PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2026-D07

PROVIDER –
PruittHealth FFY 2022 Notice of Quality Reporting Program Alleged Noncompliance CIRP Group

DATE OF RECORD HEARING –
June 12, 2024

PROVIDER NO. –
11-5573, 11-5468, 42-5085, and 11-5345

FEDERAL FISCAL YEAR –
2022

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

CASE NO. –
22-0947GC

INDEX

ISSUE STATEMENT

Whether the imposition of a two percentage-point reduction to the Providers' (as "Providers" is defined in the Introduction) Federal Fiscal Year ("FFY") 2022 Annual Payment Update ("APU") (also referred to as "market basket percentage" or "market basket index percentage") under the Skilled Nursing Facility ("SNF") Quality Reporting Program ("QRP") was proper.[1]

DECISION

After considering the Medicare law and regulations, the arguments presented and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that CMS properly reduced the FFY 2022 APU for the Providers by two percentage points.

INTRODUCTION

Christian City Rehabilitation Center (Provider Number 11-5573), PruittHealth – Blue Ridge (Prov. No. 11-5468), PruittHealth – Orangeburg (Prov. No. 42-5085), and PruittHealth – Toccoa (Prov. No. 11-5345) (collectively, the "Providers"), are Medicare-participating skilled nursing facilities[2] operating under the parent organization PruittHealth, Inc. ("PruittHealth").[3] The Providers' assigned Medicare contractor[4] is WPS Government Health Administrators ("Medicare Contractor").

On March 22, 2020, CMS announced that participants in Medicare QRPs would be granted an exception for "data reflecting services provided January 1, 2020 through June 30, 2020 . . . [in order] to reduce the data collection and reporting burden on providers responding to the COVID-19 pandemic."[5] By letters dated July 15, 2021, CMS notified each of the Providers that they failed to meet the SNF QRP reporting requirements for CY 2020 because CMS found that the Providers had not achieved an 80% threshold on the Minimum Data Set ("MDS") reporting requirements for the period of July 1, 2020 – December 31, 2020.[6] Failure to meet the SNF QRP reporting requirements resulted in a two percentage-point reduction in each of the Providers' FY 2022 APU.[7] Each of the Providers timely submitted reconsideration requests.[8] After review of each reconsideration request, CMS upheld its decisions in letters issued on September 21, 2021.[9]

The Providers timely appealed CMS' reconsideration decision to the Board and met the jurisdictional requirements for a hearing before the Board. The Board approved a record hearing

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[1] Joint Stipulations of Undisputed Facts and Principles of Law (hereinafter "Stip.") at ¶ 3 (Jun. 11, 2024).
[2] *Id*. at ¶ 1.
[3] Provider Representation Letter at 1 (Mar. 15, 2022).
[4] 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.
[5] Exhibit (hereinafter "Ex.") P-1 at P0005-0006; Stip. at ¶ 4.
[6] Ex. P-6; Stip. at ¶ 5.
[7] *Id*.
[8] Ex. P-8; Stip. at ¶ 6.
[9] Ex. P-7; Stip. at ¶ 7.

on June 12, 2024. The Providers were represented by Richard E. Gardner III, Chief Compliance Officer of PruittHealth. The Medicare Contractor was represented by Joseph Bauers, Esq., of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS

CMS requires SNFs to report their standardized patient assessment data on a quarterly basis.[10] On March 22, 2020, CMS announced exceptions to the SNF QRP reporting requirements for first quarter ("Q1") and second quarter ("Q2") of 2020 in response to the COVID-19 pandemic.[11] Therefore, the APU payment impact for FY 2022 was based upon data collected in third quarter ("Q3") and fourth quarter ("Q4") of 2020 only.[12] Reporting is tracked via Certification and Survey Provider Enhanced Reports ("CASPER Reports").

In their requests for reconsideration and their appeals to the Board, the Providers submitted individual CASPER Reports dated December 31, 2020 showing between 81% and 85% of "MDS 3.0 Assessment Submitted Complete" for the period January 1, 2020 through December 31, 2020.[13] However, the Providers did not submit CASPER Reports broken down by quarter, nor did the Providers submit any evidence of their QRP data submission other than the full year 2020 CASPER reports. CMS determined, on July 15, 2021, that Providers "did not achieve an 80% threshold on the Minimum Data Set (MDS) reporting for CY 2020 (July 1, 2020 to December 31, 2020)."[14] The Providers acknowledge this deficiency.

