PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2026-D08

PROVIDER –
Phelps County Regional Medical Center

PROVIDER NO. –
26-0017

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

HEARING DATE –
January 28, 2025

FEDERAL FISCAL YEAR –
2023

CASE NO. –
23-1023

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor properly applied the two (2) percentage-point reduction in the Federal Fiscal Year ("FFY") 2023 annual payment update ("APU") (also known as annual increase factor or "AIF") for Phelps County Regional Medical Center's ("Phelps Health" or "Provider") Inpatient Rehabilitation Facility ("IRF") for failure to meet the quality reporting requirements.[1]

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the two (2) percentage point reduction of the Medicare AIF for FFY 2023 for Phelps Health was proper.

INTRODUCTION:

Phelps County Regional Medical Center is an acute care hospital that operates an Inpatient Rehabilitation Facility located in Rolla, Missouri.[2] The Provider's assigned Medicare Contractor[3] is WPS Government Health Administrators ("Medicare Contractor" or "MAC").

In order to receive the full AIF for FFY 2023 reimbursement under the IRF prospective payment system, IRFs such as Phelps Health were required to submit data on certain quality measures during calendar year ("CY") 2021. In a letter dated June 27, 2022, the Medicare Contractor notified Phelps Health that it had not met one or more of the QRP requirements for FFY 2023 and that its FFY 2023 AIF would be reduced by two (2)-percentage points.[4] In a letter dated July 12, 2022, CMS notified Phelps Health of the same.[5]

Following Phelps Health's July 27, 2022 formal reconsideration request,[6] on September 14, 2022, WPS issued a written reconsideration determination that upheld the payment reduction.[7]

Phelps Health timely appealed the reconsideration determination to the Board and met the jurisdictional requirements for a hearing. The Board held a virtual hearing via Zoom on January 28, 2025. Phelps Health was represented by Katherine Sheffield, Esq. of Phelps Health. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

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[1] Transcript of Proceedings ("Tr.") at 5:12-20 (Jan. 28, 2025).
[2] *See* Provider's Final Position Paper ("Provider's FPP") at ¶¶ 2, 3 (Oct. 28, 2024); *see also* Tr. at 12:11-16.
[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 know 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 ("Ex.") P-1.
[5] Ex. P-7.
[6] Ex. P-2.
[7] Ex. P-3.

STATEMENT OF RELEVANT FACTS:

As mentioned above, Phelps Health is an acute care hospital that operates an IRF subunit. The IRF subunit is excluded from the inpatient prospective payment system and has a different CMS certification number, or "CCN," which makes it subject to the IRF Quality Reporting Program.[8] As discussed more fully below, CMS added a COVID-19 reporting measure for IRFs in the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2022 and Updates to the IRF Quality Reporting Program Final Rule.[9] According to the Provider, it timely submitted the COVID-19 data under the acute care CCN, *not* the IRF CCN.[10]

On June 27, 2022, the Provider received a letter from the Medicare Contractor notifying Phelps Health, (whose CMS Certification Number for the IRF is 26T017),[11] that it was, "subject to a reduction in payment for not meeting the Affordable Care Act (ACA) of 2010 requirement for IRFs to submit quality data."[12] Specifically, the letter indicated that the Provider was subject to a 2% reduction to its FY 2023 annual increase factor for the following reasons:

- The IRF failed to submit the required data to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network; and/or
- The IRF failed to submit the required quality measures that are to be submitted to the CMS Quality Improvement Evaluation System (QIES) system [sic].[13]

This Notice also outlined the process for requesting reconsideration and indicated that the request must be submitted on or before August 11, 2022.[14]

On July 12, 2022, CMS issued a second notice to the Provider with the title, "Non-Compliance that May Result in 2% Reduction to Your FY 2023 Annual Increase Factor for CCN ***26T017***."[15] This notice specified that the Provider did not meet the program reporting requirements for the following reasons:

> {Did not submit NQF #0431 Influenza Vaccination Coverage among Healthcare Personnel data}.
> {Did not submit all required months of complete COVID-19 Vaccination Coverage among Healthcare Personnel data}[16]

This July 12, 2022 Notice was sent via the Internet Quality Improvement and Evaluation System ("iQIES"). This Notice also included instructions for reconsideration and indicated that the request must be submitted on or before August 11, 2022.[17]

