Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: December 31, 2007
United Medical Home Care, Inc., (CCN: 55-7683),	)	
	)	Docket No. C-06-251
Petitioner,	)	Decision No. CR1713
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner's Home Health Agency (HHA) provider agreement is terminated effective August 30, 2005.

I. Background

Petitioner, United Medical Home Care, Inc., Panorama City, California, requested a hearing by an administrative law judge (ALJ) by letter dated February 3, 2006. Petitioner seeks to challenge a determination of the Centers for Medicare & Medicaid Services (CMS), reflected in its August 15, 2005 letter to Petitioner, that Petitioner voluntarily terminated its Medicare provider agreement by ceasing to provide services to the community in February 2005. The CMS letter cites as the basis for its conclusion the regulation at 42 C.F.R. § 489.52(b)(3), which provides that "[a] cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community." The case was assigned to me for hearing and decision on February 22, 2006, and a Notice of Case Assignment and Prehearing Case Development Order was issued at my direction.

On March 10, 2006, CMS moved to dismiss Petitioner's request for hearing pursuant to 42 C.F.R. § 498.70(b), arguing that Petitioner had no right to a hearing because a "voluntary termination" is not an initial determination of the Secretary subject to appeal and review. On March 21, 2006, Petitioner filed its rebuttal or opposition to the CMS motion to dismiss, arguing that while it ceased providing services for a period, it did not cease doing business and it never voluntarily terminated its provider agreement.

After review of the pleadings, the pertinent provisions of the Social Security Act (the Act), and the applicable regulations, I concluded that additional clarification of the parties' legal positions was required. By Order dated April 3, 2006, I directed that the parties brief four specific issues. Petitioner filed briefs on the issues on May 2 and May 19, 2006, and CMS filed briefs addressing the issues on May 5 and May 30, 2006. On October 26, 2006, I denied the CMS motion to dismiss, lifted the stay, and reestablished the schedule to hearing. In my Ruling dated October 26, 2006, I concluded that CMS had mischaracterized the nature of the termination in this case and that CMS had involuntarily terminated Petitioner's provider agreement pursuant to 42 C.F.R. § 489.53. Thus, I concluded that Petitioner had a right to a hearing pursuant to 42 C.F.R. § 498.5(b). The general issue remaining for decision is whether or not CMS has a basis for the termination of Petitioner's provider agreement. I advised the parties by my Ruling that there remained an issue of the adequacy of the August 15, 2005 CMS notice letter as a notice of involuntary termination, and that I would address that specific issue in my decision on the merits.

On November 21, 2006, I notified the parties that the case was set for hearing on December 21, 2006. On December 6, 2006, Petitioner filed a written waiver of the right to appear and present evidence at an oral hearing. On December 7, 2006, I issued an order accepting Petitioner's waiver of oral hearing, and cancelled the scheduled oral hearing, resolved various evidentiary matters, and established a briefing schedule.

Petitioner filed its prehearing brief, which I treat as its opening brief (P. Brief), on November 28, 2006. Petitioner filed its reply brief (P. Reply) with its proposed findings of fact and conclusions of law, and its revised exhibit list of 16 exhibits, on January 18, 2007. CMS filed its prehearing brief, which I also treat as its opening brief (CMS Brief), on November 30, 2006. CMS filed its Brief in Rebuttal (CMS Reply) on January 19, 2007, with its proposed findings of fact and conclusions of law, its list of proposed exhibits and its exhibits 1 through 5. On March 13, 2007, Petitioner offered another exhibit. Although I find many of the exhibits offered by both parties to be of minimal relevance given the issues remaining for resolution in this case, CMS exhibits (CMS Ex.) 1 through 5 and Petitioner exhibits (P. Ex.) 1 through 17 are admitted.

II. Discussion

A. Findings of Fact

The findings of fact are based upon the exhibits admitted, the parties' joint stipulations of facts, and the undisputed statements of fact in the pleadings of the parties. Citations not provided here may be found in the analysis section of this decision.

