PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2026-D22

PROVIDER –
Berkley Palliative Care & Hospice, LLC

PROVIDER NUMBER –
06-1594

vs.

MEDICARE CONTRACTOR –
CGS Administrators

HEARING DATE –
April 29, 2025

FEDERAL FISCAL YEAR –
2024

CASE NUMBER –
24-0109

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor's four (4) percentage point reduction to Berkley Palliative Care & Hospice, LLC's Federal Fiscal Year ("FFY") 2024 Annual Payment Update ("APU"), for failure to meet all Hospice Quality Reporting Program ("HQRP") requirements was proper.[1]

DECISION:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that Berkley Palliative Care & Hospice, LLC did not submit its hospice quality data in the form and manner, and at a time specified by the Secretary of Health and Human Services ("Secretary") and thus, the four (4) percentage point reduction in its FY 2024 APU was proper.

INTRODUCTION:

Berkley Palliative Care & Hospice, LLC ("Berkley" or "Provider") is a freestanding hospice provider located in Aurora, Colorado.[2] Berkley's assigned Medicare contractor[3] is CGS Administrators, LLC ("Medicare Contractor").[4]

By letter dated July 14, 2023, the Medicare Contractor notified Berkley that it was subject to a reduction of its APU by four (4) percentage points for FFY 2024 "for not meeting the Affordable Care Act ("ACA") of 2010 requirement for hospices to submit quality data."[5] Specifically, the Notice stated that the Provider was noncompliant with the quality data reporting requirements for the timely submission of Hospice Item Set ("HIS") data.[6]

Berkley requested reconsideration of the APU reduction. By letter dated October 11, 2023, CMS notified Berkley that it upheld the four (4) percentage point reduction to Berkley's FFY 2023 APU.[7] CMS found that Berkley "did not provide evidence that it submitted required quality measure data during the required timeframes."[8]

On October 27, 2023, Berkley timely appealed the reconsideration determination to the Board and met the jurisdictional requirements for a hearing.

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[1] *See* Stipulation of Undisputed Facts (hereinafter "Stip.") at ¶ 3 (Apr. 29, 2025); Transcript of Proceedings (hereinafter "Tr.") at 5 (Apr. 29, 2025).
[2] Stip. at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted to organizations known as Medicare Administrative Contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs, as appropriate and relevant.
[4] Stip. at ¶ 2.
[5] Exhibit (hereinafter, "Ex.") C-1 (Medicare Contractor Notification of APU Reduction) at C-0002.
[6] *Id.*
[7] Ex. C-2 (Medicare Contractor Denial of Reconsideration) at C-0006.
[8] *Id.*

The Board held a video hearing via Zoom on April 29, 2025. Berkley was represented by Gary Ruvins of Berkley Palliative Care & Hospice, LLC. The Medicare Contractor was represented by Robert A. Evarts, Esq. of Federal Specialized Services.

STATEMENT OF RELEVANT FACTS:

Hospice providers are required to report quality data, including HIS survey data, unless exempted from the reporting requirements.[9]

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 patient's admission date for HIS-Admission records or the patient's discharge date for HIS-Discharge records.[10] HIS records must be submitted "using software that creates files that meet the requirements detailed in the current HIS Data Submission Specifications . . ."[11] Berkley typically submitted its HIS data from an office environment because of secure computer communications with the HIS portal.[12]

In 2022, Berkley had an administrative staff of three (3): the manager, an intake person, and one additional clerk.[13] The manager was the only employee responsible for submitting HIS records.[14] In or about April or May 2022, the manager contracted COVID-19, and experienced Long COVID lasting until June 2022.[15] As a result, HIS reporting for Berkley lapsed during the period of May and June of 2022.[16]

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**

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[9] *See* 42 C.F.R. § 418.312(b), (d), discussed *infra*. *See also* Ex. C-4 at C-0035.
[10] 80 Fed. Reg. 47142, 47191 (Aug. 6, 2015). *See also* Ex. C-7 (Hospice Quality Reporting Program Public Reporting Tip Sheet 2nd Edition) at C-0078.
[11] Ex. C-12 (HIS Manual, Effective Feb. 16, 2021) at C-0116.
[12] *See* Tr. at 24:3-8.
[13] *Id.* at 22:20 – 23:4.
[14] *See* Tr. at 11:20-22, 23:4-7.
[15] *See* Tr. at 23:15 – 24:3, 25:3-6. "Long COVID is defined as a chronic condition that occurs after SARS-CoV-2 infection and is present for at least 3 months." Long COVID Basics, May 6, 2026, https://www.cdc.gov/long-covid/about/index.html. (last accessed 07/09/2026).
[16] *See* Tr. at 24:21, 25:5.

> 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.
>
> **(B) Noncumulative application**
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> 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.[17]

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 (effective October 1, 2021 to September 30, 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.***

[17] (Bold headers in original, bold and italics emphasis added.)

(1) Standardized set of admission and discharge items Hospices are required to complete and submit an admission Hospice Item Set (HIS) and a discharge HIS for each patient to capture patient-level 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 through 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.