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[8] Tr. at 12:17-24.
[9] 86 Fed. Reg. 42362 (Aug. 4, 2021).
[10] *See* Provider's FPP at ¶¶ 13-16.
[11] *Id*. at ¶ 2.
[12] Ex. P-1.
[13] *Id.*
[14] *Id.*
[15] Ex. P-7 at 1 (Emphasis added).
[16] *Id.*
[17] *Id.*

STATEMENT OF RELEVANT LAW:

A. 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."[18] 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."[19] 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."[20] 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."[21] 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."[22]

B. Inpatient Rehabilitation Facility Quality Reporting Program Requirements

Under IRF PPS, the Medicare program pays an IRF predetermined, standardized amounts per discharge, subject to certain payment adjustments.[23] The standardized IRF PPS payment amounts are increased each year by an AIF to account for increases in operating costs.[24]

Section 3004(b)(2) of the Patient Protection and Affordable Care Act amended 42 U.S.C. § 1395ww(j) to establish the IRF QRP.[25] As a result, each IRF is required to submit certain quality of care data "in a form and manner, and at a time, specified by the Secretary."[26] Further, 42 U.S.C. § 1395ww(j)(7)(A)(i) specifies that an IRF that fails to report the quality data required under the IRF QRP is subject to a two (2)-percentage point reduction to its AIF. The regulation governing IRF QRP data submission is located at 42 C.F.R. § 412.634 and states, in pertinent part:

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[18] 42 C.F.R. § 405.1871(a)(3) (as of Oct. 1, 2020).
[19] 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).
[20] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).
[21] 42 C.F.R. § 405.1853(a)(3).
[22] 42 C.F.R. § 405.1867.
[23] *See* 42 C.F.R. § 412.624 (2018). *See also* 42 U.S.C. § 1395ww(j). The term "rehabilitation facility" as used in 42 U.S.C. § 1395ww(j) refers to "inpatient hospital services of a rehabilitation hospital or a rehabilitation unit."
[24] *See* 42 U.S.C. § 1395ww(j)(3).
[25] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 at 369 (2010).
[26] *Id.* at § 3004(b)(2); *see also* 42 U.S.C. § 1395ww(j)(7)(C).

> **(b)** *Submission requirements.*
>
> **(1)** IRFs must submit to CMS data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, as applicable. Such data must be submitted in the form and manner, and at a time, specified by CMS.
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> ****
>
> **(f)** *Data Completion Thresholds.*
>
> **(1)** IRFs must meet or exceed two separate data completeness thresholds: One threshold set at 95 percent for completion of required quality measures data and standardized patient assessment data collected using the IRF-PAI submitted through the CMS designated data submission system; and a second threshold set at 100 percent for measures data collected and submitted using the CDC NHSN.
>
> **(2)** These thresholds (95 percent for completion of required quality measures data and standardized patient assessment data on the IRF-PAI; 100 percent for CDC NHSN data) will apply to all measures and standardized patient assessment data requirements adopted into the IRF QRP.
>
> **(3)** An IRF must meet or exceed both thresholds to avoid receiving a 2 percentage point reduction to their annual payment update for a given fiscal year, beginning with FY 2016 and for all subsequent payment updates.[27]

C. Federal Register and Additional CMS Guidance

The quality data required by 42 U.S.C. § 1395ww(j) are collected through the Centers for Disease Control and Prevention's ("CDC") National Healthcare Safety Network ("CDC NHSN system" or "NHSN").[28] IRFs must take certain steps in order to ensure that data is entered into the CDC NHSN system and transmitted to CMS by the applicable deadline.[29]

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[27] 42 C.F.R. § 412.634(b), (f) (2019) (bold and underline emphasis added and italics in original).
[28] 42 C.F.R. § 412.634(f)(1) (2019).
[29] The Centers for Medicare and Medicaid Services Inpatient Rehabilitation Facilities Quality Reporting Program Guidance for Reporting Data Into The Centers for Disease Control and Prevention's National Healthcare Safety Network (Jan. 2019) (hereinafter "CMS IRF QRP NHSN Guidance") at 2, available at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-CDC-Submission-Guidance-January-2019.pdf (last accessed Dec. 18, 2025).

