PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2025-D46

PROVIDER –
Assisted Hospice Care

HEARING HELD –
February 6, 2024

PROVIDER NO. – 03-1658

FISCAL YEAR– 2019

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

CASE NO. – 21-0778

INDEX

ISSUE STATEMENT

Whether Assisted Hospice Care should be subject to a two-percentage point reduction to its Fiscal Year ("FY") 2021 annual payment update ("APU") for failure to meet hospice quality reporting program requirements in calendar year 2019 due to extraordinary or extenuating circumstances.[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Provider did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary of Health and Human Services ("Secretary") and, thus, the two (2) percentage point reduction in its FY 2021 APU was proper.

INTRODUCTION

Assisted Hospice Care ("Assisted Hospice" or the "Provider") is a freestanding hospice located in Phoenix, Arizona.[2] Assisted Hospice's designated Medicare contractor[3] is National Government Services, Inc. ("Medicare Contractor").

The APU for FY2021 Medicare payments is impacted by CY 2019 Hospice Item Set ("HIS") data, which was required to be submitted within thirty (30) days of the patient's admission or discharge, as applicable.[4] By letter dated July 13, 2020, CMS notified the Provider that it was subject to a reduction of its APU by two (2) percentage points for FY 2021 as it "[d]id not achieve a 90% threshold on the Hospice Item Set (HIS) pay-for-reporting requirements for CY 2019 (January 1, 2019-December 31, 2019)."[5] The letter also indicated that "[i]f you believe you have been identified for this payment reduction in error, you have the right to request a reconsideration of this decision."[6]

On August 10, 2020, the Provider requested reconsideration of CMS' decision, stating "extraordinary circumstances" as it reason for noncompliance.[7] After consideration, by letter dated September 10, 2020, CMS upheld the decision to reduce the APU for Medicare payments for FY 2021 by two (2) percentage points, explaining that the Provider did not comply with the requirement to meet the HIS 90% threshold.[8] On February 19, 2021, the Provider timely appealed the reconsideration determination to the Board and met the jurisdictional requirements for a hearing.

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[1] Transcript (hereinafter "Tr.") at 5.
[2] *See* Provider's Preliminary Position Paper (hereinafter "Provider's PPP") at 1 (Oct. 14, 2021).
[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 with 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] Exhibit (hereinafter "Ex.") C-2 at C-0008 – C-0009 (CMS Hospice Quality Reporting Program: Requirements for the FY 2021 and Future FY Reporting Years - Fact Sheet) (Last updated October 2019).
[5] Ex. P-1 (Non-Compliance Notification) (July 13, 2020).
[6] *Id. See also* Ex. C-4 (MAC's Notice of FY 2021 Payment Reduction) (July 14, 2020).
[7] Ex. P-2 (Request for Hospice QRP Reconsideration) (Aug. 10, 2020).
[8] Ex. P-3 (Notice of Quality Reporting Program Noncompliance Decision Upheld) (Sept. 10, 2020).

The Board held a video hearing on February 6, 2024. The Provider was represented by Deborah Bartlett, Esq. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services ("FSS").

STATEMENT OF RELEVANT FACTS

Assisted Hospice operates in multiple locations, including Phoenix, Arizona (the subject of this appeal), Los Angeles County, California, and Ventura County, California.[9] The corporate offices are located in Thousand Oaks, Ventura County, California and house a company-wide Quality and Compliance Department, as well as the company-wide computer servers and IT department.[10] The Quality and Compliance Department is responsible for "oversight of Medicare Compliance, Quality Management, ADRs and Appeals for all agency locations."[11] In and around the time period in which the applicable reporting was required, several disasters took place in the vicinity of Assisted Hospice's corporate offices.[12]

In late-2017, the Thomas Fire, a large brushfire, spread through Ventura County.[13] As a result, Ventura County and Santa Barbara County were declared disaster areas by Federal Emergency Management Agency ("FEMA").[14]

In February 2018, CMS granted exceptions to quality reporting and value-based purchasing programs to providers located in Ventura County or Santa Barbara County.[15] In January 2019, CMS again granted exceptions to providers located in Butte, Los Angeles, or Ventura Counties, as they had been designated affected counties by FEMA as a result of the California Wildfires.[16] Neither of these CMS-granted exceptions applied to reporting periods in FFY 2019.

In late-2018, a mass shooting occurred in the immediate neighborhood of Assisted Hospice's corporate office.[17] Immediately after the shooting, two wildfires, the Hill and Woolsey wildfires, significantly impacted Assisted Hospice's corporate office.[18] The serious nature of the wildfires coupled with rains prompting mudslides and power outages resulted in reactivation of the Provider's preparedness plan several times in 2019.[19]

As further explained in the Statement of Relevant Law below, Medicare-certified hospice providers that failed to comply with either of two reporting requirements – the Hospice Item Set

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[9] Provider's PPP at 4.
[10] *Id.*
[11] *Id.* at 6.
[12] Provider's PPP at 4-6.
[13] *Id.* at 5.
[14] *Id.*
[15] The terminology "exception and extension" is used as a general term intended for ease of reference, to collectively refer to policies established under separate programs, and may not be consistent with the specific terminology established under each individual program. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/downloads/memo-applicability-of-reporting-requirements-for-certain-health-care_december-wildfires_2018-02-08.pdf. *Also see* Ex. P-5 (which indicates that these exceptions were for the reporting of "calendar year (CY) 2017 quarters 3 and 4" only).
[16] *See* Ex. P-6 at 1-2 (which indicates that this exception was for the reporting of CY 2018 quarter 4 only).
[17] Provider's PPP at 5-6.
[18] *Id.* at 6-8.
[19] *Id.* at 8.

