient outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) A hospice that receives notice of its CMS certification number before November 1 of the calendar year before the fiscal year for which a payment determination will be made must submit data for the calendar year.

(d) Medicare-certified hospices must contract with CMS-approved vendors to collect the CAHPS® Hospice Survey data on their behalf and submit the data to the Hospice CAHPS® Data Center.

> (e) If the hospice's total, annual, unique, survey-eligible, deceased patient count for the prior calendar year is less than 50 patients, the hospice is eligible to be exempt from the CAHPS® Hospice Survey reporting requirements in the current calendar year. In order to qualify for this exemption the hospice must submit to CMS its total, annual, unique, survey-eligible, deceased patient count for the prior calendar year.
>
> [* * *]
>
> (h) Reconsiderations and appeals of Hospice Quality Reporting Program decisions.
>
> (1) A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the Hospice Quality Reporting Program for a particular reporting period. A hospice must submit a reconsideration request to CMS no later than 30 days from the date identified on the annual payment update notification provided to the hospice.
>
> (2) Reconsideration request submission requirements are available on the CMS Hospice Quality Reporting Web site on CMS.gov.
>
> (3) A hospice that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

For the FFY 2023 reporting year, all Medicare-certified hospice providers must comply with the Hospice Item Set ("HIS") and Hospice Consumer Assessment of Healthcare Providers and System ("CAHPS") survey reporting requirements to avoid the two-percentage point penalty in their APU.[23]

To comply with the reporting requirements for HIS, hospices submit their data through the Quality Improvement and Evaluation System ("QIES") Assessment Submission and Processing ("ASAP") system.[24] Further,

> Beginning with the FY 2018 reporting year, hospices' compliance with HIS requirements will be based on a timeliness threshold. Hospices will be required to submit a minimum percentage of their HIS records by the 30-day submission deadline. For hospitals to be HIS compliant, CMS requires hospices to submit a percent of all required HIS records, which is referred to as the timeliness

[23] Ex. C-2 at C-0009 (*Hospice Quality Reporting Program: Requirements for the Fiscal Year (FY) 2021 and Future FY Reporting Years*) (Last updated October 2019).
[24] *Id.* at C-0010.

> compliance threshold. Since FY 2020, the APU determination is at least 90% of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the 2 percentage-point reduction.[25]

With regard to CAHPS, "Medicare-certified hospices must contract with CMS-approved vendors to collect the CAHPS Hospice Survey data on their behalf and submit the data to the Hospice CAHPS Data Center."[26] For FFY 2023 and all subsequent years, the Secretary required the CAHPS quarterly data submissions as follows:

> The data submission deadlines for *CAHPS® Hospice Survey data* are the second Wednesday of the month for the months of February, May, August, and November. It is important for hospices to submit their patient counts to their selected vendor monthly. Approved CAHPS vendors submit data on behalf of their client hospices on or before that date. Late data is not accepted. . .[27]

Consequently, as set forth in 42 C.F.R. § 418.306(b)(2) (Oct. 1, 2021), a hospice that fails to submit quality data "as specified by the Secretary" is subject to a two (2)-percentage point reduction in its APU for a particular payment year:

> (2) For fiscal years 2014 and through 2023, in accordance with section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that does not submit hospice quality data, as specified by the Secretary, the payment rates are equal to the rates for the previous fiscal year increased by the applicable hospice payment update percentage increase, minus 2 percentage points. Beginning with fiscal year 2024 and subsequent fiscal years, the reduction increases to 4 percentage points. Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the payment amounts for a subsequent fiscal year.

The HIS and CAHPS data collection and reporting period tied to the FFY 2023 APU at issue ran from January 1, 2021, through December 31, 2021.[28]

B. Exception Process

Pursuant to 42 C.F.R. § 418.312(i) (Oct. 1, 2021), a hospice may be granted an exception or extension to the reporting requirements when certain extraordinary circumstances exist:

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[25] *Id.*
[26] 42 C.F.R. § 418.312(d).
[27] Ex. C-2 at C-0006.
[28] *Id.* at C-0012.

(i) Exemptions and extensions requirements.

(1) A hospice may request and CMS may grant exemptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the hospice.

(2) A hospice requesting an exemption or extension must do so within 90 days of the date that the extraordinary circumstances occurred by sending an email to CMS Hospice QRP Reconsiderations at HospiceQRPReconsiderations@cms.hhs.gov that contains all of the following information:

(i) Hospice CMS Certification Number (CCN).

(ii) Hospice Business Name.

(iii) Hospice Business Address.

(iv) CEO or CEO-designated personnel contact information including name, title, telephone number, email address, and mailing address (the address must be a physical address, not a post office box).

(v) Hospice's reason for requesting the exemption or extension.

(vi) Evidence of the impact of extraordinary circumstances beyond the hospice's control, including, but not limited to photographs, newspaper, other media articles, or independent sources attesting to the incident that can be reasonably corroborated. Include dates of occurrence and other documentation that may support the rationale for seeking extension or exemption.