1. Petitioner did not have any patients for a period from February 9, 2005 to August 23, 2005 (the relevant period). CMS Exs. 1-4; P. Reply at 2-3, 8-9; P. Proposed Findings of Fact at 2-3.

2. Because Petitioner did not have any patients, during the relevant period, Petitioner was not primarily engaged in providing skilled nursing and other therapeutic services to patients.

3. CMS sent Petitioner a letter dated August 15, 2005, advising Petitioner that CMS considered Petitioner's provider agreement voluntarily terminated because Petitioner ceased providing services in February 2005. CMS Ex. 1.

4. CMS's letter dated August 15, 2005, is the first notice to Petitioner that CMS considered Petitioner's provider agreement terminated.

B. Conclusions of Law

1. An entity must meet the statutory definition of an HHA at section 1861(o) of the Act to qualify as a Medicare provider under the Act. 42 C.F.R. § 488.3.

2. The statutory definition of an HHA at section 1861(o) of the Act requires that an HHA be primarily engaged in providing skilled nursing services and other therapeutic services.

3. During the relevant period, Petitioner did not meet the definition of an HHA, as it was not primarily engaged in providing skilled nursing and other therapeutic services, because it was not providing such services to patients.

4. CMS has the discretion to terminate a provider when the provider no longer meets the definition of an HHA. 42 C.F.R. § 489.53(a)(1).

5. CMS was authorized to terminate Petitioner's provider agreement effective August 30, 2005, 15 days after its notice dated August 15, 2005. 42 C.F.R. § 489.53(c).

6. Petitioner received adequate notice of involuntary termination.

C. Issues

Whether there was a basis for termination of Petitioner's HHA provider agreement.

Whether the CMS notice of termination was sufficient.

D. Applicable Law

Pursuant to section 1861(m) of the Act, Medicare covers "home health services" provided by an HHA as defined in section 1861(o). Section 1861(o)(1) requires that the HHA be "primarily engaged in providing skilled nursing services and other therapeutic services." The Secretary of Health and Human Services (the Secretary) has promulgated regulations at 42 C.F.R. Part 484, which govern the participation of HHAs in the Medicare program. 42 C.F.R. § 484.1(a)(1) states that "[s]ections 1861(o) and 1891 establish the conditions that an HHA must meet in order to participate in Medicare." The provisions in 42 C.F.R. §§ 484.10-484.55 set forth the requirements for Medicare participation of HHAs and establish conditions of participation for these entities. The regulations prescribe the conditions of participation which include specific standards of participation.

CMS, on behalf of the Secretary, is required to determine whether a Medicare provider of services, including an HHA, is complying substantially with the Medicare participation requirements established by the Act and regulations. Act, section 1866(b)(2). A provider's participation agreement may be terminated if CMS determines that "the provider fails substantially to meet the applicable provisions of section 1861." Act, section 1866(b)(2)(B).

In order to remain certified as a Medicare provider, an HHA must remain in substantial compliance with all conditions of participation. 42 C.F.R. §§ 489.53(a)(1) and (3). The process and criteria for determining whether a provider is complying substantially with Medicare participation requirements are established by regulations at 42 C.F.R. Part 488. CMS has entered into agreements with state survey agencies to conduct periodic surveys of providers, including HHAs, in order to ascertain whether the providers are complying with Medicare participation requirements. Act, section 1864(a); 42 C.F.R. §§ 488.10, 488.11, and 488.20. State survey agencies conduct surveys of HHAs and make recommendations to CMS as to whether such facilities meet federal participation

requirements for the Medicare program. Act, section 1864(a); 42 C.F.R. §§ 488.10, 488.11, and 488.20. CMS considers survey results from the state survey agencies as the basis for its determination regarding the initial or continued participation of an HHA in the Medicare program. 42 C.F.R. §§ 488.11 and 488.12.

