Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Benevolent Home Health Care
(CCN: 14-8065),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1416

Decision No. CR4125

Date: August 14, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS) terminated Benevolent Home Health Care's (Petitioner) Medicare provider agreement as a home health agency (HHA) with the Medicare program effective July 28, 2014, because CMS found Petitioner in violation of multiple conditions of participation. Petitioner requested a hearing to dispute some of the condition-level deficiencies. Because Petitioner did not dispute all of the condition-level deficiencies, CMS moved for summary judgment. Based on the undisputed facts in this case, I grant summary judgment and affirm CMS's termination of Petitioner's Medicare provider agreement.

I. Background and Procedural History

Petitioner is an HHA that provided services to Medicare beneficiaries in the state of Illinois. Following surveys conducted by the Illinois Department of Public Health (state agency) on April 3, 2014, and May 29, 2014, CMS terminated Petitioner's Medicare provider agreement based on a finding that Petitioner was not in compliance with multiple conditions of participation for HHAs. CMS found Petitioner had deficiencies in regard to certain condition-level requirements including: 42 C.F.R. §§ 484.14 (organization, services, and administration), 484.16 (group of professional personnel), 484.18 (acceptance of patients, plan of care, and medical supervision), and 484.52 (evaluation of the agency's program). CMS Exhibit (Ex.) 4 at 1; CMS Ex. 21.

CMS notified Petitioner that it terminated Petitioner's Medicare provider agreement effective July 28, 2014. CMS Ex. 4. Petitioner timely requested a hearing and asserted that CMS failed to provide Petitioner with sufficient time to correct the condition-level deficiencies; however, Petitioner did not dispute the existence of the deficiencies. I issued a prehearing order and established a briefing schedule. The parties filed prehearing exchanges, which included a motion for summary judgment and prehearing brief (CMS Br.), a response brief (P. Br.), and proposed exhibits (CMS Exs. 1-35 and P. Exs. 1-5).

II. Issue

Whether CMS's determination to terminate Petitioner's Medicare provider agreement should be affirmed because Petitioner failed to contest several of the condition-level deficiencies identified in CMS's determination.

III. Findings of Fact, Conclusions of Law, and Analysis[1]

The Social Security Act (Act) sets forth requirements for HHAs participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. 42 U.S.C. §§ 1395x(m), (o), 1395bbb. The Secretary's regulations governing HHA participation in the Medicare program are found at 42 C.F.R. Part 484.

In order to participate in the Medicare program and obtain reimbursement for services provided to beneficiaries, an HHA must comply with all applicable conditions as specified in 42 C.F.R. Part 484. Periodic review of compliance with the conditions of participation is required and such reviews or surveys are generally conducted by a state agency. 42 C.F.R. § 488.10. Based upon the survey results, the state agency certifies whether the HHA is complying with the conditions of participation. 42 C.F.R. §§ 488.20, 488.24, 488.26.

The state agency will certify that an HHA is not complying with the conditions of participation when the deficiencies are "of such character as to substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b). Whether or not there is compliance with a condition of participation depends upon "the manner and degree to which the provider . . . satisfies the various standards within each condition." 42 C.F.R.

[1] My findings of fact and conclusions of law are in bold and italics.

§ 488.26(b). State surveyors are required to "directly observe the actual provision of care and services to residents and/or patients, and the effects of that care, to assess whether the care provided meets the needs of individual residents and/or patients." 42 C.F.R. § 488.26(c)(2).

CMS is authorized to terminate a Medicare provider agreement when the HHA no longer meets the requirements of the Act or fails to meet the conditions of participation, among other grounds listed in the regulation. 42 U.S.C. §§ 1395x(o)(6), 1395cc(b)(2)(B), 1395bbb(e); 42 C.F.R. § 489.53(a). Notably, CMS may terminate an HHA's provider agreement if the HHA has a single condition-level deficiency and such a decision is discretionary. *United Medical Home Care, Inc.*, DAB No. 2194, at 13-14 (2008).

1. Summary judgment is appropriate because there are no disputed issues of material fact.

When appropriate, administrative law judges may decide a case arising under 42 C.F.R. pt. 498 by summary judgment. Civil Remedies Division Procedures § 7 (eff. July 6, 2009);[2] *see Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004)). Summary judgment is appropriate and an in-person hearing is not required if the record shows that there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). To determine whether there are genuine issues of material fact for an in-person hearing, the administrative law judge must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id*.

