Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Hartford HealthCare at Home, Inc.
Docket No. A-17-10
Decision No. 2787
April 27, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Hartford HealthCare at Home, Inc. (Petitioner), a home health agency in Connecticut, requests review of an Administrative Law Judge's decision sustaining the imposition against Petitioner of a civil money penalty (CMP) of $5,000 per day for the period December 7, 2015 through January 7, 2016. *Hartford HealthCare at Home, Inc*., DAB CR4695 (2016) (ALJ Decision). CMS imposed the penalty for Petitioner's undisputed noncompliance with requirements for home health agencies (HHAs) caused by Petitioner's administration of incorrect and excessive dosages of prescription painkillers to a patient in its care. The ALJ rejected Petitioner's only argument, that the CMP should be reversed because of language in letters from the state agency that, Petitioner says, assured it that the CMP would not be imposed if Petitioner corrected the noncompliance by a stated date. The ALJ concluded that he was not authorized to reverse the CMP based on claims of equitable estoppel and could not grant the equitable relief Petitioner sought.

For the reasons below, we sustain the ALJ Decision.

Applicable law

HHAs that participate in the Medicare program must meet conditions of participation in section 1891 of the Social Security Act (Act) and 42 C.F.R. Part 484 and their subsidiary standards in the regulations. CMS determines HHA compliance with these requirements through surveys performed by state agencies under agreements with CMS. 42 C.F.R. §§ 488.10-488.12; 488.18 - 488.26; subpart I (488.700-488.745, "Survey and Certification of Home Health Agencies").

CMS may impose sanctions including CMPs and termination of Medicare participation on an HHA with deficiencies, i.e., a violation of the law or regulations in Part 484, and require the HHA to submit a plan of correction (POC) for CMS's approval. 42 C.F.R. §§ 488.705, 488.810, 488.820, 488.850.

If an HHA–

> is no longer in compliance with the conditions of participation, either because the deficiency or deficiencies substantially limit the provider's capacity to furnish adequate care but do not pose immediate jeopardy, **have a condition-level deficiency or deficiencies that do not pose immediate jeopardy**, or because the HHA has repeat noncompliance that results in a condition-level deficiency based on the HHA's failure to correct and sustain compliance, **CMS will:** . . .

"Terminate the HHA's provider agreement" or "[i]mpose one or more alternative sanctions[,]" which include CMPs. 42 C.F.R. §§ 488.830(a) (emphasis added), 488.820 (listing "[a]vailable sanctions" including CMPs). Per-day CMPs for repeat or condition-level deficiencies that do not constitute immediate jeopardy but are directly related to poor quality patient care outcomes range from $1,500 to $8,500. 42 C.F.R. § 488.845(b)(4). A per-day CMP "may start accruing as early as the beginning of the last day of the survey that determines that the HHA was out of compliance, as determined by CMS" and "stops on the day the HHA agreement is terminated or the HHA achieves substantial compliance, whichever is earlier." *Id*. at § 488.845(d), (d)(4)(ii). The regulations provide several factors that CMS "takes into account" in determining the amount of a CMP, which are not at issue here. *Id*. at § 488.845(b)(1).

An HHA "may request a hearing before an ALJ on the determination of the noncompliance that is the basis for imposition of the [CMP]," and either party may appeal an ALJ's decision to the Board. *Id*. at §§ 488.845(c)(2), 498.3(b)(13), 498.80. An HHA may challenge "the finding of noncompliance leading to the imposition of enforcement actions . . . but not the determination as to which sanction was imposed." *Id*. at § 498.3(b)(13). When an ALJ or the Board "finds that the basis for imposing a civil monetary penalty exists," the ALJ or the Board "may not— (1) Set a penalty of zero or reduce a penalty to zero; [or] (2) Review the exercise of discretion by CMS to impose a [CMP]" or "[c]onsider any factors in reviewing the amount of the penalty other than those specified" in the regulations. *Id*. at §§ 488.845(h), 498.3(b)(13).