With respect to the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431), the IRF CDC guidance states the following:

> . . . each IRF must submit Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) data for all health care personnel (HCP) physically working in the inpatient locations for at least 1 day between October 1 and March 31.[30]

That guidance also outlines the ability of IRFs to enroll in NHSN as Acute Care Hospital units designated as IRFs or as freestanding Inpatient Rehabilitation Facilities. However, if the IRF "is not enrolled in NHSN as a separate facility, and instead is currently submitting data as part of an acute-care hospital, i.e., as an acute care hospital unit designated as an IRF, it ***must*** have its own unique IRF CCN."[31] The CMS IRF QRP NHSN Guidance also states that if the IRF "is a freestanding [IRF] and is not currently enrolled in NHSN as a separate facility, it will have to be enrolled in NHSN as a separate facility with a unique orgID that is identified as an IRF."[32]

In the FY 2022 IRF Final Rule, the agency finalized its proposal to require IRFs to submit COVID-19 Vaccination Coverage among Healthcare Personnel ("HCP"):

> We proposed that IRFs would submit data for the measure through the CDC/NHSN data collection and submission framework. This framework is currently used for reporting the CAUTI (NQF #0138) and Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measures. IRFs would use the COVID–19 vaccination data reporting module in the NHSN Healthcare Personnel Safety (HPS) Component to report the number of HCP eligible who have worked at the facility that week (denominator) and the number of those HCP who have received a completed COVID–19 vaccination course (numerator). IRFs would submit COVID–19 vaccination data for at least 1 week each month. If IRFs submit more than one week of data in a month, the most recent week's data would be used for measure calculation purposes. Each quarter, the CDC would calculate a summary measure of COVID–19 vaccination coverage from the three monthly modules reported for the quarter. This quarterly rate would be publicly reported on the Care Compare website. Subsequent to the first refresh, one additional quarter of data would be added to the measure calculation during each advancing refresh, until the point four full quarters of data is reached. Thereafter, the measure would be reported using four rolling quarters of data on Care Compare.

[30] CMS IRF QRP NHSN Guidance at 1.
[31] *Id.* at 4 (emphasis added).
[32] *Id.*

> For purposes of submitting data to CMS for the FY 2023 IRF QRP, IRFs would be required to submit data for the period October 1, 2021 through December 31, 2021. Following the data submission quarter for the FY 2023 IRF QRP, subsequent compliance for the IRF QRP would be based on four quarters of such data submission.[33]

The Proposed Rule had received a number of comments to which the agency responded and ultimately concluded:

> After careful consideration of the public comments, we are finalizing our proposal to require IRFs to submit COVID-19 Vaccination Coverage among HCP measure data through the NHSN for at least 1 week each month for the CDC to report to CMS quarterly.[34]

In addition to the NHSN guidance and FY 2022 Final rule, CMS provides various materials with guidance on reporting protocols and requirements, including charts with data collection and submission guidelines, quick reference guides for FFY 2023 specific to COVID-19 vaccination reporting, etc., with high-level information on the IRF Quality Reporting Program, including frequently asked questions.[35]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

To satisfy certain IRF quality reporting program requirements, Phelps Health was required to collect the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) data between October 1, 2021, through December 31, 2021, and the Influenza Vaccination Coverage among Healthcare Personnel data between October 1, 2021 and March 31, 2022, both with deadlines of May 16, 2022.[36] Failure to submit the data in the correct form and manner, and at the correct time, would result in a two (2) percentage-point reduction to an IRF's AIF.[37] On July 12, 2022, CMS informed the Provider that it was non-compliant with the IRF QRP because it failed to meet the program requirements for both the Influenza Vaccination Coverage among Healthcare Personnel data (NQF #0431) and the COVID-19 Vaccination among Healthcare Personnel data.[38]

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[33] 86 Fed. Reg. at 42388-89 (footnotes omitted).
[34] *Id.* at 42400.
[35] *See generally* Exs. C-8 – C-14.
[36] Ex. C-8 at C-0057.
[37] 42 C.F.R. § 412.634(f)(3) (2019).
[38] Ex. P-7. The Board takes notice that Phelps Health did not appeal its citation for noncompliance with the NQF #0431 Influenza Vaccination Coverage among Healthcare Personnel data measure requirement; thus, the Board's ultimate determination will only be relative to the COVID-19 HCP vaccination noncompliance citation (although the Influenza reporting requirement may be referenced). *See* Provider's FPP Ex. P-2 (Request for Reconsideration); *see also* Provider's FPP at ¶ 5.