("HIS") or Hospice Consumer Assessment of Healthcare Providers and System ("CAHPS") survey reporting requirements – received a two-percentage point APU reduction. Based on the CASPER report – FY2021 Hospice Timeliness Compliance Threshold report provided by Assisted Hospice, it submitted seventy-six (76) HIS records in 2019, sixty-five (65) – or eighty-six percent (86%) – of those records were submitted on time.[20]

STATEMENT OF RELEVANT LAW

A. Hospice Quality Reporting Requirements

The statute addressing a hospice provider's eligibility for its full APU increase is found at 42 U.S.C. § 1395f(i)(5) (2018), and states:

> **(5) Quality reporting**
>
> **(A) Reduction in update for failure to report**
>
> **(i) In general**
> For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of clauses (iv) and (vi) of paragraph (1)(C), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.
>
> **(ii) Special rule**
> The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.
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> **(B) Noncumulative application**
> Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.
>
> **(C) Submission of quality data**
> For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in

[20] Ex. P-11 (CASPER Report – run date 7/27/2020).

> a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.
>
> **(D) Quality measures**
>
> **(i) In general**
> Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1395aaa(a) of this title.
>
> **(ii) Exception**
> In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.
>
> **(iii) Time frame**
> Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.
>
> **(E) Public availability of data submitted**
> The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.

The regulations providing the data submission requirements under the hospice quality reporting program are found at 42 C.F.R. § 418.312 (2014) and state:

> (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.
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> (b) Submission of Hospice Quality Reporting Program data. Hospices are required to complete and submit an admission Hospice Item Set (HIS) and a discharge HIS for each patient admission to hospice, regardless of payer or patient age. The HIS is a standardized set of items intended to capture patient-level data.

(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.

(f) Vendors that want to become CMS–approved CAHPS® Hospice Survey vendors must meet the minimum business requirements. Survey vendors must have been in business for a minimum of 4 years, have conducted surveys in the approved survey mode for a minimum of 3 years, and have conducted surveys of individual patients for a minimum of 2 years. For Hospice CAHPS®, a "survey of individual patients" is defined as the collection of data from at least 600 individual patients selected by statistical sampling methods, and the data collected are used for statistical purposes. Vendors may not use home-based or virtual interviewers to conduct the CAHPS® Hospice Survey, nor may they conduct any survey administration processes (for example, mailings) from a residence.

(g) No organization, firm, or business that owns, operates, or provides staffing for a hospice is permitted to administer its own Hospice CAHPS® survey or administer the survey on behalf of any other hospice in the capacity as a Hospice CAHPS® survey vendor. Such organizations will not be approved by CMS as CAHPS® Hospice Survey vendors.

(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.

The FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule provided data submission and compliance thresholds for payment determinations which were applicable to the FY 2021 APU determination:[21]

> The timeliness threshold would be set at 80 percent for the FY 2019 APU determination and at 90 percent for the FY 2020 APU determination and subsequent years. The threshold corresponds with the overall amount of HIS records received from each provider that fall within the established 30 day submission timeframes. Our ultimate goal is to require all hospices to achieve a timeliness requirement compliance rate of 90 percent or more. To summarize, we proposed to implement the timeliness threshold requirement beginning with all HIS admission and discharge records that occur on or after January 1, 2016, in accordance with the following schedule.
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> ***
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> Beginning on or after January 1, 2018 to December 31, 2018, hospices must score at least 90 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2020.[22]

B. Extensions and Exemptions to HQRP Reporting Requirements

CMS does provide an opportunity for exceptions to or exemptions from the HQRP reporting requirements, as explained in the "Resources and Frequently Asked Questions" section of the "Hospice Quality Reporting Program: Requirements for the Fiscal Year (FY) 2021 and Future

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[21] 80 Fed. Reg. 47142, 47192 (Aug. 6, 2015). The Board notes that the Secretary did not codify the data submission thresholds regulation text at § 418.312(j) as established in the FY 2016 final rule until FY 2024, "Under this section, we proposed to codify our requirement that hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge) and submit the data through the CMS designated data submission systems. […] We are finalizing the data submission thresholds regulation text at § 418.312(j) as established in prior rulemaking." 88 Fed. Reg. 51164, 51185 (Aug. 2, 2023).

[22] The Board notes that this 90 percent threshold remains in place in the years after 2018.