Case background

The following facts from the record and the ALJ Decision are not disputed:

The Connecticut Department of Public Health (DPH), by letter dated December 16, 2015 from a supervising nurse consultant (initials LN), notified Petitioner that a complaint survey completed on December 7, 2015 had found that Petitioner was not in substantial compliance with two HHA conditions of participation, for "Organization, Services and Administration" (42 C.F.R. § 484.14) and "Skilled Nursing Services" (42 C.F.R. § 484.30), and had other "standard level" deficiencies. P. Ex. 1, at 1. The complaint survey findings concerned Petitioner's failure to ensure that a home health patient it treated during the period November 2014 to early January 2015 received correct dosages of prescription medication including painkillers; CMS alleged that the patient sometimes received duplicate doses and was hospitalized following improper medication administration, adverse drug reactions, and medication side effects. CMS Ex. 1 (statement of deficiencies). CMS alleged that these failures constituted violations of the requirements (among others CMS cited) that an HHA administrator, who may also be the supervising physician or registered nurse required by the regulations, "organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff" and that the registered nurse "initiates the plan of care and necessary revisions[.]" CMS Ex. 1, at 1, 12-32, 33-43; 42 C.F.R. § 484.14(c); 484.30. Petitioner has not disputed CMS's determinations in the statement of deficiencies.

The December 16, 2015 letter stated that DPH "would recommend to" CMS that it terminate Petitioner from the Medicare program and impose CMPs, and told Petitioner that failure to "submit an acceptable PoC by 12/30/15 may result in the Termination from the Medicare program by March 7, 2016." P. Ex. 1, at 1-2. The letter also offered Petitioner the opportunity to show that it had corrected the deficiencies, in the following paragraph that is the sole basis of Petitioner's appeal of the CMP and the ALJ Decision:

> If you believe these deficiencies have been corrected, you may contact [the] Supervising Nurse Consultant [who was the signatory of the letter] with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. **We may accept the written allegation of compliance and presume compliance until substantiated by a revisit by January 21, 2016 or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.**

Id. at 2 (bold added).

This same paragraph also appeared in mostly identical letters (nonetheless titled "amended") from the supervising nurse consultant dated December 21, 2015 and January 4, 2016. *Id*. at 4-9.

By email to LN on December 21, 2015, Petitioner requested an unspecified extension of time from December 30, 2015 to submit its POC because most of its staff were on holiday vacations. P. Ex. 2, at 2. LN granted an extension but advised that "there is a 90-day termination track by CMS and I have no control over each day (including holidays and weekends) that goes by." *Id*. at 1. Petitioner responded that it intended to submit the POC by January 6, 2016. *Id*.

On January 6, 2016, four of Petitioner's management staff including its executive director attended a conference with LN at DPH. P. Exs. 4, at 2; 5, at 2; 6, at 2 (decls.). Three of them each reported that "our discussion clearly reiterated our understanding of the 3 prior letters [LN] had sent to us, as well as all the prior conversations and emails we had all had with her, namely that no remedies were going to be imposed on [Petitioner] once it was found to be in compliance" and that LN "did not state anything to the contrary." *Id*.

On January 8, 2016, LN sent another DPH letter to Petitioner which did not contain the last two sentences of the above-quoted paragraph (in bold) indicating that "the previously recommended remedy(ies)" would not be imposed if the state agency accepted a written allegation of compliance. P. Ex. 1, at 10-12. (The DPH letters dated December 21, 2015 and January 4 and 8, 2016 continued to state that DPH would recommend to CMS that termination and CMPs be imposed. *Id*. at 4, 7, 10.)

The supervising nurse consultant, in emails with Petitioner's executive director on January 8, 2016, addressed the absence, from her January 8, 2016 letter, of the bolded language from the three previous letters. The executive director had sought clarification because the "original letter indicated . . . [t]hat if we were in compliance after the re-visit, that neither CMS regional office nor the State Medicaid Office will impose the previously recommended remedies at that time[,]" whereas "[t]his letter that was just sent, reads as if you have already recommended to CMS that penalties. [sic] Is this accurate and if so, why was the above sentence deleted from this current letter?" P. Ex. 3, at 2. The supervising nurse consultant replied that:

> It dawned on me when you were here last, at the DPH office conference [that] the cover letter led you to believe the civil money penalties would not be implemented if the revisit found you back in compliance.