In determining whether a provider complies with a particular condition of participation, the state survey agency evaluates the manner and degree of the provider's satisfaction of the various standards within each condition. 42 C.F.R. § 488.26(b). The state survey agency also makes a recommendation to CMS as to whether there is a basis for termination. CMS may accept or reject the recommendation after reviewing the survey findings. 42 C.F.R. § 488.12.

CMS may terminate participation in Medicare when it determines, either on its own initiative or based on a state survey agency report, that a provider is not complying with one or more Medicare conditions of participation. Act, section 1866(b)(2)(A); 42 C.F.R. §§ 488.20, 488.24, 488.26, and 489.53(a)(1) and (3). Failure to comply with a condition of participation occurs where deficiencies, either individually or in combination, 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).

A provider whose participation in Medicare is terminated may request a hearing by an ALJ in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 489.53(d).

E. Analysis

1. Petitioner received adequate notice of involuntary termination.

I left open the question of the adequacy of CMS's notice to Petitioner in my Ruling dated October 26, 2006. There is no question that the notice (CMS Ex. 1) does not satisfy the regulatory requirements for involuntary termination. 42 C.F.R. §§ 489.53(c) and (d). However, in this case, the notice did advise Petitioner that CMS considered its provider agreement terminated and informed Petitioner of the basis for the termination. The fact that Petitioner's appeal rights were not specifically listed is cured by CMS's waiver of Petitioner's late filing and the administrative process accorded Petitioner in this case. Petitioner has had a full and fair opportunity to present its position.

2. CMS had sufficient grounds on which to terminate Petitioner's provider agreement.

The facts pertinent to the issues before me are few and undisputed. There is no dispute that Petitioner did not have any patients for a period from February 9, 2005 to August 23, 2005. There is no dispute that CMS sent Petitioner a letter dated August 15, 2005, which

advised Petitioner that CMS considered Petitioner's provider agreement voluntarily terminated because Petitioner had ceased providing services in February 2005. There is no dispute that CMS's letter of August 15, 2005, is the first notice to Petitioner that CMS considered Petitioner's provider agreement terminated. Jt. Stip.; CMS Ex. 1-4; CMS Brief at 8-9; P. Reply at 2-3; P. Proposed Findings of Fact at 1-5. Thus, the only issues for resolution in this case are issues of law.

I note first that this case does not involve whether Petitioner failed to comply with participation requirements found during a state survey. Instead, the case turns on whether Petitioner continued to meet the statutory definition of an HHA. The regulation at 42 C.F.R. § 488.3(a) states that to be approved for participation, a prospective provider or supplier must meet the applicable statutory definitions in (among other sections) section 1861. The Departmental Appeals Board (Board) has observed that:

> The ALJ's holding that Petitioner was required to meet the definition at section 1861 is consistent with the Board's observation that determining whether an entity qualifies as a provider within the meaning of the Act and regulations is not limited to determining whether it meets the quality of care or health and safety requirements, and that meeting any aspect of the statutory definition of a hospital or other entity that may be a provider of services is a prerequisite to qualifying as a provider. . . .

Arizona Surgical Hospital, LLC, DAB No. 1890, at 9 (2003); *Specialty Hospital of Southern California-La Mirada*, DAB No. 1730, at 8-9, n. 9 (2000), *aff'd, Specialty Healthcare Servs. v. Thompson*, No. 00-08438-ABC (CTX) (S.D.Ca. Aug. 1, 2001). Although an HHA was not the type of provider involved in *Arizona*, the reasoning regarding the requirement to meet the definition at section 1861 remains the same. To remain a provider, Petitioner must meet the statutory definition of its particular type of provider - in its case it must meet the definition of an HHA. The statutory definition of an HHA at section 1861(o) requires that Petitioner be "primarily engaged in providing skilled nursing services and other therapeutic services." Act, section 1861(o)(1). During the relevant period, a period lasting more than six months, Petitioner was not engaged in providing such services.