CMS provides training related to SNF quality reporting.[15] SNFs may also register with a CMS subcontractor to receive informational messages about data and reporting.[16] The Providers submitted no evidence that they availed themselves of any of these guides.

STATEMENT OF RELEVANT LAW

The data submission requirements under the SNF QRP are set forth in 42 C.F.R. § 413.360 (Oct. 1, 2019), which states, in pertinent part:

> (a) ***Participation start date.*** Beginning with the FY 2018 program year, a SNF must begin reporting data in accordance with paragraph (b) of this section no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the SNF as operating in the CMS designated data submission system. For purposes of this section, a program year is the fiscal year in which the market basket percentage

[10] *See* Statement of Relevant Law, *infra*.
[11] Stip. at ¶ 4.
[12] *See* Ex. P-6.
[13] *See* Ex. P-5.
[14] Ex. P-6.
[15] *See* Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 8, listing a number of these training materials.
[16] *Id*.

described in § 413.337(d) is reduced by two percentage points if the SNF does not report data in accordance with paragraph (b) of this section.

(b) ***Data submission requirement.***

(1) Except as provided in paragraph (c) of this section, and for a program year, SNFs must submit to CMS data on measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Social Security Act and standardized resident assessment data in accordance with section 1899B(b)(1) of the Social Security Act, in the form and manner, and at a time, specified by CMS.

(2) ***CMS will consider a SNF to have complied with paragraph (b)(1) of this section for a program year if the SNF reports: 100 percent of the required data elements on at least 80 percent of the MDS assessments submitted for that program year.***[17]

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

. . .

(c) ***Exception and extension requests.***

(1) A SNF may request and CMS may grant exceptions 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 SNF.

(2) A SNF may request an exception or extension within 90 days of the date that the extraordinary circumstances occurred by sending any email to SNFQRPReconsiderations@cms.hhs.gov that contains all of the following information:

. . .

[17] Emphasis added.

> (3) Except as provided in paragraph (c)(4) of this section, CMS will not consider an exception or extension request unless the SNF requesting such exception or extension has complied fully with the requirements in this paragraph (c).
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> (4) CMS may grant exceptions or extensions to SNFs without a request if it determines that one or more of the following has occurred:
>
> (i) An extraordinary circumstance affects an entire region or locale.
>
> (ii) A systemic problem with one of CMS's data collection systems directly affected the ability of a SNF to submit data in accordance with paragraph (b) of this section.

A SNF that fails to report the required quality data under the QRP is penalized by a reduction of the SNF's market basket index percentage change for the relevant year, as explained in 42 C.F.R. § 413.337(d)(4) (Oct. 1, 2018):

> ***(4) Penalty for failure to report quality data.*** For fiscal year 2018 and subsequent fiscal years—
>
> (i) In the case of a SNF that does not meet the requirements in § 413.360, for a fiscal year, the SNF market basket index percentage change for the fiscal year (as specified in paragraph (d)(1)(v) of this section, as modified by any applicable forecast error adjustment under paragraph (d)(2) of this section, reduced by the MFP adjustment specified in paragraph (d)(3) of this section, and as specified for FY 2018 in section 1888(e)(5)(B)(iii) of the Act), is further reduced by 2.0 percentage points.
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> (ii) The application of the 2.0 percentage point reduction specified in paragraph (d)(4)(i) of this section to the SNF market basket index percentage change may result in such percentage being less than zero for a fiscal year, and may result in payment rates for that fiscal year, and may result in payment rates for that fiscal year being less than such payment rates for the preceding fiscal year.
>
> (iii) Any 2.0 percentage point reduction applied pursuant to (d)(4)(i) of this section will apply only to the fiscal year involved and will not be taken into account in computing the payment amount for a subsequent fiscal year.