> I realized after you left that the cover letter was inaccurate, and checked with [initial 'D'] and the CMS State Operations Manual (SOM) chapter 10, which confirmed that in the case of a successful revisit: the sanctions would be imposed from the exit date through the date you allege compliance (in this case from December 7, 2015 through January 8, 2016).
>
> I definitely apologize on behalf of the clerical staff about the inaccurate letter template.

Id. at 1.

Petitioner submitted its final POC on January 12, 2016, alleging compliance as of January 8, 2016.[1] CMS Ex. 4, at 58-65; P. Ex. 4, at 2. DPH conducted a revisit survey on January 19, 2016. CMS Ex. 4, at 66-130. CMS informed Petitioner in a letter dated February 8, 2016 that Petitioner had attained substantial compliance effective January 8, 2016, and that a CMP was imposed of $5,000 per day for the 32 days beginning December 7, 2015 and continuing through January 7, 2016, for a total of $160,000. CMS Ex. 2, at 7-9. Petitioner appealed CMS's determination.

The ALJ Decision

CMS moved for summary judgment and filed nine exhibits with the ALJ; Petitioner opposed CMS's motion and filed six exhibits, including affidavits of three witnesses. ALJ Decision at 1. The ALJ received the exhibits into the record and decided the case on the written record on the basis that CMS had offered no witnesses and had not requested to cross-examine Petitioner's witnesses. *Id*.

The ALJ found that "Petitioner has not disputed the findings of noncompliance on which CMS bases its penalty determination, nor has it disputed the duration of its noncompliance or the reasonableness of the penalty amount." *Id*. at 2. Petitioner's "sole argument" before the ALJ was "that it was misled by statements made to it by a representative of the State of Connecticut into believing that, if it corrected its noncompliance by a date certain, no penalties would be imposed against it." *Id*. The ALJ found this argument "without merit" because "[a]s a matter of law, CMS generally may not be estopped from imposing remedies, including civil money penalties, against a noncompliant facility" which the ALJ said has been upheld repeatedly, and that "neither the administrative law judge nor the Departmental Appeals Board has authority to redress

[1] Handwritten notations at the top of each page of Petitioner's POC include the name of the supervising nurse consultant and state "POC accepted 1/13/16." CMS Ex. 4, at 58-65.

claims for equitable relief." *Id*., citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Amber Mullins, N.P.*, DAB No. 2729 (2016); *US Ultrasound*, DAB No. 2302 (2010). The ALJ rejected Petitioner's argument that this case "falls within an exception to [this] general rule" because "a government agent affirmatively misled it into delaying correcting its deficiencies" and thus committed "active malfeasance rather than mere error." *Id*. The ALJ found "nothing in those statements [from LN] suggesting malfeasance." *Id*.

The ALJ also found that although the language in the three DPH letters "suggests that remedies might not be imposed against Petitioner if it submitted allegations of compliance that were subsequently verified[,]" it "contains nothing suggesting that either the State of Connecticut or CMS would *definitely* withhold imposition of remedies in that event." *Id*. at 3 (ALJ's italics). The ALJ found that "use of the word 'may' and the subsequent reference to "in such a case'" in the cited language "plainly implies that the State and CMS had discretion to decide whether, and under what circumstances, they would impose remedies." *Id*.

The ALJ agreed that Petitioner's communications with DPH could be considered "ambiguous" and "could have given Petitioner reason to believe that remedies might ultimately be withheld." *Id*. He found, however, that the DPH letters "do not affirmatively tell Petitioner that remedies would be withheld" and that Petitioner's management staff "do not aver that a State representative ever made such a promise to them" and "aver only that the State's representative neither warned them explicitly that remedies would be imposed nor did she ever state anything in meetings that contradicted the quoted language of the notices." *Id*. citing P. Exs. 4, 5, 6. The ALJ held that Petitioner thus "cannot argue credibly that anyone promised it that remedies would be withheld if it corrected its deficiencies" and that "Petitioner has not established grounds for finding an exception to the rule that estoppel will not lie against the government." *Id*.

Standard of review

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ's finding is supported by substantial evidence in the record. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (*Guidelines*), accessible at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html.