Phelps Health's primary arguments are that 1) it did not receive adequate and timely notice of its noncompliance in accordance with due process under the law, and 2) it substantively complied with all reporting requirements. The Board addresses these two arguments as follows:

1) ***Whether substantive compliance meets data submission requirements set forth in 42 C.F.R. § 412.634.***

According to Phelps Health's request for reconsideration:

> The Phelps Health Inpatient Rehabilitation Unit (CCN 26T017) is a unit of Phelps Health (CCN 26017). The facility-wide inpatient hospital COVID-19 staff vaccination data for fourth quarter 2021 was submitted timely by Phelps Health to the National Healthcare Safety Network, using the facility-wide inpatient location code.
>
> Since the reporting was done on a system level, was timely reported, and included the inpatient rehabilitation data, we ask for a reconsideration with a favorable determination be granted for our Inpatient Rehabilitation unit, including reversal of the 2% payment reduction.[39]

At the hearing, Phelps Health reiterated the argument that they "substantively complied" with the reporting requirements, as the influenza and COVID-19 vaccination data was submitted, but as part of the reporting under the acute care facility's CCN rather than the reporting under the IRF's CCN.[40]

The issue, however, is that Phelps Health Inpatient Rehabilitation Unit is a subunit of Phelps Health and has its own CCN, 26-T017, which is separate from the Phelps Health CCN 26-0017. Based on the NHSN reporting requirements, IRFs that have their own CCN are required to submit the reporting requirements under that CCN. Furthermore, the Final Rule that implemented the Influenza Vaccination Coverage Among HCP reporting requirement specifically addressed the question of whether IRFs that are affiliated with an acute care hospital must report the data separately under the IRF CCN:

> *Comment*: . . . However, a majority of commenters expressed a conditional support for this measure in which they support the use of the measure by IRFs that are freestanding hospitals, but do not support the use of this measure by IRF units that are affiliated with an acute care facility. These commenters believe that IRF units should be excluded from this measure because most IPPS hospitals include IRF unit employees in reporting health care personnel influenza vaccination rates to NHSN under the IPPS Quality Reporting program.

[39] Ex. P-2.
[40] Tr. at 47:7-17.

> *Response:* The intent of NQF measure #0431 is to incentivize full influenza vaccination coverage of all healthcare workers (HCWs) within a specific kind of facility and to measure the extent to which that goal is accomplished within that facility. We regard an IRF unit that is affiliated with an acute care facility to be its own separate type of facility, with its own responsibility for HCW vaccination and data submission. The submission of data by an IRF unit that is affiliated with an acute care facility will constitute location-specific reporting to NHSN for the HCWs who have worked within that specific unit. These IRF units will need to account for any staff that work within the unit for one day or more between Oct 1st and March 31st of a flu season and fall within the 3 required categories of staff as defined by the NHSN protocol, including payroll employees, licensed independent practitioners, and students/trainees/volunteers. The acute care facility will have the same requirements for submission of data, but will need to cover all of its inpatient care units, which will include any existing IRF units that are affiliated with an acute care facility, and will essentially be reporting facility-wide counts. The data submitted for these two separate requirements will never be summed together.[41]

Additionally, the MAC's exhibits included several guidance documents that further establish that the COVID-19 HCP vaccination data was required to be submitted by the IRF unit, not under the umbrella of the acute care facility. For instance, as explained in the January 2021 edition of the *CMS certified IRF Locations within Acute Care, Critical Access, and Long-Term Acute Care Hospitals Location Mapping* publication (as updated January 2021):

> *NHSN allows users with inpatient rehabilitation units within a facility to appropriately designate whether the unit is a separately licensed Inpatient Rehabilitation Facility (IRF).* This applies only to those units who have an 'R', ***'T'***, 'TA', 'TB', 'TC', 'TE', 'TF', 'TG', 'TH', 'TJ' or 'TK' in the 3rd position of their CMS Certification Number (CCN). ***It's important to note that rehab units will have a different CCN than the hospital itself.*** Therefore, it is essential to double check the CCN with the billing/administrative departments at your facility prior to moving forward with location set-up.
>
> NHSN will allow users to designate specific rehab locations within the facility ***as separately licensed CMS units***. In addition, users will be able to enter the rehab specific CCN, thus ***allowing the data to be appropriately sent to CMS to satisfy IRF PPS reporting requirements***.[42]

[41] 78 Fed. Reg. 47860, 47905-06 (Aug. 6, 2013).
[42] Ex. C-12 at C-0140.