(vii) Date when the hospice believes it will be able to again submit data under paragraph (b) of this section and a justification for the proposed date.

(3) CMS may grant exemptions or extensions to hospices without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance, such as an act of nature including a pandemic, affects an entire region or locale.

> (ii) A systemic problem with one of CMS' data collection systems directly affect the ability of a hospice to submit data under paragraph (b) of this section.

C. Burden of Proof and Standard of Review

A Board decision must include findings of fact and conclusions of law that "the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."[29] Additionally, "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare contractor] and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[30] In *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 230 (1938), the U.S. Supreme Court held, "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[31] Accordingly, in an appeal before the Board, a provider must prove by a preponderance of substantial, relevant evidence that it is entitled to the relief sought.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Medicare-certified hospices must submit quality data in the form and manner, and at a time, specified by CMS to avoid a two (2) percentage point reduction to the hospice's APU. PIC maintains its should not be subject to a two (2) percentage point reduction to its FFY 2023 APU because, due to extraordinary circumstances related to the COVID-19 pandemic, it was unable to timely submit its quality data to CMS.[32] PIC argues that "for the same reasons we were granted the full APU FY2022 we should also be granted full APU FY2023."[33]

PIC states in its reconsideration request to CMS that it "had an employee make a change to our CCN number, which was initially entered incorrectly unbeknownst to us, that resulted in submissions being rejected that were unaware of" and refers to a "letter from [he] EMR software company explaining the series of events regarding the CCN number error."[34] PIC states that, as of July 27, 2021, it "submitted all data to current and are in compliance."[35] The Board notes that the reporting period in question ran from January 1, 2021 through December 31, 2021,[36] and therefore, this attestation is incomplete as far as any reconsideration of quality reporting requirements of the FFY 2023 APU.

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[29] 42 C.F.R. § 405.1871(a)(3).
[30] 42 U.S.C. § 1395oo(d). This statutory provision also confirms: "[t]he 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 any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." *See also* 42 C.F.R. § 405.1869(a).
[31] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[32] Provider's Final Position Paper (hereinafter "Provider's FPP") at 1.
[33] *Id.*
[34] Ex. P-7 at P017.
[35] *Id.*
[36] Ex. C-2 at C-0012.

The Medicare Contractor asserts that PIC "did not comply with the requirements to submit Hospice Quality Reporting data by the deadlines set by the final rule. Furthermore, the Provider–initiated request for Exemption or Extension for extraordinary circumstances request was not properly completed."[37] Additionally, the Medicare Contractor acknowledges the effects of the pandemic and the error in the implementation of the EMR process, but argues that PIC did not utilize the process for requesting an exemption or extension in submitting quality data.[38]

PIC admits that they failed to report the data,[39] and fails to put forward any arguments supported by statute or regulation to justify this failure. Further, PIC did not submit a request for an extension or exemption pursuant to the process memorialized in 42 C.F.R. § 418.312(i)(1)-(2) (as discussed above), nor has it established that it met the requirements for such an extension or exemption. The Board notes that it does not have jurisdiction to grant any exceptions as part of the appeal process, simply identifying the fact that this was a failure on the part of PIC to avail itself of the opportunities that were available. CMS, upon reviewing the PIC's reconsideration request, found that "this hospice did not provide evidence that it submitted required quality measure data during the required timeframes" and did not discuss any extension or exemption request.[40] The Board acknowledges that PIC made an effort to correct the deficiencies in its HIS data submission after being notified of the APU reduction. Nevertheless, it is undisputed that PIC did not submit its data in the correct format within the required timeframe.

PIC maintains that the "same circumstances/issues/events" that resulted in a full reversal of the FY 2022 APU payment reduction "continued through July 27, 2021, which also effected FY2023."[41] While CMS did overturn the FFY 2022 APU reduction, that does not mean CMS is bound to approve a subsequent reconsideration request for the same circumstances if the issue persists.

Accordingly, the Board finds that PIC did not comply with the Hospice Quality Reporting data requirements set forth by CMS. Thus, PIC did not prove by a preponderance of substantial, relevant evidence that it complied with 42 C.F.R. § 418.312 and is, therefore, properly subject to the two-percentage point reduction in its Annual Payment Update for FFY 2023.

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence submitted, the Board finds CMS' decision to reduce Partners In Care Hospice, LLC's FFY 2023 Annual Payment Update by two (2) percentage points was proper.

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[37] Medicare Contractor's Final Position Paper at 16. (May 10, 2024)
[38] *Id.* at 11.
[39] Provider's FPP at 1.
[40] Ex. P-12 at P042.
[41] Provider's FPP at 1.

BOARD MEMBERS PARTICIPATING

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FOR THE BOARD:

9/18/2025

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: Kevin D. Smith -A