Analysis

Petitioner does not dispute CMS's determination that Petitioner had two "condition-level" and other deficiencies for noncompliance with requirements in the HHA regulations, based on Petitioner's failure, over a period of months, to ensure the safe and accurate administration of medications. CMS Ex. 1. Petitioner also does not dispute that CMS was authorized to impose a CMP of $5,000 per day for each day of Petitioner's noncompliance, or CMS's determination that the noncompliance continued for the period December 7, 2015 through January 7, 2016. *See* ALJ Decision at 2 ("Petitioner has not disputed the findings of noncompliance on which CMS bases its penalty determination, nor has it disputed the duration of its noncompliance or the reasonableness of the penalty amount.").

Petitioner argues only that it should not be liable for *any* penalty for that period of noncompliance because of the statement in three letters from the DPH supervising nurse consultant, which Petitioner says assured it that CMS would not impose a penalty if Petitioner attained compliance by January 21, 2016 after filing an approved POC/written allegation of compliance. Petitioner "submits that the ALJ erred in his finding that CMS should not be estopped from imposing any CMP against [Petitioner] and further erred in his decision not to grant equitable relief to [Petitioner]." P. Request for Review (RR) at 1. Petitioner also argues that the ALJ "[m]isconstrued the [l]anguage of the DPH [l]etter" in finding it "ambiguous" as to whether no CMPs would be imposed if Petitioner timely attained compliance. RR at 7-8. We explain below why none of these arguments demonstrates any grounds for reversing the ALJ Decision.

1. *Petitioner has not shown that the ALJ's reading of the language in the DPH letters was unreasonable or that the language of the DPH letters is even material in light of the fact that CMS, not the state agency, has the authority to determine noncompliance and impose sanctions.*

Petitioner disputes the ALJ's reading of the language in the DPH letters as potentially "ambiguous" but containing "nothing suggesting that either the State of Connecticut or CMS would *definitely* withhold imposition of remedies in that event" because "[t]he use of the word 'may' and the subsequent reference to 'in such a case' plainly implies that the State and CMS had discretion to decide whether, and under what circumstances, they would impose remedies." ALJ Decision at 3. Petitioner argues that the ALJ misconstrued the DPH language, which Petitioner denies is ambiguous. Petitioner argues in effect that the language states that *if* DPH accepted the POC/written allegation of compliance and substantiated Petitioner's allegation of compliance by January 21, 2016, *then* CMS would definitely not impose the proposed remedies. RR at 7-8; P. Ex. 1, at 1-9.

Regardless of whether Petitioner's reading of the language in the DPH letters might have some merit in isolation, the ALJ's reading is reasonable when considered in the context of the requirements in the regulations. Indeed, given those requirements, the ALJ would have been justified in concluding that the language in the state agency letters was not material since the regulations (and the Act) vest the Secretary and CMS, not the state agency, with the authority to determine whether to impose remedies for noncompliance. Act § 1891(e); 42 C.F.R. §§ 488.810, 488.815, 488.830, 488.835, 488.840, 488.845. The regulations state that if the HHA is no longer in compliance with the conditions of participation because it has "a condition-level deficiency or deficiencies that do not pose immediate jeopardy" then "***CMS will***: . . . (1) Terminate the HHA's provider agreement; or . . . (2) Impose one or more alternative sanctions set forth in §488.820(a) through (f) [which include per-day CMPs] as an alternative to termination, for a period not to exceed 6 months[,]" after which "CMS terminates" the HHA. 42 C.F.R. § 488.830(a), (d) (emphasis added); *see also* 42 C.F.R. §§ 488.11 (state and local survey agencies "make recommendations regarding the issues listed in §488.10" which include "whether: . . . [p]roviders or prospective providers meet the Medicare conditions of participation"), 488.1 (HHA is a "provider"). The regulations further provide that "***CMS*** provides written notification to the HHA of the intent to impose the sanctions." 42 C.F.R. § 488.810(f) (emphasis added). We note that the DPH letters (put into evidence by Petitioner) expressly stated that they "would ***recommend***" the stated sanctions to CMS, a recognition (and notice to Petitioner) that CMS, not the state agency, ultimately had the authority to impose sanctions for noncompliance. *See, e.g.*, P. Ex. 1 (emphasis added). In other words, the material notice letters with respect to the imposition of sanctions here are the notice letter sent by CMS on February 5, 2016 and the corrected notice letter sent by CMS on February 8, 2016, not the letters sent by the state agency.