Additionally, the November 2021 version of the *Review of COVID-19 Vaccination Module: Frequently Asked Questions and Data Entry* publication included the following FAQ for IRFs:

> I am reporting data for an IRF unit that is physically located within our acute care facility. The IRF unit has the same CMS Certification Number (CCN) as the hospital except for an "R" or "T" in the third position. How should I report the IRF unit data in NHSN?
>
> COVID-19 vaccination summary data for HCP working in this IRF unit should be reported separately from the acute care hospital summary data because the unit has a different CCN. You would need to add a separate monthly reporting plan for the IRF unit.[43]

As another example, in that same publication, the CDC stated:

> Facilities should follow the guidance below when making determinations about which areas of the acute care facility to include when reporting HCP COVID-19 vaccination summary data to NHSN as part of the CMS Hospital Inpatient Quality Reporting (IQR) Program:
>
> **Include** all inpatient units/departments of the acute care facility *sharing the exact same CMS Certification Number [CCN] (100% identical) as the acute care facility*, regardless of distance from the facility.
>
> * * *
>
> **Exclude** all inpatient and outpatient/units departments of the acute care facility *with a different CCN (even if different by only one letter or number) from the acute care facility*.[44]

Phelps Health argues that these guidance documents are "buried" on the CMS website and that subregulatory materials are not binding or legal authority.[45] However, Phelps Health's sole witness, Phelps Health's Associate VP of Quality, testified that as a Medicare provider, Phelps Health has been reporting quality data for "quite a few years"[46] and in order to stay "up to date with the requirements of all the different areas,"[47] one has to navigate the CMS website for guidance and instructions. Additionally, the Provider's witness acknowledged that she has

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[43] Ex. C-9 at C-0092.
[44] Ex. C-9 at C-0068 (bold emphasis in original, italics emphasis added).
[45] Tr. at 39:24-40:17; 61:10-62:4.
[46] *Id*. at 74:5-12.
[47] *Id*. at 76:1-14.

previously relied upon subregulatory guidance and instructions on the CMS website to ensure compliance with quality reporting requirements.[48]

Moreover, the Provider's witness' testimony addressed Phelps Health's reporting procedures. The Medicare Contractor inquired whether IRFs are required to submit the influenza and COVID-19 vaccination separately to which the Provider's witness responded, "Yes."[49] When asked by the Provider Representative, the witness again confirms that "Phelps Health did, in fact, report all inpatient rehabilitation facility personnel vaccinations, for both flu and COVID -- admittedly, under the hospital reporting umbrella."[50] The witness also testified that Phelps Health had never had a 2% reduction applied prior to the FFY 2023 reductions.[51] Therefore, the Board reasonably concludes that Phelps Health properly reported the influenza vaccination coverage under the IRF CCN in prior calendar years (the inception of the IRF QRP compliance requirements were in FY 2015) up until 2020 (*i.e.*, the previous reporting year), and thus was aware of the distinct IRF subunit reporting requirement.[52]

Accordingly, the Board finds Phelps Health's substantive compliance argument and its nonbinding subregulatory guidance arguments unpersuasive. First, pursuant to 42 C.F.R. § 412.634(f), IRFs are required to meet a 100% threshold for data measures submitted via the CDC's NSHN for the IRF QRP—that is, submitted by the IRF unit under its own CCN, where applicable. Second, to receive reimbursement under the Medicare program, Medicare providers are contractually obligated to comply with all applicable laws and regulations as well as "***program instructions"*** in the form of subregulatory guidance.[53] It is unfathomable that every technical component of the reporting requirements under the Medicare Program (including quality reporting programs) be set forth in a statute or regulation. Here, the law, 42 C.F.R. § 412.634(b), states that an IRF must submit quality reporting data "in the form and manner, and at a time, specified by CMS."[54] And, as argued by the MAC, failure to follow published

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[48] *Id*. at 74:21–76:14.
[49] *Id*. at 58:16-18.
[50] *Id*. at 47:7-17.
[51] *Id*. at 46:1-7.
[52] *See* 79 Fed. Reg. 45872, 45909 (where CMS discussed the adoption of the HCP Influenza Vaccination data measure requirement referencing the FY 2014 IRF PPS final rule (78 FR 47905 through 47906)) (Aug. 6, 2014); *see also* IFR QRP Archives (which includes Phelps Health CCN 26T017 on APU Compliant Lists identifying IRFs That Successfully Met QRP Reporting Requirements for FY 2017, FY 2018, and FY 2019) (available at https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-archives) (last accessed December 18, 2025).
[53] *See* Medicare Provider Enrollment Application (CMS-855a) where providers must attest to the following:

I agree to abide by the Medicare laws, regulations ***and program instructions*** that apply to me or to the organization listed in section 2B1 of this application. The Medicare laws, regulations, ***and program instructions*** are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, ***and program instructions*** (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (Section 1877 of the Social Security Act)). (Emphasis added.) Available at: https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855a.pdf (last accessed December 18, 2025). *See also* the requirements for enrolling in the Medicare program at 42 C.F.R. § 424.510 (requiring that the provider attest that it "is aware of, and abides by, all applicable statutes, regulations, and program instructions.")
[54] *See also* 76 Fed. Reg. 47836, 47873 (Aug. 5, 2011); *also* at Ex. C-5 at C-0022).

subregulatory guidance on how to timely submit the data in the proper form and manner is at the provider's own peril.[55]

Based on the foregoing, it is clear that IRFs are required to report their data under the specific CCN. Therefore, Phelps Health's submission of the IRF data along with the parent facility is insufficient for its IRF unit's compliance with the 100% data completion threshold requirement set forth in 42 C.F.R. § 412.634.

2) Whether CMS has violated Constitutional due process requirements.

Phelps Health also raises due process arguments including a lack of detail in the initial non-compliance notice, and inadequate or untimely notice of their noncompliance with the distinct IRF CCN reporting requirement.[56] The Board finds, however, that the Provider did have appropriate notice in accordance with due process, in both instances.

Phelps Health argues that the June 27, 2022 Notice of Noncompliance issued by the MAC failed to place them on notice of the specific reporting requirements for which Phelps Health was cited noncompliant.[57] The Board recognizes that the June 27, 2022 notice of noncompliance does not specifically state which specific reporting requirement(s) the Provider did not meet. However the D.C. Circuit Court has held that even where adverse action notice letter explanations are "basic," such may still meet the fundamental due process requirement of adequate notice if the subject is provided an opportunity to "flesh out the notice at any stage" prior to a final and irrevocable determination.[58] In this case, the June 27, 2022 Notice of Noncompliance sets forth the reconsideration request process and provides the contact information of the notice letter's signatory for questions.[59] Additionally, the notice letter informs the Provider that they must request reconsideration before they can file an appeal before the Board, which indicates that the noncompliance determination communicated in the letter is not final.[60] Additionally, the July 12, 2022 notice issued by CMS ***does*** specifically identify the requirements that CMS alleges the Provider did not meet.[61] Moreover, Phelps Health acknowledges that the contents of the July 12, 2022 notice issued by CMS (within 2 weeks of the MAC's notice) specifies the HCP Influenza and COVID-19 Vaccination Coverage data measures requirements as the basis of the

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[55] Tr. at 101:15-102:1.
[56] Provider's Preliminary Position Paper (hereinafter "Provider's PPP") at ¶¶ 14-18 (Oct. 19, 2023).
[57] *Id.* at ¶ 14.
[58] *Bailey v. Mut. of Omaha Ins. Co,* 534 F. Supp. 2d 43, 54–55 (D.D.C. 2008) (where the Court held that a Medicare fiscal intermediary's denial of coverage explanation, "the information provided does not support the need for this service or item," did not violate due process where beneficiaries had the right to initiate procedures for obtaining additional information and a right to request a redetermination or an appeal); *see also Gray Panthers v. Schweiker,* 652 F.2d 146, 169 (D.C. Cir. 1980) (where the Court held "It may be that in some circumstances a lack of precise initial notice of the grounds for denial may be compensated for by ready access to the adverse evidence or a summary thereof" and that claimants should have an opportunity to "flesh out the notice at any stage. . . before a final and irrevocable denial of benefits is made.")
[59] See Ex. P-1; *Cf. Gray Panthers v. Schweiker,* 652 F.2d at 157 (where the notice at issue provided a telephone number but the Court found that record did not demonstrate that by calling the number would one be able to speak directly with a decision maker about the denial of their claim).
[60] *See* Ex. P-1.
[61] *See* Ex. P-7.

noncompliance determination.[62] Accordingly, Phelps Health's due process argument as to the inadequacy of the contents of the June 27, 2022 notice fails.