In its response to CMS's motion for summary judgment, Petitioner asserts that it timely submitted a plan of correction to correct the condition-level deficiencies and that the four alleged condition-level deficiencies resulted from Petitioner's failure to have a director of nursing. P. Br. at 3. Petitioner also contends its corrective efforts (namely hiring a director of nursing and conducting in-service training) were sufficient to maintain compliance with Medicare requirements and that CMS did not abide by its own rules and regulations in deciding to terminate Petitioner's Medicare provider agreement. P. Br. at 3-5, 8. However, neither in its hearing request nor its prehearing brief did Petitioner dispute the condition-level deficiencies at 42 C.F.R. §§ 484.14 (organization, services, and administration) and 484.18 (acceptance of patients, plan of care, and medical

[2] On January 1, 2015, the Civil Remedies Division modified its procedures and moved the summary judgment provision to section 19(a).

supervision) addressed in CMS's motion for summary judgment. *See* 42 C.F.R. § 498.40(b) (the hearing request must "[i]dentify the specific issues, and the findings of fact and conclusions of law with which the affected part disagrees" and "[s]pecify the basis for contending that the findings and conclusions are incorrect."). Therefore, because the material facts on which this case turns are not in dispute and because the case presents a purely legal issue, summary judgment is appropriate.

2. The undisputed material facts support a finding that Petitioner failed to comply with two conditions of participation.

On April 3, 2014, the state agency completed a recertification survey that found Petitioner not in compliance with six conditions of participation: 42 C.F.R. §§ 484.14 (organization, services, and administration), 484.16 (group of professional personnel) 484.18 (acceptance of patients, plan of care, and medical supervision), 484.36 (home health aide services), 484.52 (evaluation of the agency's program), and 484.55 (comprehensive assessment of patients). CMS Ex. 6. The state agency conducted a revisit survey on May 27-29, 2014. The May 29, 2014 survey found that Petitioner continued to fail to meet the requirements of four HHA conditions of participation: 42 C.F.R. § 484.14 (organization, services, and administration); 42 C.F.R. § 484.16 (group of professional personnel); 42 C.F.R. § 484.18 (acceptance of patients, plan of care, and medical supervision); and 42 C.F.R. § 484.52 (evaluation of the agency's program). CMS Exs. 21-31. CMS terminated Petitioner's Medicare provider agreement effective July 28, 2014, based on a review of the surveys. CMS Ex. 4. In its motion for summary judgment, CMS contends that there is no genuine dispute of material fact concerning Petitioner's noncompliance with two conditions of participation (42 C.F.R. §§ 484.14 and 484.18) at the time of the revisit survey and CMS was authorized to terminate Petitioner's participation in the Medicare program. CMS Br. at 2.

In its response to the CMS motion for summary judgment, Petitioner does not argue that it was in compliance with all HHA conditions of participation at the time of the May 29, 2014 revisit survey. Rather, Petitioner suggests that in the absence of immediate jeopardy, an HHA has a right to correct a deficiency within six months before its Medicare provider agreement can be terminated. Petitioner also contends that CMS instructed the state surveyors to conduct the revisit survey early, without sufficient time to allow Petitioner to correct the deficiencies at issue. Lastly, Petitioner believes that CMS had an obligation to consider an alternative sanction less severe than termination and that terminating Petitioner's Medicare provider agreement, when other remedies were available, was inappropriate. P. Br. at 8-11.

Petitioner's argument fails to acknowledge that if I conclude Petitioner was out of compliance with a single condition of participation, that noncompliance is a legitimate basis for termination, and I must uphold CMS's determination to terminate. Maintaining compliance with all conditions of participation is required of HHAs participating in the Medicare program. *See* 42 C.F.R. § 488.24. As relevant here, an HHA must properly coordinate patient services. 42 C.F.R. § 484.14. During both surveys, the surveyors found violations concerning the administrator's failure to organize and direct Petitioner's ongoing functions, the absence of an acting agency supervisor during business hours, a lack of performance evaluations, and missing information from staff records. CMS Ex. 2, at 3-14. Also, an HHA must assure that its plans of care are accurate, complete, reviewed periodically, and reflect the physician's orders. 42 C.F.R. § 484.18. The surveyors noted numerous examples where Petitioner's staff failed to perform in accordance with the residents' plans of care, and failed to develop new plans of care. CMS Ex. 21 at 18-24. Furthermore, the cited deficiencies are both repeat violations. CMS Ex. 4.