The regulations further state that CMS may impose a per-day CMP for "the number of days the HHA is not in compliance" with one or more conditions of participation; that the CMP "may start accruing as early as the beginning of the last day of the survey that determines that the HHA was out of compliance, as determined by CMS"; that "the daily accrual of per day civil money penalties is imposed for the days of noncompliance prior to the notice" of intent to impose a CMP "and an additional period of no longer than 6 months following the last day of the survey" and "stops on the day the HHA agreement is terminated or the HHA achieves substantial compliance, whichever is earlier." 42 C.F.R. § 488.845(a)(1), (d)(1)(i), (d)(4).

These regulations put Petitioner on notice that CMS (not the state agency) imposes per-day CMPs for each day an HHA is not in compliance up until noncompliance is corrected, and that the ameliorative effects of re-attaining compliance are to stop the CMPs from accruing further and to prevent the termination of the HHA's Medicare provider agreement, so long as the HHA re-attains compliance within six months. *See, e.g., Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395, at 8 (2011) ("participants

in the Medicare program, . . . are presumed to have constructive notice of the statutes and regulations that govern their participation as a matter of law"), citing *Waterfront Terrace, Inc.*, DAB No. 2320, at 7 (2010) (provider of Medicare services "should be expected to possess at least a rudimentary understanding of program rules and terminology"), citing *Heckler v. Cmty. Health Servs. of Crawford Cnty.*, 467 U.S. 51, 63, 64 (1984) (participant in the Medicare program had "duty to familiarize itself with the legal requirements for cost reimbursement"); *see also Thomas M. Horras & Christine Richards*, DAB No. 2015, at 34 (2006) (officer and principal of provider had responsibility to be aware of and adhere to applicable law and regulations), *aff'd, Horras v. Leavitt*, 495 F.3d 894 (8th Cir. 2007).

In view of the regulations discussed above, Petitioner has not shown that the ALJ's reading of the language in the DPH letters was unreasonable or that the language of those letters was even material since, as a matter of law, CMS, not the state agency, is authorized to determine noncompliance and impose sanctions for that noncompliance. Nor, for this reason and the other reasons stated above, has Petitioner shown that equitable estoppel was available, or that the ALJ erred in concluding that he could not grant equitable relief to excuse Petitioner from paying the CMP imposed for its uncontested deficiencies.

2. *Petitioner has shown no error in the ALJ's determination that Petitioner "has not established grounds for finding an exception to the rule that estoppel will not lie against the government." ALJ Decision at 2.*

Petitioner states it "is well aware that those who deal with the government are expected to know the law and may not rely on the conduct of the government's agents which is contrary to the law" [citation omitted] but argues that "[t]he U.S. Supreme Court explicitly refused to hold that equitable estoppel would 'never lie against the government[.]'" RR at 5, citing *Richmond*, 496 U.S. at 423. We make no holding as to whether the state agency here acted, as a matter of law, as "CMS's duly authorized agent" as Petitioner asserts. RR at 6. Nor do we find any misrepresentation in the state agency letters. However, even assuming the truth of those assertions by Petitioner, Petitioner's admission that it could not rely on "conduct of the government's agents which is contrary to the law" undercuts its estoppel argument because any misrepresentations by the state agency as to the imposition or non-imposition of remedies would be contrary to the laws authorizing CMS, not the state agency, to impose sanctions.