Section 1866(b)(2)(B) gives the Secretary, and his delegee, CMS, the discretion to terminate when a provider no longer meets the definition of an HHA at section 1861(o)(1). 42 C.F.R. § 489.53(a)(1). And, CMS has the discretion to decide how long a cessation of services is too long. Petitioner admits that "during the period of February 9, 2005 to August 23, 2005, [it] did not provide patient services," reinforcing the fact that during a six month period it was not so primarily engaged. P. Reply at 8-9. Although Petitioner argues that temporarily suspending services for six months was not a "substantial" violation of section 1861(o)(1) (P. Reply at 6), I disagree. A six month

cessation of the provision of such services is not a temporary or emergency cessation. It is reasonable for CMS to determine that an HHA which is not providing skilled nursing services and other therapeutic services to patients for six months does not continue to meet the definition of an HHA.

Petitioner argues in defense of its failure to provide patient services during the relevant period that it was "a compliant home health agency forced into a situation of temporary noncompliance due to . . . financial suspension" by CMS's agent and that it was otherwise maintaining its staff, office, and had a California license (P. Reply at 8-9). Petitioner asserts that it was forced to temporarily suspend its patient services due to a circumstance beyond its control (the suspension) and that its involuntary termination would violate public policy (P. Reply at 16). Petitioner is essentially arguing that CMS should be estopped from terminating its provider agreement due to this extraordinary circumstance -- the suspension of program reimbursement.

The suspension of program payment is not an extraordinary circumstance. Petitioner had the ability to continue providing services during the suspension, which could be reimbursed when the suspension ended, or voluntarily terminate its participation and reapply when it was ready to provide services to patients. Moreover, my jurisdiction in cases involving CMS is limited to hearing and deciding those issues which the Secretary has delegated authority for me to hear and decide, as set forth at 42 C.F.R. §§ 498.3 and 498.5. The regulations authorize me only to hear and decide cases involving specified initial determinations by CMS. I have no authority to determine that CMS's actions would violate public policy and no authority to award damages or fashion extraordinary relief. Moreover, I have no authority to hear and decide claims of equitable estoppel against the Secretary. *See, Office of Personnel Management v. Richmond*, 496 U.S. 414, 110 S.Ct. 2465, 110 L.Ed.2d 387 (1990); *Heckler v. Community Health Services of Crawford County, Inc.,* 467 U.S. 51, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984). While the Supreme Court has not ruled that estoppel will never lie against the government, the decisions in these cases make clear that equitable estoppel will not lie against the government in cases involving benefits to be paid from the Treasury, particularly in the complicated area of Medicare.

After terminating a provider agreement, CMS can only accept a new provider agreement if the provider has made satisfactory arrangements to fulfill all of the statutory and regulatory responsibilities of its previous agreement. 42 C.F.R. § 489.57. Here, even though Petitioner accepted a new patient after the six month cessation of services, it was up to CMS to determine whether Petitioner again met the definition of an HHA. It is irrelevant in this regard that Petitioner maintained its California license as an HHA, as it was up to CMS, not the state, to decide whether Petitioner met the definition of an HHA and was otherwise in compliance with participation requirements.

3. Petitioner's termination is effective August 30, 2005.

Petitioner received notice of termination on August 15, 2005. Pursuant to the regulations, an involuntary termination would be effective 15 days later on August 30, 2005. 42 C.F.R. § 489.53(c). Petitioner asserts that by August 30, 2005, it had cured any possible violation because it admitted a patient on August 23, 2005, a date before the involuntary termination effective date of August 30, 2005. However, admitting a patient after being notified of the termination, but before the effective date, does not mean that Petitioner was in compliance with the requirements of an HHA, absent a CMS finding that it was in compliance. CMS made no such finding.

III. Conclusion

For the foregoing reasons, Petitioner's provider agreement is terminated effective August 30, 2005.

/s/
Keith W. Sickendick
Administrative Law Judge