Petitioner does not contest either condition-level deficiency (42 C.F.R §§ 484.14 and 484.18) CMS cited in its motion for summary judgment. Despite the fact that Petitioner did not contest the condition-level deficiencies, I have reviewed all of the documents the parties submitted and find the record reflects a number of circumstances that represent violations of one or both of these conditions of participation.

For example, Petitioner does not dispute that when the state surveyor arrived at Petitioner's facility for a revisit survey on May 27, 2014, Petitioner did not have an acting supervising physician or registered nurse who could be contacted during business hours. *See* CMS Ex. 21 at 3-21. The individual Petitioner designated as an acting supervising registered nurse could not be reached by telephone on May 27 or 28, 2014 during Petitioner's business hours, when the state surveyors conducted the revisit survey. CMS Ex. 21 at 10-12; CMS Ex. 22 at 2. Also, when the surveyor asked Petitioner's administrator for information concerning the acting supervising registered nurse, the administrator could produce only an employee's application and personnel file. When reviewing the file, the surveyor determined that the file lacked information to show that the employee was qualified for the position of acting supervising registered nurse pursuant to Petitioner's policies. CMS Ex. 21 at 7-8; CMS Ex. 28; CMS Ex. 30 at 3. The surveyors also could not find any written acknowledgment indicating that the employee had agreed to act as a supervising registered nurse or that she had been informed of the requirements of this position. CMS Ex. 21 at 10-12; CMS Ex. 32 at 2. The surveyors found there to be "potentially serious consequences" of these violations and stated that "[Petitioner] had no supervising nurse to arrange care, consult with those providing services, assign duties or contact outside providers for necessary services. There was no oversight and coordination . . . ." CMS Ex. 32 at 2. The regulations require Petitioner to

have a supervising registered nurse on staff and state that all skilled nursing services furnished by HHAs must be under the supervision and direction of a physician or registered nurse who is available at all times during operating hours and participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel. 42 C.F.R. § 484.14(d). Petitioner does not dispute that it was in violation of this requirement at the time of the revisit survey.

In addition to the surveyors' findings regarding the lack of an acting supervising registered nurse at the time of the revisit survey, the surveyors also found other undisputed examples of Petitioner's failure to comply with 42 C.F.R. § 484.14. For example, the surveyor requested to review ten patients' clinical records as part of the revisit survey. The administrator could not provide the ten records requested and only provided the surveyor with five current patients' clinical records and one record from a discharged patient. CMS Ex. 21 at 5-6; CMS Ex. 32 at 2. Additionally, the administrator could not provide a schedule showing nursing care and services provided to Petitioner's patients and could provide only incomplete information regarding the services these patients needed. CMS Ex. 21 at 13-14; CMS Ex. 32 at 2-3. The administrator also could not demonstrate that Petitioner complied with its policy to ensure complete and accurate personnel records, including documenting that employees met necessary qualifications and received proper training. *See* CMS Ex. 21 at 7-8; CMS Ex. 30 at 5-7. The regulation at 42 C.F.R. § 484.14 requires HHAs to maintain certain standards with regard to organization, services, and administration. Namely, administrative control and lines of authority for the delegation of responsibility down to the patient care level must be clearly set forth in writing and readily identifiable. 42 C.F.R. § 484.14. Also, the administrator is required to organize and direct the HHA and ensure its ongoing functions. 42 C.F.R. § 484.14(c). Based on the undisputed facts, Petitioner's administrator could not adequately organize and direct Petitioner's ongoing functions. Therefore, Petitioner was not in compliance with 42 C.F.R. § 484.14 at the time of the May 27, 2014 revisit survey.