A. MDS Threshold Calculation pursuant to 42 CFR 413.360(b)(2).

The SNF QRP Quick Reference Guide for FY 2022 provides, in pertinent part:

> The MDS threshold is calculated by taking the total number of assessments with 100% of the required MDS data elements (numerator) divided by the number of successfully submitted assessments (denominator). The resulting number is multiplied by 100 to determine the threshold percentage. In general, MDS records submitted for patient admissions and/or discharges occurring during the reporting period will be included in the denominator. ***For FY 2022, providers must submit 80% or more of all assessments with 100% of the required MDS data elements to be in compliance with SNF QRP requirements.***
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> $$\frac{\text{Numerator}}{\text{Denominator}} = \frac{\text{Assessments with 100\% of the required MDS data elements}}{\text{Assessments submitted successfully before the submission deadlines*}}$$
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> For example, for FY 2022 compliance determination, if during the reporting period (01/01/2020-12/31/2020) a facility has submitted 1000 assessments and 800 of the assessments submitted have 100% of the required MDS data elements the threshold percentage would equal 80%. Thus, the facility would be deemed compliant with SNF MDS data reporting requirements for APU compliance purposes.
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> The SNF QRP Table for Reporting Assessment-Based Measures for the FY 2021 SNF QRP APU table outlines which MDS items are required for the purposes of APU. The table for FY 2022 can be found in the Downloads box on the Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information web page.
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> ***Note: The calculation algorithm will be adjusted if the SNF was granted an extension or exemption by CMS**.*[18]

B. Public Health Emergency Temporary Relief

On March 22, 2020, in response to the COVID-19 public health emergency, CMS issued a press release entitled, "CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19."[19] The press release stated, in pertinent part:

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[18] See *Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Quick Reference Guide FY 2022,* Updated 7/9/2020 at 1-2, available at https://www.cms.gov/files/document/pac-snf-fy2022-quickreferenceguide-v12.pdf (last accessed Dec.18, 2025).

[19] Ex. C-4; *see also*, Ex. P-1.

> Specifically, CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for the following CMS programs:
>
> * * *

Post-Acute Care (PAC) Programs	**2019 Data Submission**	**2020 Data Submission**
*** ***Skilled Nursing Facility Quality Reporting Program***	Deadlines for October 1, 2019 – December 31, 2019 (Q4) data submission optional. If Q4 is submitted, it will be used to calculate the 2019 performance and payment (where appropriate).	Data from January 1, 2020 through June 30, 2020 (Q1-Q2) does not need to be submitted to CMS for purposes of complying with quality reporting program requirements.

> For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report. ***In addition, no data reflecting services provided January 1, 2020 through June 30, 2020 will be used in CMS's calculations for the Medicare quality reporting and value-based purchasing programs.*** This is being done to reduce the data collection and reporting burden on providers responding to the COVID-19 pandemic. [20]

On March 27, 2020, CMS also issued a Program Guidance Memo that set forth exceptions and extensions for Quality Reporting Requirements for skilled nursing facilities and other provider types, which stated, in pertinent part:

> CMS is granting an exception to the Quality Reporting Program (QRP) reporting requirements for all HHAs, Hospices, IRFs, LTCHs and SNFs. In accordance with 42 C.F.R. 412.560(c), 412.634(c), 413.360(c), 484.245(c), these providers are excepted from the reporting of data on measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and standardized patient assessment data required under these programs for the post-acute care (PAC) quality reporting programs for calendar years (CYs) 2019 and 2020 for the following quarters specific to each program:

[20] Ex. C-4 at C0011, C0015-C0018. ***Bold italics and underline*** emphasis added.

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- SNFs–Skilled Nursing Facility QRP
  o October 1, 2019–December 31, 2019 (Q4 2019)
  o January 1, 2020–March 31, 2020 (Q1 2020)
  o April 1, 2020–June 30, 2020 (Q2 2020) [21]

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."[22] 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."[23] 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."[24] 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. 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."[25]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

To find in favor of the Providers, the Board must find that the Providers submitted the required data in the form and manner, and at a time, required by CMS. As detailed above in Statement of Relevant Law, CMS granted exceptions to the SNF QRP requirements for Q1 and Q2 of 2020 in response to the COVID-19 Public Health Emergency,[26] and specifically stated:

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[21] Ex. C-5 ("Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS eligible Clinicians Affected by COVID-19," (March 27, 2020)) at C0020-0021 (footnotes omitted).
[22] 42 C.F.R. § 405.1871(a)(3).
[23] 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).
[24] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[25] 42 C.F.R. § 405.1867.
[26] *See* Ex. P-1 ("CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19") (Mar. 22, 2020); Ex. P-2 ("Exceptions and Extensions for Quality Reporting Requirements for . . . Skilled Nursing Facilities . . . Affected by COVID-19") (Mar. 27, 2020). *See also* Stip. at ¶ 4.