Petitioner also has not explained why it would have relied on the questioned language in the state agency letters given the fact that those letters clearly stated that the state agency was only making ***recommendations*** to CMS with respect to the imposition of remedies. As a Medicare provider, Petitioner should have known that CMS, not the state agency,

would make the ultimate determination. *See, e.g., Pepper Hill Nursing & Rehab. Ctr., LLC* at 8 ("participants in the Medicare program . . . are presumed to have constructive notice of the statutes and regulations that govern their participation as a matter of law"); *Waterfront Terrace, Inc.* at 7 (provider "should be expected to possess at least a rudimentary understanding of program rules and terminology"); *Heckler v. Cmty. Health Servs. of Crawford Cnty.*, 467 U.S. at 64 (participant in the Medicare program had "duty to familiarize itself with the legal requirements for cost reimbursement"); *see also Thomas M. Horras & Christine Richards* at 34 (officer and principal of provider had responsibility to be aware of and adhere to applicable law and regulations).

Even assuming Petitioner could meet the "reliance" prong of the estoppel test (and that the language in the state agency letters would be material), Petitioner has not shown that the other elements of estoppel are present or that the ALJ erred in determining that this case does not fall within what the ALJ described as "an exception to the general rule" that "CMS generally may not be estopped from imposing remedies, including civil money penalties, against a noncompliant facility" which "has been upheld repeatedly" by the Board. ALJ Decision at 2. Specifically, Petitioner has failed to demonstrate that the inclusion of the later-removed language in the three DPH letters rises to the level of "affirmative misconduct." *See, e.g., US Ultrasound* at 8 ("estoppel against the federal government, if available at all, is presumably unavailable absent 'affirmative misconduct,' ***such as fraud***, by the federal government"). In the recent decision of *Foot Specialists of Northridge*, DAB No. 2773 (2017), the Board reiterated this precedent and rejected the argument that the contractor statements at issue rose to the level of "affirmative misconduct" as defined in those cases. *See also N.M. Human Servs. Dep't*, DAB No. 708, at 8 (1985), *aff'd sub nom. Vigil v. Bowen*, No. 86-17-JC (D. N.M. Oct. 7, 1987), and *Shenandoah Prof'l Standards Review Found.*, DAB No. 652, at 11 (1985) (emphasis added) (both noting "the absence of any affirmative misconduct, ***such as fraud or deliberate misrepresentation***" in rejecting claims of equitable estoppel). The Board has similarly recognized that affirmative misconduct "appears to require something more than failing to provide accurate information or negligently giving wrong advice." *Traylor Prods. & Servs., Inc.*, DAB No. 1331, at 7 (1992), citing *Ga. Dep't of Human Res.*, DAB No. 870, at 10 (1987); *Shenandoah Prof'l Standards Review Found.* at 10.

Petitioner here has not shown that the language in the three state agency letters was akin to fraud or deliberate misrepresentation or resulted from anything other than mere negligence or error by the supervising nurse consultant, who corrected Petitioner's view of that language shortly after it was brought to her attention during the conference on January 6, 2016. In this respect, Petitioner has not supported its suggestions that that supervising nurse consultant steadfastly reinforced the questioned language in the face of Petitioner's repeated requests for reassurance. RR at 7 (alleging that LN "had multiple phone conversations; sent at least one email; and met with [Petitioner's] staff in person, at which time in <u>each instance</u> she communicated the same message: No CMP's")

(Petitioner's emphasis). Instead, Petitioner's three witnesses are uniformly vague as to the actual content of any oral communications between them and LN prior to that conference that would have confirmed Petitioner's view. They aver only that "[a]t all times between December 7, 2015 and January 8, 2016, all communications from DPH were that no civil monetary penalties were going to be imposed by CMS" but do not allege or report the content of any specific statements to that effect by DPH or LPN beyond the language in the three DPH letters. P. Exs. 4, at 2; 5, at 2; 6, at 2. It is only with respect to the January 6, 2016 conference with LN that the witnesses allege that "our discussion clearly reiterated our understanding . . . that no remedies were going to be imposed on [Petitioner] once it was found to be in compliance" and that LN "did not state anything to the contrary." *Id*. This is consistent with the emails between Petitioner and LN indicating that she realized after the January 6, 2016 conference that she had included "inaccurate" information in her prior letters, and that she therefore removed that language from the January 8, 2016 letter and apologized for Petitioner's mistaken belief that it was relieved of any penalty for its deficiencies. P. Ex. 3, at 1-2.