The undisputed facts in the record also indicate that at the time of the revisit survey Petitioner's patients were not provided with services in accordance with their care plans, either because Petitioner could not provide the required services or because Petitioner's staff did not comply with the instructions in the patients' care plans. *See* CMS Ex. 21 at 21-24. The surveyors found that Petitioner did not have accurate, current information concerning the care its patients required. CMS Ex. 21 at 19-26; CMS Exs. 23-27, 34. The surveyors found several examples where Petitioner's records indicated that Petitioner did not provide skilled nursing or nurse aide services, or arrange for physical therapy or social worker visits, in accordance with patients' care plans. *See, e.g.*, CMS Ex. 21 at 19-21; CMS Ex. 23 at 2 (patient record lacked summaries and notes regarding nursing services received and indicates that nurse aide services are not being provided);

CMS Ex. 24 at 2, 5-6 (patient record not updated, no indication that required physical therapy services were provided, and missing notes regarding services and plan of care for certain time periods); CMS Ex. 26 at 2 (patient record indicates patient's plan of care required a physical therapy evaluation, skilled nursing services, and a social worker visit, and there is no record these services were provided prior to the revisit survey). Moreover, three patients did not have current care plans or records to show active services; however, Petitioner's administrator and one of the patients stated that Petitioner's staff continued to provide services. CMS Ex. 21 at 21-24; CMS Ex. 23 at 2, 6; CMS Ex. 24 at 2, 6; CMS Ex. 25 at 2, 6.

Petitioner does not dispute that it did not meet the requirements of 42 C.F.R. § 484.18. Section 484.18 requires that an HHA only accept patients for treatment when that HHA reasonably expects it can adequately meet the patient's medical, nursing, and social needs. Further, that HHA must follow a written plan of care that a physician establishes and periodically reviews. The undisputed facts indicated above show a condition-level deficiency for failure to meet the requirements of 42 C.F.R. § 484.18.

These undisputed facts detailed above show a significant lack in coordination of services, ability to ensure Petitioner's ongoing functions, medical supervision, and documentation in patients' medical records and plans of care. Petitioner's failures "substantially limit [Petitioner's] capacity to furnish adequate care" and "adversely affect the health and safety of patients," which resulted in condition-level deficiencies subjecting Petitioner to termination. 42 C.F.R § 488.24(b); *see Excelsior Health Care Servs., Inc.*, DAB No. 1529 (1995). Petitioner does not dispute these assertions and has pointed to no evidence to the contrary. Accordingly, I conclude that Petitioner failed to meet certain Medicare conditions of participation that substantially limited Petitioner's capacity to furnish adequate care at the time of the May 29, 2014 survey.

3. CMS was authorized to terminate Petitioner's Medicare provider agreement because Petitioner was not in compliance with two conditions of participation at the time of state surveys.

Rather than disputing the underlying facts giving rise to the violations of 42 C.F.R. §§ 484.14 and 484.18, Petitioner challenges CMS's authority to terminate Petitioner's Medicare provider agreement based on condition-level deficiencies that were not at the immediate jeopardy level before the six-month mandatory termination deadline. 42 U.S.C. § 1395bbb(e)(2). CMS argues that it has the discretionary authority to terminate an HHA prior to the six month deadline for condition-level deficiencies that do not rise to the immediate jeopardy level. CMS cites *Aspen Grove Home Health*, DAB No. 2275 (2009), as support because that case indicates that CMS was authorized to

terminate Petitioner's Medicare provider agreement within three months of a recertification survey finding a non-immediate jeopardy condition-level deficiency.

The regulations do not require CMS to establish that the deficiencies resulted in immediate jeopardy to patients in order to find noncompliance with the conditions of participation. 42 C.F.R. § 488.24(b). *See Excelsior Health Care Servs., Inc.*, DAB No. 1529. Instead the relevant regulation states that:

> (a) *Noncompliance.* If the 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:
>
> > **(1) Terminate the HHA's provider agreement; or**
> > (2) Impose one or more alternative sanctions set forth in §488.820(a) through (f) of this part as an alternative to termination, for a period not to exceed 6 months.

42 C.F.R. § 488.830(a) (emphasis added).

CMS is authorized to terminate an HHA's Medicare provider agreement when the HHA is not in compliance with any of the Medicare conditions of participation. 42 C.F.R. § 488.865(b)(1); 42 C.F.R. § 489.53(a)(1), (3). CMS may impose the termination sanction immediately or impose up to a six month period of alternative sanctions prior to terminating the HHA's Medicare participation. 42 C.F.R. § 488.830(a). Furthermore, "CMS may terminate an HHA that is not in substantial compliance with program requirements, and failure to meet one or more conditions of participation is considered a lack of substantial compliance. [42 U.S.C. §§ 1395cc(b)(2)(B) 1395x(o)(6)]; 42 C.F.R. § 489.53(a)(3)." *Aspen Grove Home Health*, DAB No. 2275, at 3. CMS is not required to allow the HHA an opportunity to correct its failure to comply with a condition of participation before terminating the HHA. *Id.* at 23; *Excelsior Health Care Servs., Inc.*, DAB No. 1529, at 6-7. Petitioner's argument that it essentially had six months to take corrective action before CMS could impose the remedy of termination is without merit. *Aspen Grove Home Health*, DAB No. 2275, at 3; *see also Cmty. Home Health*, DAB No. 2134 (2007). Thus, CMS was authorized to terminate Petitioner's Medicare provider

