PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D19

PROVIDER –
Hospice Care Corporation d/b/a West Virginia Caring

HEARING HELD –
June 26, 2025

PROVIDER NO. – 51-1504

FEDERAL FISCAL YEAR– 2024

vs.

MEDICARE CONTRACTOR –
CGS Administrators

CASE NO. – 24-0168

INDEX

ISSUE STATEMENT:

Whether the four (4) percentage point reduction in the Medicare Annual Payment Update ("APU") for Hospice Care Corporation d/b/a West Virginia Caring ("West Virginia Caring" or "Provider") for the failure to meet the requirements of the Hospice Quality Reporting Program ("HQRP") was proper.[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 four percentage point reduction in its FY 2024 APU was proper.

INTRODUCTION AND PROCEDURAL HISTORY:

Hospice Care Corporation d/b/a West Virginia Caring ("West Virginia Caring" or "Provider") "is a Medicare-certified, nonprofit hospice provider that is located in West Virginia."[2] West Virginia Caring's designated Medicare contractor[3] is CGS Administrators ("Medicare Contractor").[4]

The APU for FY 2024 Medicare payments is impacted by CY 2022 Hospice Item Set ("HIS") data, which was required to meet a threshold that ninety percent (90%) of all required records be submitted within thirty (30) days of the patient's admission or discharge, as applicable.[5] By letter dated July 14, 2023, the Medicare Contractor notified the Provider that it was subject to a reduction of its APU by four (4) percentage points for FY 2024, finding "that your agency is noncompliant for the reporting requirements for Hospice Item Set (HIS)."[6] The letter also indicated that if the Provider believed it was identified for this payment reduction in error, "[y]ou have the right to request a reconsideration of this decision."[7]

The Provider requested reconsideration of CMS' decision.[8] After reviewing the request for reconsideration, by letter dated October 11, 2023, the Medicare Contractor notified the Provider

---

[1] Transcript of Proceedings [hereinafter "Tr."] at 5:8-17 (Jun. 26, 2025).
[2] *Id*. at 7:23-8:1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted 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] Medicare Contractor's Final Position Paper [hereinafter "Medicare Contractor's FPP"] at 1, 12 (Apr. 25, 2025).
[5] 86 Fed. Reg. 42528, 42576 (Aug. 4, 2021), *available as* Exhibit [hereinafter "Ex."] C-4 at C00035.
[6] Ex. C-1 (Non-Compliance Notification) at C00002.
[7] *Id*.
[8] *See* Ex. C-2 (4% Uphold Letter). The Board notes that while the original request for reconsideration was not provided for the record, the Medicare Contractor's 4% Uphold Letter at Ex. C-2 refers to such a request.

that CMS was "upholding the decision to reduce the [APU] for Medicare payments for FY 2024" by four (4) percentage points, explaining that the Provider "did not provide evidence that it submitted required quality measure data during the required timeframes."[9] On November 14, 2023, the Provider timely appealed the reconsideration determination to the Board and met the jurisdictional requirements for a hearing.

The Board held a live hearing on June 26, 2025. The Provider was represented by Kristen Andrews Wilson, Esq. of Steptoe & Johnson, PLLC. The Medicare Contractor was represented by Charles Moreland, Esq. of Federal Specialized Services ("FSS").

STATEMENT OF RELEVANT FACTS:

Hospice providers are required to report quality data, including HIS survey data, unless exempt from the reporting requirements.[10] HIS data is submitted through the Quality Improvement and Evaluation System ("QIES") Assessment Submission and Processing ("ASAP") system and must be submitted within 30 days of the event date, "which is the patient's admission date for HIS-Admission records or discharge date for HIS-Discharge records."[11] For the FY 2024 APU determination, at least 90% of all HIS assessments must be submitted within 30 days of the event date to avoid the payment reduction.[12]

As mentioned above, by letter dated July 14, 2023, the Medicare Contractor notified the Provider that it was subject to a reduction of its APU by four (4) percentage points for FY 2024 finding "that your agency is noncompliant for the reporting requirements for Hospice Item Set (HIS)."[13] In their position paper, West Virginia Caring acknowledges this by stating:

> [A] glitch in the 2022 reporting data resulted in WV Caring uploading the same HIS data to the portal for a number of months. West Virginia Caring had the correct data for submission the entire time, but the correct documents were not uploaded. Unfortunately, the problem was not discovered until July 14, 2023, when CGS, WV Caring's Medicare Administrative Contractor, sent a letter notifying WV Caring of its failure to comply with its HIS reporting requirements.[14]

Via testimonial and documentary evidence, West Virginia Caring explained the "glitch" as follows: West Virginia Caring collected the required data for the HIS report and entered it into its third-party vendor's site.[15] The vendor returned a secure email with a compressed file

---

[9] Ex. C-2.
[10] *See* 42 C.F.R. § 418.312(b), (d), discussed *infra*.
[11] 80 Fed. Reg. 47142, 47191 (Aug. 6, 2015).
[12] Hospice Quality Reporting Program Quick Reference Guide at 1-2, available at https://www.cms.gov/files/document/hqrp-quickreferenceguide-fy-2023-and-all-future-yearsseptember2021.pdf (accessed June 18, 2026).
[13] Ex. C-1 at 00002.
[14] Provider's Final Position Paper [hereinafter "Provider's FPP"] at 1 (Mar. 28, 2025).
[15] *See* Tr. at 17 – 19.

formatted for submission to Medicare.[16] West Virginia Caring then saved the compressed file to a thumb drive.[17] Then, West Virginia Caring used the thumb drive to submit that data to CMS.[18] Thus, the error occurred as a result of a failure of the "new" data to properly save on a thumb drive used for the data prior to reporting it to CMS and as a result, "old data" was uploaded for 2022.[19]

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) (2022), 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 (***or for fiscal year 2024 and each subsequent fiscal year, 4 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.

---

[16] *See* Tr. at 19, *see also* Ex. P-2 (Emails from HCF).
[17] *See* Tr. at 20:23-25; *see also* Tr. at 21:10 – 15.
[18] *See* Tr. at 20:23-25.
[19] *See* Tr. at 22:18 – 22. *See also* Provider's FPP at 1 (Mar. 28, 2025). *See also* Medicare Contractor's FPP at 6 (Apr. 25, 2025).

(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 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 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, including exemptions and extensions requirements, are found at 42 C.F.R. § 418.312 (2023) 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.
>
> (b) Submission of Hospice Quality Reporting Program data.
>
> (1) Standardized set of admission and discharge items Hospices are required to complete and submit an admission Hospice Item Set (HIS) and discharge HIS for each patient to capture patient-level data, regardless of payer or patient age. The HIS is a standardized set of items intended to capture patient-level data.
>
> (2) Administrative data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay, are required and fulfill the HQRP requirements for § 418.306(b).
>
> . . .
>
> (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.

(i) Exemptions and extensions requirements.

(1) A hospice may request and CMS may grant exemptions or extensions to the reporting requirements under paragraph (b) of

this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the hospice.

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

(i) Hospice CMS Certification Number (CCN).

(ii) Hospice Business Name.

(iii) Hospice Business Address.

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

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

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

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

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

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

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

(j) Data completion thresholds.

> (1) Hospices must meet or exceed data submission threshold set at 90 percent of all required HIS or successor instrument records within 30-days of the beneficiary's admission or discharge and submitted through the CMS designated data submission systems.
>
> (2) A hospice must meet or exceed the data submission compliance threshold in paragraph (j)(1) of this section to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as described under § 412.306(b)(2) of this chapter.