Petitioner argues that the questioned language rises to the level of "deliberate misrepresentation, not silence, not error, nor a failure to act" because it appeared in three letters and was not withdrawn or contradicted in phone conversations or during the meeting with Petitioner's staff. RR at 7, quoting *Revath Bingi, Ed.D.*, DAB CR1573, at 9 (2007). The quoted observation from an ALJ decision, which was not appealed to the Board, was dicta, as the ALJ there *rejected* a claim of equitable estoppel. Moreover, the language Petitioner quotes from *Bingi* does not support its argument, as it distinguishes the "deliberate misrepresentation" presumably required to support equitable estoppel from mere error. This distinction is consistent with the Board decisions, cited above, observing that affirmative misconduct appears to require "something more" than "failing to provide accurate information or negligently giving wrong advice," such as fraud or deliberate misrepresentation.

In any event, that ALJ decision, like the other ALJ decisions Petitioner cites, is not binding or precedential here. The Board "has long held that ALJ decisions 'are not precedential and are not binding authority on the Board or other ALJs.'" *Littlefield Hospitality*, DAB No. 2756, at 13 (2016), citing *Zahid Imran, M.D.*, DAB No. 2680, at 12 (2016); *Green Oaks Health & Rehab. Ctr.*, DAB No. 2567, at 9 (2014); and *Lopatcong Ctr.*, DAB No. 2443, at 12 (2012).[2]

Ultimately, Petitioner cites no authority for the notion that mere repetition raises a mistaken or negligent representation by a government employee to the level of fraud or near fraud that arguably might support equitable estoppel. The fact that the state agency ultimately issued a notice that removed the questioned language also undercuts this notion.

[2] For this reason, we do not address other ALJ decisions Petitioner and CMS cited.

Based on this record, we find no error in the ALJ's determinations that there "is nothing in those statements [in the DPH letters] suggesting malfeasance" and that the facts of this case do not rise to the level of affirmative misconduct necessary to find an exception to the general rule that estoppel will not lie against the government. ALJ Decision at 2-3.

3. The ALJ's conclusion that he did not have authority to grant equitable relief was correct.

The ALJ accurately cited Board decisions concluding that "[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements" (*US Ultrasound* at 8) and that the Board may not overturn a denial of provider enrollment in Medicare on equitable grounds (*UpturnCare Co., d/b/a Accessible Home Health Care*, DAB No. 2632, at 19 (2015)). ALJ Decision at 2; *see also Sunview Care & Rehab Ctr. LLC*, DAB No. 2713, at 12 (2016) (declining to overturn on equitable grounds ALJ's dismissal of appeal of termination of nursing facility for uncorrected deficiencies on basis that Board has "consistently held that neither it nor the ALJs have the authority to provide equitable relief"); *Ridgecrest Healthcare Ctr.*, DAB No. 2493, at 16 (2013) ("the Board is bound by applicable laws and regulations and does not have the authority to provide equitable relief" by ordering CMS to pay for care of Medicare residents during period of noncompliance).

Petitioner argues that the ALJ erred in not granting equitable relief and failed to address any of the arguments it made "regarding granting of equitable relief." RR at 8. Petitioner presumably means that, even if equitable estoppel is not available, the CMP should be reversed as a matter of fairness. We note at the outset that this argument assumes that Petitioner relied to its detriment on the statements in the DPH letters when, as we have concluded, it had no legal or factual basis for that reliance. In addition, Petitioner relies on out-of-context statements from Board decisions that do not support its position. Petitioner cites the statement in *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009), that an ALJ (Petitioner states "the Board") "may, consistent with the applicable regulations and statutes, take steps to ensure procedural fairness." RR at 8. That observation, however, simply clarified that the long-recognized inability of ALJs (or the Board) to "invalidate either a law or regulation on any ground, even a constitutional one" did not preclude the ALJ's considering whether the petitioner had received the benefit of the procedural steps provided in the regulations. *1866ICPayday.com* at 14. Indeed, the Board held that "procedural fairness" did *not* require affording Petitioner a pre-revocation hearing not provided by the regulations, which permit post-revocation hearings. *Id*. The Board's statement in *1866ICPayday.com* thus does not support Petitioner's case, as

granting equitable relief here would *not* be consistent with the applicable regulations authorizing CMS to impose CMPs for the duration of noncompliance. Petitioner here has received the benefit of all procedural steps the regulations providing for challenging CMS's imposition of remedies for noncompliance and thus all the "procedural fairness" to which it is entitled.