agreement effective July 28, 2014, based on the undisputed violations of two conditions of participation. 42 C.F.R. §§ 484.14, 484.18.

Further, Petitioner essentially argues that CMS required the state surveyors to conduct a second survey early and Petitioner should have received more time to prepare for the revisit survey. P. Br. at 2. Petitioner contends that on May 12, 2014, the state agency granted Petitioner 30 days (until June 11, 2014) to hire a new director of nursing. CMS Ex. 3. However, on May 29, 2014, the state agency conducted the revisit survey, which occurred within the time period allowed to replace the director of nursing and less than 45 days from the date of CMS's notice of potential termination of Petitioner's Medicare provider agreement. CMS Exs. 1-2. CMS counters that the regulations do not permit a challenge to a state agency's decision regarding when to schedule a discretionary revisit survey. CMS Br. at 11; *see also* 42 C.F.R. § 498.3; 42 C.F.R. § 488.28(c). Also, CMS argues that the May 12, 2014 letter from the state agency was based on state requirements for home health agencies and those state requirements are not identical to the federal regulations governing Medicare participation which control the outcome of this case. CMS Br. at 11; CMS Ex. 3.

I agree with CMS that I do not have jurisdiction to review the timing of the state agency's revisit survey. 42 C.F.R. § 498.3. Moreover, although Petitioner cites to the State Medicare Operations Manual (SOM) to support its argument that the timeframe of the second survey was inappropriate, the SOM states that the state agency is to conduct a "first revisit survey no later than the 45th calendar day after the date of the . . . termination notice to the provider or supplier." SOM § 5110.4(c)(1). The May 29, 2014 revisit survey was conducted approximately 30 days after the date of the termination notice and within the time period established by the SOM. CMS Ex. 1, 2; SOM § 5110.4(c)(1). CMS may authorize the state agency to conduct a second revisit survey prior to termination under certain circumstances; however, a second revisit survey is entirely discretionary. SOM § 5110.4(c)(1), (2). Thus, I find that in accordance with CMS's guidance, the state agency exercised its discretion with regard to the timing of the revisit survey and that this is not an initial determination subject to my review. 42 C.F.R. § 498.3(b).

4. I have no jurisdiction to review CMS's decision to impose termination rather than an alternative sanction.

Petitioner also argues that I should not impose the remedy of termination of Petitioner's Medicare provider agreement because other remedies are available and CMS had an obligation to consider these other remedies. Petitioner contends I should consider imposing an alternative sanction, such as appointing a temporary manager for Petitioner. However, I have no jurisdiction to review CMS's decision to impose termination of

Petitioner's Medicare provider agreement. CMS's decision to impose termination rather than choosing to appoint a temporary manager for Petitioner is not an initial determination subject to appeal, thus I have no jurisdiction to consider whether CMS should have considered any alternative sanction or remedy instead of terminating Petitioner's Medicare provider agreement. 42 C.F.R. § 498.3(d)(14); *United Medical Home Care, Inc.*, DAB No. 2194, at 14.

IV. Conclusion

CMS is authorized to terminate an HHA's Medicare provider agreement if the HHA has a condition-level deficiency. 42 U.S.C. §§ 1395x(o)(6), 1395cc(b)(2)(B), 1395bbb(e); 42 C.F.R. § 489.53(a). As discussed above, CMS's decision to terminate a Medicare provider agreement is discretionary. *United Medical Home Care, Inc.*, DAB No. 2194, at 13-14. Petitioner simply does not dispute the condition-level deficiencies at 42 C.F.R. § 484.14 (organization, services, and administration) and 484.18 (acceptance of patients, plan of care, and medical supervision). Accordingly, I grant CMS's motion for summary judgment and affirm CMS's determination to terminate Petitioner's Medicare provider agreement.

/s/
Scott Anderson
Administrative Law Judge