B. Guidance

The Hospice Quality Reporting Program (HQRP) COVID-19 Public Reporting Tip Sheet ("Tip Sheet") issued by CMS provides:

> **Temporary HQRP Exemptions Due to the COVID-19 PHE**
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> The CMS March 27, 2020 Medicare Learning Network (MLN) memo provided temporary exemptions to the HQRP data submission requirements due to the COVID-19 PHE. CMS made data submissions optional or temporarily exempted providers from the submission of the CAHPS® Hospice Survey and HIS assessment and discharge data for the quarters in Figure 1.
>
> [Figure omitted]

> These exemptions to the HQRP data submission requirements ended on **June 30, 2020**.[18]

Further, the Tip Sheet states:

> **Data Submission After July 1, 2020 – Refresher**
> *Please refer to the HQRP COVID-19 PHE Tip Sheet for more details.*
>
> **Starting on July 1, 2020,** hospices were to resume timely quality data collection and submission. There are two reporting requirements for the HQRP:
>
> - HIS
> - CAHPS® Hospice Survey
>
> **HIS**
>
> All new HIS admission records and any HIS discharge records occurring on or after July 1, 2020, should be submitted. This means that data submission must occur for all patients within 30 days of admission and discharge at least 90 percent of the time.[19]

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."[20] 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."[21] 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."[22] 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

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[18] Ex. C-6 at C-0069 (bold and italics in original). The Board notes that this information is reiterated in a Second Edition of the Tip Sheet, shown at Ex. C-7.
[19] *Id.* at C-0072.
[20] 42 C.F.R. § 405.1871(a)(3).
[21] 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).
[22] *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

considered in making its determination, . . . is included in the record."[23] 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."[24]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

To find in favor of Berkley (*i.e.*, to find that the 4% APU reduction does not apply), the Board must find that Berkley submitted the quality data in the "*form and manner, and at a time*, specified by the Secretary."[25]

Berkley makes no argument that it met the 90% threshold for timely Hospice Item Set (HIS) submissions under the Hospice Quality Reporting Program (HQRP) for FY 2022, focusing instead on why it should be exempt from the penalty.[26] Its explanation is that a single employee's illness, compounded by pandemic disruptions resulted in an accidental oversight.[27] Furthermore, the manager admitted that Berkley did not have any backup plan for the HIS data submissions because "I was responsible for the HIS submissions because I could not find anyone that I could trust with something as important."[28] Berkley's explanation falls short of the regulatory standard for relief.

The extraordinary circumstances exemption under 42 C.F.R. § 418.312(i) requires circumstances *beyond the hospice's control* in order for CMS (not the Board) to grant an exemption or extension.[29] The illness of one employee, absent any cross-training or contingency planning, reflects an internal operational failure — not an unforeseeable external event. While CMS did grant blanket exemptions as a result of the COVID-19 pandemic, those exemptions were temporary and addressed reporting in the beginning of the pandemic. The temporary exemptions expired on June 30, 2020.[30] Berkley's failed HIS reporting was in 2022, almost two years later.[31] The Medicare Contractor proffers that Berkley never submitted a formal extension request to CMS, despite clear agency guidance directing providers to send its exception or extension requests via email to HospiceQRPReconsiderations@cms.hhs.gov.[32] Berkley's counterpoint is that it "could not have known" one late submission would trigger the APU reduction.[33] However, Berkley's explanation is unavailing as the regulations and guidance make clear that noncompliance with all requirements may result in the reduction penalty.

The Board does not take lightly the difficult circumstances Berkely, indeed all providers, faced during the COVID-19 pandemic. Further, the Board notes that Berkley has made efforts to

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[23] 42 C.F.R. § 405.1853(a)(3).
[24] 42 C.F.R. § 405.1867.
[25] 42 U.S.C. § 1395f(i)(5)(C); 42 C.F.R. § 418.312(a) (emphasis added).
[26] Provider's Final Position Paper ("Provider's FPP") at 2-4 (Jan. 22, 2025).
[27] Stip. at ¶ 9; *see also* Tr. at 11:20 – 12:5 and 23:1 – 24:8.
[28] Tr. 23:4-7.
[29] *See* 42 C.F.R. § 418.312(i).
[30] CMS COVID-19 Blanket Waivers for Health Care Providers (expired June 30, 2020); *see also* Ex. C-10 at C-0093.
[31] Medicare Contractor's Final Position Paper at 12 (Feb. 26, 2025).
[32] *Id.* at 12-13; *see* 42 C.F.R. § 418.312(i).
[33] Provider's FPP at 3.

correct its deficiencies after receiving notification of the APU reduction. However, while Berkley's circumstances may invite the Board's sympathy, the record is clear: Berkley did not submit its HIS data in the required form, manner, and at a time mandated by statute and regulation.

In addition, the Board is not a tribunal of equity and is bound by the law, and is therefore, unable to grant extensions or exemptions to Berkley unless specifically authorized under the relevant regulation, 42 C.F.R. § 418.312. Here, the limited exemptions/extensions provided under § 418.312(i) must be granted by CMS (not the Board), but Berkley did not request nor did CMS grant any exemptions/extensions under § 418.312(i). Regardless, as discussed above, the record is clear that Berkley failed to qualify for any exemptions/extensions under §418.312(i).

Accordingly, the Board finds that Berkley did not comply with the Hospice Quality Reporting data requirements set forth by CMS. Thus, Berkley did not prove by a preponderance of substantial, relevant evidence that it complied with 42 C.F.R. § 418.312 and is, therefore, properly subject to the four-percentage point reduction in its Annual Payment Update for FFY 2024.

DECISION:

After considering the Medicare law, and regulations, the arguments presented, and the evidence admitted, the Board finds that Berkley Palliative Care & Hospice, LLC did not submit its hospice quality data in the form and manner, and at the time specified by the Secretary and, thus, the four (4) 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:

7/15/2026

X Kevin D. Smith, CPA

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