> For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report. In addition, no data reflecting services provided January 1, 2020 through June 30, 2020 will be used in CMS's calculations for the Medicare quality and value-based purchasing programs. This is being done to reduce the data collection and reporting burden on providers responding to the COVID-19 pandemic.[27]

The MAC "asserts each SNF failed to meet the reporting requirements for CY 2020, specifically, the 80 percent data completion threshold as set forth in 42 C.F.R. § 413.360(f)(1)(i), for the period of July 1, 2020 through December 31, 2020."[28] While the Providers acknowledge that "they did not achieve an 80% threshold on the MDS reporting for July 1, 2020 to December 31, 2020,"[29] they have maintained that they did "achieve[] an 80% threshold on the Minimum Data Set (MDS) reporting requirement for the entirety of CY 2020 (January 1, 2020-December 31, 2020)[.]"[30]

In their Reconsideration Requests, the Providers submitted CASPER reports for the entirety of CY 2020 to demonstrate compliance with the reporting requirements and argued "[t]he provider should not be punished by a calculation that only looks at two quarters of data, in contravention of CMS's published guidance."[31] However, Providers overlook the SNF QRP Quick Reference Guide FY 2022, updated on July 9, 2020 (just 8 days after the CMS exception period ended), which explicitly stated that the MDS threshold "calculation algorithm will be adjusted if the SNF was granted an extension or exemption by CMS."[32] Nonetheless, the Providers argue that they met and "exceeded the 80% threshold for QRP reporting for CY 2020."[33] As evidence thereof, the Providers submitted CASPER Reports which they maintain show that over 80% of MDS Assessments were submitted for CY 2020 for each Provider. However, the Board finds that the Providers' evidence fails to prove that they met and exceeded the 80% threshold for QRP reporting for the relevant time period of July 1, 2020 through December 31, 2020.

Additionally, in their Final Position Paper, the Providers cite the Medicare Act and argue that they were "punished for following rules established through formal notice and comment rulemaking rather than following 'exceptions' announced informally."[34] They go on to contend that:

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[27] Ex. P-1 at P0005-0006.
[28] Stip. at ¶ 12.
[29] Providers' Final Position Paper (hereinafter "Providers' FPP") at 3 (Mar. 14, 2024). The Providers describe this as "the height of the COVID-19 pandemic in 2020."
[30] *Id*.
[31] Ex. P-8. The CASPER Reports were also separately submitted as Ex. P-5 in this appeal.
[32] See *Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Quick Reference Guide FY 2022,* Updated 7/9/2020 at 2, available at https://www.cms.gov/files/document/pac-snf-fy2022-quickreferenceguide-v12.pdf (last accessed Dec. 18, 2025).
[33] Providers' FPP at 12. *See also* Ex. P-5 and P-8.
[34] Providers' FPP at 13; *see also* Provider's FPP at 1-2, where the Provider states that the relief provided by CMS is "reminiscent of President Ronald Reagan's famous claim that the 'nine most terrifying words in the English language are: I'm from the government and I'm here to help.'" In their review of this case, the Board was reminded of the words of President Martin Van Buren, "It is easier to do a job right than to explain why you didn't."

> [W]hile CMS's informal communications were sufficient to notify SNFs that CMS "is granting exceptions" to the written rules and of their option not to follow the written rules, they are not sufficient to preclude SNFs who do not need the exception from following and relying on the rules as written in formal regulations.[35]

The relevant portion of the Medicare Act is found at 42 U.S.C. § 1395hh(a) and reads:

> **(a) Authority to prescribe regulations; ineffectiveness of substantive rules not promulgated by regulation**
>
> (1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.
>
> (2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

The Board finds that the exception made to Q1 and Q2 reporting requirements was not a new rule, nor a change to a substantive legal standard, that would require notice-and-comment rulemaking, but CMS acting within its authority under 42 C.F.R. § 413.360(c)(4) to grant an exception to SNFs without a request if it determines that "an extraordinary circumstance affects an entire region or locale." Further, the exception was announced in advance of the respective deadlines and through various means.

While the Board is sympathetic to the difficulties presented to the Providers during the COVID-19 pandemic, the Board must nonetheless conclude that the Providers failed to report the quality data "in the form and manner, and at a time, specified by CMS."[36]

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[35] *Id*.
[36] 42 C.F.R. § 413.360(b)(1).

DECISION

After considering the Medicare law and regulations, the arguments presented and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that CMS properly reduced the FFY 2022 APU for the Providers by two percentage points.

Board Members Participating

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Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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FOR THE BOARD:

12/19/2025

X Kevin D. Smith, CPA

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