FY Reporting Years" fact sheet, included as Exhibit C-2, and last updated in October, 2019. The topic is addressed as follows:

> **What if I have extenuating circumstances (e.g., a natural disaster) that prevent me from submitting HQRP data or cause me to submit HQRP data late?**
> CMS will make accommodations in the event a hospice is unable to submit quality data due to extraordinary circumstances beyond their control (e.g., natural or man-made disasters) or when a systemic problem with CMS data collection systems or the Hospice CAHPS® Data Warehouse directly affect the ability of a hospice to submit data. *If a hospice is affected by an extraordinary circumstance, they can submit an exception or extension request to CMS. Hospices should submit this request via email within 90 calendar days of the occurrence of the extraordinary circumstance.* Please visit the Extensions and Exemptions Requests section of the CMS HQRP website for more information.[23]

C. Standard of Review and Burden of Proof

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."[24] 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."[25] 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."[26] 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. And while the provider has the burden of proof, the Medicare contractor must "[e]nsure that the evidence it considered in making its determination, . . . is included in the record."[27] Further, the "Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[28]

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[23] Ex. C-2 at C-0011 (bold emphasis in original, italics and underline emphasis added).
[24] 42 C.F.R. § 405.1871(a)(3) (as of Oct. 1, 2020).
[25] 42 U.S.C. § 1395oo(d). This statutory provision further confirms that "[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).
[26] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[27] 42 C.F.R. § 405.1853(a)(3).
[28] 42 C.F.R. § 405.1867.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

To find in favor of Assisted Hospice (*i.e.*, to find that the 2% APU reduction does *not* apply), the Board must find that Assisted Hospice submitted the quality data in the "*form and manner, and at a time,* specified by the Secretary."[29]

At issue in this case is the Provider's submission of its HIS records. As discussed above, "hospices must score at least ninety percent for all HIS records received within the 30-day submission timeframe for the year."[30] Here, as explained by both parties, the Provider timely submitted 86% of the HIS records, thus, it did not reach the 90% threshold. Therefore, the Board finds that the Provider did not submit the quality data in the form and manner, and at the time specified by the Secretary.[31]

According to the Provider, it did not reach the 90% threshold due to a number of extenuating circumstances, including several wildfires and a mass shooting in the area of the Assisted Hospice corporate office in Thousand Oaks (Ventura County), California.[32] As an initial matter, the Board notes that the provider that missed the submission deadline is physically located in Phoenix, Arizona, and not in the corporate offices located in Thousand Oaks, California where the multiple incidents that the Provider referenced took place. If it were presumed that the corporate offices handled the submission for all of its entities, there could be merit to the argument that the incidents near the corporate office could have impacted the quality data submission. However, the Provider also stated at the hearing that the two other Assisted Hospice providers (it has 3 Medicare provider numbers and 7 locations) ***did timely submit*** the 90% HIS records.[33] Further, the Provider's testimony confirmed that the data for this Provider was available but was not submitted due to an oversight.[34]

Further, as discussed above, CMS recognizes that there are instances where an extraordinary or extenuating circumstance beyond the hospice's control may delay or prevent submission of required data.

Assisted Hospice contends the effects of the wildfires had a "profound effect on [the] patients, staff and IT resources throughout 2019."[35] An additional sudden change in staff responsible for submitting CMS HIS data through the Quality Improvement and Evaluation System ("QIES") created a delay in submissions.[36] Assisted Hospice notes that despite these external and internal challenges, for the 2019 reporting year, it submitted 100% of the required records and timely submitted 86% of the records, 4% short of the required compliance threshold.[37]

However, despite the argument that several incidents impacted their ability to timely submit the required quality data, Assisted Hospice admits that it did not request an extension due to

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[29] 42 U.S.C. § 1395f(i)(5)(C); 42 C.F.R. § 418.312(a) (emphasis added).
[30] 80 Fed. Reg. 47192.
[31] Tr. at 8, 14.
[32] Provider's PPP at 4-5.
[33] Tr. at 19-20.
[34] Tr. at 24-25.
[35] Provider's PPP at 9.
[36] *Id.* at 9-10.
[37] *Id.* at 10. *Also see* Ex. P-11.

extraordinary circumstances, and confesses that "[i]t didn't even occur to us that we needed to file one."[38] The Board finds that Assisted Hospice did not request an extraordinary circumstances exception.

Further, the Board is bound by the applicable statutes as an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination by its Medicare contractor or by CMS. The Board's authority is limited to the statutory and regulatory requirements and to the facts and circumstances of the issues presented, and the Board has no equitable authority in these appeals.[39]

Although the Board is sympathetic to the struggles the Provider faced with respect to the various incidents in Ventura County, the Board must find that the Provider did not submit the quality data in the form and manner, and at the time specified by the Secretary.

For the reasons stated above, the Board concludes that Assisted Hospice has failed to meet its burden of production of evidence and burden of proof under 42 C.F.R. § 405.1871(a)(3), and that CMS correctly assessed Assisted Hospice a two (2) percentage point reduction in its FY 2021 payments.

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that Assisted Hospice did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary and, thus, the two (2) percentage point reduction in its FY 2021 APU was proper.

BOARD MEMBERS PARTICIPATING:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

9/22/2025

X Kevin D. Smith, CPA

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

[38] Tr. at 25.
[39] 42 C.F.R. § 405.1867.