Next, Phelps Health argues that CMS' issuance of the July 12, 2022 Noncompliance Letter via iQIES violates due process because they did not receive the letter directly and because there is no proof that CMS deposited the letter into iQIES.[63] Here too, Phelps Health's due process arguments fail. First, 42 C.F.R. § 412.634(d) clearly states:

> (d) ***Reconsideration.***
>
> (1) IRFs that do not meet the requirement in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: ***The CMS designated data submission system,***[64] the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).[65]

Additionally, the IRF QRP FAQs published as of February 2021, stated, in pertinent part:

> **16. Does the Centers for Medicare & Medicaid Services (CMS) tell IRFs if they are non-compliant with the QRP requirements?**
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> Yes. Any IRF found non-compliant will receive a letter of notification from its Medicare Administrative Contractor (MAC). ***Compliance letters will be distributed electronically into the Non-***

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[62] Tr. at 41:11-42:20; *see also id*. at 92:6-10 (where Provider's counsel states, "We understand this notice appears to, potentially, comply with due process, and that it does tell you specific requirements. However, again, we did not receive that.").

[63] Provider's FPP at ¶ 22.

[64] A review of the history of 42 C.F.R. § 412.634(d) shows that as early as August 2, 2017, this subsection referenced the retired QIES ASAP system as a method of noncompliance notification (in addition to U.S. Mail). On October 8, 2018, the subsection was amended to indicate notices of noncompliance would be issued either through QIES ASAP, U.S. Mail, or via email from the MAC. On October 1, 2019, the subsection was amended as follows and to-date states:

> (d) ***Reconsideration.***
>
> (1) IRFs that do not meet the requirement in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: ~~Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP)~~ The CMS designated data submission system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

See also 84 Fed. Reg. 39054, 39161 (Aug. 8, 2019) (where CMS' proposal to migrate to iQIES and to generically amend the language in § 412.634(d) was subject to public comment and implemented via the final rule); *see also* 81 Fed. Reg. 52056, 52125 (Aug. 5, 2016) (where CMS clarified that the QIES mechanism may be used as a noncompliance notification mechanism in addition to U.S. Mail).

[65] Emphasis added.

Compliance Notification folders in the Internet Quality Improvement and Evaluation System (iQIES) for each IRF to access. This letter also includes the reason(s) for failing annual increase factor (AIF) compliance.

17. I received a letter of notification that my IRF is non-compliant with the IRF QRP requirements. Can I ask CMS to reconsider the decision?

If an IRF believes the finding of non-compliance is an error, or it has evidence that an extraordinary circumstance prevented timely submission of data, the IRF may file for a reconsideration. An example of extraordinary circumstances might include a fire in the building. The notification letter sent by the MAC will include instructions for requesting reconsideration of this decision. An IRF disagreeing with the payment reduction decision may submit a request for reconsideration to CMS within 30 days ***from the date at the top of the non-compliance notification letter distributed electronically using iQIES.*** CMS will not accept any requests submitted after the 30-day deadline.[66]

Phelps Health has argued that subregulatory guidance and instructions are nonbinding and do not carry the weight of the law and takes the position that only statutes or published regulations are binding.[67] Accordingly, Phelps Health cannot dispute that since October 1, 2019, 42 C.F.R. § 412.634, a published regulation, clearly states that CMS issues written notification of IRF QRP non-compliance through at least one of three methods including "[t]he CMS designated data submission system," which is the Internet Quality Improvement and Evaluation System (iQIES).[68] Further, Phelps Health does not dispute that, as required, it registered for iQIES access.[69] However, despite Phelps Health maintaining responsibility for IRF quality reporting, its acute rehab therapy services contractor, LifePoint, monitors Phelps Health's iQIES account.[70]

Phelps Health contends that it did not timely receive the July 12, 2022 Noncompliance Notice because there is no evidence that LifePoint was alerted that a noncompliance letter had been issued via iQIES.[71] This argument simply fails. As stated above, the regulation clearly states that written notifications of noncompliance will be issued by one of three methods, all of which must be monitored by the provider (or its designee) to determine whether they have received any such notice. Additionally, on July 13, 2022, CMS issued an IRF QRP Spotlight & Announcement[72] stating:

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[66] Ex. C-14 at C-0160.
[67] Tr. at 8:1-9.
[68] *See infra* n. 74.
[69] *See* Ex. C-14 at C-0157 (where the FAQ indicates that providers are required to create iQIES accounts and establish credentials).
[70] Tr. at 68:20-69:17, 71:8-72:22.
[71] Tr. at 88:14-89:19.
[72] These types of announcements date back as early as 2014. *See* IRF QRP Archives, 2014 IRF Spotlight Announcements (ZIP), September 23, 2014, Attention Inpatient Rehabilitation Facility (IRF) Providers! (located at

> **July 13, 2022**
>
> **IRF QRP: Non-Compliance Notifications**
>
> The Centers for Medicare & Medicaid Services (CMS) is providing notifications to Inpatient Rehabilitation Facilities (IRFs) that were determined to be out of compliance with IRF Quality Reporting Program (QRP) requirements for calendar year (CY) 2021, which will affect their fiscal year (FY) 2023 Annual Increase Factor (AIF). ***Non-compliance notifications will be distributed by the Medicare Administrative Contractors (MACs) and will be placed into facilities' My Reports folders in Internet Quality Improvement and Evaluation System (iQIES) on* July 13, 2022.** Facilities that receive a letter of non-compliance may submit a request for reconsideration to CMS **via email no later than 11:59 pm, August 11, 2022.** If you receive a notice of noncompliance and would like to request a reconsideration, see the instructions in your notification letter and on the IRF Quality Reporting Reconsideration and Exception & Extension webpage.
>
> **Please note:** Any reconsideration containing protected health information (PHI) will not be processed. All PHI must be removed in order for a reconsideration to be reviewed.[73]

Despite the regulation's unambiguous language and the fact that an announcement was published on the CMS website in a section dedicated to the IRF Quality Reporting Program, Phelps Health places the onus on CMS or the MAC to alert them to check their "Non-Compliance Notification" or "My Reports" folders in iQIES, which also equates to expecting an alert that a letter is being mailed via the Postal Service or that an email is forthcoming—none of which is required or sensible.

In this case, it is clear that between July 13, 2022 and August 11, 2022, despite having the capability to do so, no one checked Phelps Health iQIES account for a noncompliance notification. This is apparent from the Provider's witness' testimony:

> Q: Sure. In this specific letter, under No. 2, they -- the MAC requests a compliance letter distributed electronically into the noncompliance notification folder in the Internet Quality Improvement and Evaluation System?

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https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-archives) (last accessed December 10, 2025).

[73] *See Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Spotlights & Announcements* (original emphasis in bold and bold italics emphasis added) (available at https://www.cms.gov/files/document/2023-march-irf-spotlight-and-announcements-archive.pdf) (last accessed December 18, 2025).

A: Yes, that's what it says.

Q: Okay. And after I provided you with Exhibit 5, ***what actions did you take to locate this requested letter from the MAC***?

A: ***I reached out to the contracted company.***

Q: ***And so the contracted company, they then located this letter?***

A: ***Yes***.[74]

***

Q: There has been a lot of questions, as well, regarding the subcontractor, LifePoint, for the IRF, receiving this -- I believe it's Exhibit 7 of the Provider's exhibits. There's been a lot of questions regarding how that might have been received by this subcontractor. ***Is it your understanding that that document was found in the iQIES folder*** when we requested it during this appeal?

A: ***Correct.***[75]

Undoubtedly, providers are permitted to delegate certain functions to subcontractors; however, providers must properly monitor their respective delegated entities because the providers are ultimately responsible for complying with all "Medicare laws, regulations and program instructions" as agreed upon enrollment as a Medicare provider. In this case, Phelps Health failed to provide adequate oversight of and/or failed to collaborate with LifePoint regarding iQIES noncompliance notification monitoring.[76]

Based on the foregoing, the Board finds that neither the contents of the June 27, 2022 notice letter issued by the MAC nor the issuance of the July 12, 2022 notice letter from CMS violate the well-established premise that "adequate notice lies at the heart of due process."[77]

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[74] Tr. at 44:7-22 (emphasis added).
[75] *Id*. at 88:14-25 (emphasis added).
[76] *See id*. at 69:7-17 (where the Provider's witness admits that at the time in question, Phelps Health did not have monthly meetings with LifePoint but now they do).
[77] *Gray Panthers v. Schweiker*, 652 F.2d at 168 ("It is universally agreed that adequate notice lies at the heart of due process.").

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the two (2) percentage-point reduction of the Medicare AIF for FFY 2023 for Phelps Health was proper.

BOARD MEMBERS PARTICIPATING:

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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