B. Guidance

The HIS Submission User's Guide provides instructions for submitting HIS data. Particularly, at Steps 5, 6 and 8, it provides:

> 5. Select the **OK** button if you wish to proceed with the upload of the selected file.
> The name of the selected file is populated into the *File Name* field on the Hospice File Submission **File Upload** page and the upload proceeds immediately. The Hospice File Submission **File Upload** page displays an "Upload in progress …" message (Figure 3-12).
>
> [Figure omitted]
>
> **NOTE**: The time it takes for the Hospice File Submission system to receive the HIS data file you submitted depends upon the size of your file and concurrent system activity. Until you receive confirmation that your file was successfully uploaded, do not exit the Hospice File Submission system or perform any other function. You risk interrupting the file upload process if you do not wait for the confirmation message.
>
> When the submitted file is successfully received at the National Submissions Database, an **Upload Completed** dialog box (Figure 3-13) is presented.
>
> [Figure omitted]
>
> 6. Select the **OK** button to continue.
>
> The Hospice File Submission **File Upload** page now displays a message (Figure 3-14) confirming that the file you submitted was successfully received at the National Submissions Database.
>
> [Figure omitted]

The submission received confirmation message provides the following information:

- Submission ID – the numeric identifier assigned to your file by the Hospice File Submission system
- Submission Date – the date and time that the National Submissions Database received your file in the Eastern time zone
- File Name – the name of the file that you submitted

The confirmation message also includes the following notation:

> "Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission, may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Reports."

NOTE: The confirmation message only indicates successful receipt of the file at the National Submissions Database. Errors that exist in the submitted file are identified only after the Hospice system subsequently validates the file.

[* * *]

8. You may now submit another file or log out of the Hospice File Submission system.

After your submitted HIS data file is successfully received at the National Submissions Database, the QIES ASAP Hospice system validates the file structure and data content based upon the HIS data specifications. Within 24 hours of a successful submission, you may access a Final Validation Report in the CASPER Reporting application that provides a detailed account of any errors found during the validation of the records in the submitted HIS file.

[* * *][20]

[20] Ex. C-6 (HIS Submission User's Guide) at C00093 – 95.

The HIS Submission User's Guide also lists possible file processing error messages for HIS data:

> FILE PROCESSING ERROR MESSAGES FOR HOSPICE ITEM SET DATA
>
> Within 24 hours of the successful submission of a file, the QIES ASAP system processes the file and automatically produces a Hospice Final Validation Report detailing the errors, if any, that were encountered in the submitted records. This Hospice Final Validation Report is available to you in the CASPER Reporting application.
>
> [* * *]
>
> - Duplicate record
>
> [* * *][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, 217 (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 interpretative rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[25]

---

[21] Ex. C-6 (HIS Submission User's Guide) at C00106. *See also* Tr. at 101:7-25.
[22] 42 C.F.R. § 405.1871(a)(3).
[23] 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." S*ee 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.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

To find in favor of West Virginia Caring (*i.e.*, to find that the 4% APU reduction does *not* apply), the Board must find that West Virginia Caring submitted the quality data in the "*form and manner, and at a time,* specified by the Secretary."[26]

1. ***Whether West Virginia Caring's evidence demonstrates full compliance with the time, form and manner requirements.***

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.[27] In the instant case, West Virginia Caring admits that it failed to reach the 90% threshold.[28] According to the Provider, the failure was due to "a good faith technical error . . . glitch [in which] records were submitted during the timeframe, but they were the same record being submitted each week."[29] This issue continued "until July 14, 2023 when CGS, WV Caring's Medicare Administrative Contractor, sent a letter notifying WV Caring of its failure to comply with its HIS reporting requirements."[30] West Virginia Caring also noted that the data was available, but was not submitted due to the error.[31]

Therefore, because the error was an admitted technical glitch due to the Provider's internal data submission processes, 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.

2. ***Whether the Provider's noncompliance should be mitigated by extenuating or extraordinary circumstances.***

West Virginia Caring argues that the Board should not enforce the penalty for this failure, asking that "the Board find that the issue does not warrant enforcement under these circumstances."[32]

At the outset, with reference to any "extraordinary circumstances" averred by Provider, it is important to highlight that an evaluation of extraordinary circumstances is relative to the exception request requirements set forth in 42 C.F.R. § 418.312(i), whereby "A hospice may

---

[26] 42 U.S.C. § 1395f(i)(5)(C); 42 C.F.R. § 418.312(a) (italics emphasis added).