Petitioner also asserts that the "issue of notice" in this case is "not dissimilar to the issue" in *Raymond Lamont Shoemaker*, DAB No. 2560 (2014), where the Board reversed an ALJ decision that increased, without notice to the petitioner, the period of his exclusion from the Medicare and Medicaid programs (from 10 to 12 years) that the Inspector General (I.G.) imposed for the petitioner's criminal health care fraud convictions. The Board stated that although the regulations authorize an ALJ to increase the term of exclusion, "fundamental fairness dictates that, before an ALJ exercises this authority, a petitioner must receive adequate notice that the ALJ is considering an increase in his case and an opportunity to show that an increase is not justified." *Raymond Lamont Shoemaker* at 1. Petitioner argues that "it would be fundamentally unfair to impose sanctions" when it "had not only no notice, but actual notice that none would be imposed." RR at 9 (Petitioner's emphasis).

This case presents no "notice issue" similar to *Shoemaker,* as Petitioner argues. In the first place, *Shoemaker* involved an exclusion from the Medicare program, not imposition of a CMP, and exclusions are governed by entirely different regulations than those at issue here. Petitioner has not explained why concepts of procedural fairness in the exclusion situation would be authoritative to any extent in the context of the CMP sanction for failure to comply with Medicare requirements. Moreover, the Petitioner here, unlike the petitioner in Shoemaker, did have notice of the sanction being imposed – in the form of CMS's February 8, 2016 notice letter – and the opportunity to appeal that determination to the ALJ. Further, the ALJ here did not increase the CMP, whereas the ALJ in Shoemaker increased the exclusion period.

The Board in *Shoemaker,* moreover, took actions authorized by the applicable regulations: determining whether the length of the exclusion the I.G. imposed was reasonable based on the limited factors the regulations specify for consideration. *Shoemaker* at 2, 7-9. Indeed, the Board held that the period the I.G. imposed *was* reasonable. *Id*. Here, Petitioner, in requesting reversal of the entire CMP that CMS was authorized by law to impose for Petitioner's uncontested noncompliance, seeks relief the ALJ and the Board are not authorized to grant. The regulations limit appeal rights to "the finding of noncompliance leading to the imposition of enforcement actions" – which Petitioner does not contest – and further state that the ALJ and the Board "may not . . . [s]et a penalty of zero or reduce a penalty to zero" or "[r]eview the exercise of discretion by CMS to impose" a CMP, if the ALJ or the Board "finds that the basis for imposing a civil monetary penalty exists," which it does, based on Petitioner's failure to contest the

noncompliance findings. 42 C.F.R. § 488.845(h). Reversing the CMP on supposed equitable grounds where Petitioner does not dispute CMS's noncompliance determination would, in effect, reduce the CMP to zero, an action the regulations prohibit. Absent any finding that the findings of noncompliance that were the basis for the CMP were factually incorrect or legally erroneous, the ALJ had no authority to reverse CMS's imposition of CMP. Nor absent evidence demonstrating that the factors the regulations specify must be considered when determining the amount of a CMP did not support the amount determined by CMS could the ALJ reduce the amount of the CMP. Petitioner, we note, does not argue that any of those factors support reducing the CMP.

Petitioner also attempts to distinguish its appeal from cases (some of which CMS cited to the ALJ) where ALJs and the Board declined to reverse agency actions on equitable grounds because, Petitioner says, the agency actions were mandated by statute and thus not subject to Board or ALJ review. RR at 9, citing, e.g., *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 31 (2011) (petitioner's "equitable estoppel claim . . . is, at its root, a request that we decline to apply binding and applicable statutory provisions and regulations governing Oaks's participation in Medicare"). As Petitioner seeks relief that the ALJ was not authorized to grant on the bases Petitioner argued, however, the distinction Petitioner avers between this case and *Oaks of Mid City* is meaningless here.

Conclusion

We affirm the ALJ Decision.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Christopher S. Randolph
Presiding Board Member