[27] 80 Fed. Reg. at 47192, *stating*:

> In order to accurately analyze quality reporting data received by hospice providers, it is imperative we receive ongoing and timely submission of all HIS-Admission and HIS-Discharge records. [. . .] The timeliness threshold would be set [. . .] 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.

[28] *See* Tr. at 8:7-10; 22:18-22; 26:3-7; 27:9-14; 29:1-5; 106:19-24.

[29] Tr. at 8:11-12; 8:23–9:2.

[30] Provider's FPP at 1.

[31] *Id*.

[32] Tr. at 10:15-17.

request and CMS may grant exemptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the hospice." Additionally, 42 C.F.R. § 418.312(i)(2) provides that such requests must be made "within 90 days of the date that the extraordinary circumstances occurred." Finally, 42 C.F.R. § 418.312(h)(3)) specifically states, "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."

In this case, the Board finds that there was no such request submitted to CMS.[33] Thus, in the absence of the required extension or exception request, the Board may not find that CMS did not properly assess any purported extraordinary circumstances and that, upon reconsideration, it improperly upheld a denial of an exception request. Here, the Provider failed to timely avail itself of the exceptions / extensions process and now requests that the Board grant such relief, which would thwart the administrative remedy exhaustion requirements applicable to the QRP program.

Assuming arguendo that West Virginia Caring requested an extraordinary circumstances exception pursuant to 42 C.F.R. § 418.312(i) and the issue was before the Board in this appeal, the evidence and testimony do not indicate "certain extraordinary circumstances beyond the control of the hospice."[34] To the contrary, the evidence and testimony show that staffing shortages and insufficient training created a complicated process for handling files, causing a technical error where the same file was repeatedly uploaded each month without staff realizing it.[35] Moreover, the witness for West Virginia Caring admitted during examination that West Virginia Caring could have used the CASPER Reporting application to validate that the submission was correct—but they did not because the witness did not know how to do so.[36]

Additionally, the Board operates as an independent panel governed by applicable statutes that provides certified Medicare service providers with a forum to appeal decisions rendered by their Medicare contractor or CMS. The Board's jurisdiction is strictly confined to statutory and regulatory requirements, as well as the facts and circumstances relevant to the issues under review; thus, it does not possess equitable authority in these appeals.[37]

---

[33] *See* 42 C.F.R. § 418.312(i)(2).

[34] 42 C.F.R. § 418.312(i)(1).

[35] *See supra* Statement of Relevant Facts. *See also*, Tr. 37:5 – 25.

> [Board Member]: I'm sorry, let me rephrase. HEALTHCAREfirst then returns the information to you via email in a ZIP file? [Witness]: Correct. [Board Member]: Which is an attachment to the email? [Witness]: Yes. [Board Member]: You then download it onto the downloads on your computer and onto a thumb drive -- [Witness]: Yes. [Board Member]: -- on your computer? [Witness]: Yes. [Board Member]: And then you use a same [sic] thumb drive in the same -- insert it into the same computer? [Witness]: Yes, ma' am. [Board Member]: Why did you not use the files that were on the computer? [Witness]: ***I was doing what I had been trained to do.***

[36] *See* Tr. at 24:25 – 25:15, 26:8-18, and 101:7 - 102: 8; *see also* Tr. 29:6-19 (where the witness acknowledges that CASPER validation reports indicate error messages including a duplicate records error message) and Tr. 40:2-5 (where the witness acknowledges her lack of training on utilizing CASPER validation reports).

[37] 42 C.F.R. § 405.1867.

For the reasons stated above, the Board finds that CMS correctly assessed West Virginia Caring a four (4) percentage point reduction in its FY 2024 payments.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that West Virginia Caring 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 four percentage point reduction in its FY 2024 APU was proper.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

6/25/2026

X Kevin D. Smith, CPA

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