Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

UpturnCare Co., d/b/a Accessible Home Health Care
Docket No. A-15-22
Decision No. 2632
April 16, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

UpturnCare Co., d/b/a Accessible Home Health Care (UpturnCare),[1] a home health agency (HHA) in Texas, requests review of the September 24, 2014 decision of the Administrative Law Judge, Decision No. CR3386 (ALJ Decision). The ALJ Decision upheld the denial of UpturnCare's application for enrollment in the Medicare program. The ALJ granted summary judgment for the Centers for Medicare & Medicaid Services (CMS) on the ground that the undisputed facts demonstrated that UpturnCare's application was properly denied pursuant to 42 C.F.R. § 424.530(a)(10) because UpturnCare was subject to the temporary moratorium on the enrollment of HHAs imposed pursuant to 42 C.F.R. § 424.570(c). For the reasons stated below, we conclude that the ALJ properly granted summary judgment for CMS.

Legal Background

To participate in the Medicare program, a "provider of services" (commonly referred to by the abbreviated term "provider") such as a HHA (Social Security Act (Act) § 1861(u)) must be enrolled in the program.[2] Enrollment confers on a provider the right to bill Medicare for health care services provided to Medicare beneficiaries. Act § 1866(j); 42 C.F.R. Part 424, subpart P. The multi-step process for the enrollment of a HHA begins with the submittal of a completed enrollment application to the designated CMS contractor, which reviews the application to verify the prospective HHA's eligibility to

[1] The caption to our decision reflects "UpturnCare Co., d/b/a Accessible Home Health Care" as stated in the caption to the ALJ Decision. We note, however, that UpturnCare's own filings reflect variations of its legal business name ("UpTurnCare Co." and "UpturnCare Co.") and its "doing business as" name ("Accessible Home Health Care of Tarrant & S. Denton County" and "Accessible Home Health Care").

[2] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

participate in the program. CMS, through a contractor, may reject an enrollment application or deny enrollment. 42 C.F.R. §§ 424.510, 424.525, 424.530; *see also* Medicare Program Integrity Manual (PIM), CMS Pub. 100-08, Ch. 15 ("Medicare Enrollment"), § 15.7. A prospective HHA that passes the initial stage of review by obtaining initial approval of the application proceeds to the next step – a survey to be performed by a state survey agency or an approved accrediting organization (*see* 42 C.F.R. Part 488) to determine compliance with Medicare conditions of participation as set out in 42 C.F.R. Part 484.

CMS has designated three enrollment application screening levels – "limited," "moderate" and "high" – for prospective providers and suppliers based on the assessment of the risk level posed by the provider or supplier category. 42 C.F.R. § 424.518. Prospective (newly enrolling) HHAs are considered to be in the "high" risk category of providers. *Id.* § 424.518(c); PIM, Ch. 15, § 15.19.2.1.C (discussing "high" risk category screening). Accordingly, prospective HHAs undergo the multi-step review and approval process as set out in the CMS guidelines, which include those in the PIM. *See, e.g.*, PIM, Ch. 15, § 15.26.3 ("Additional Home Health Agency (HHA) Review Activities"); Survey & Certification (S&C) Letter, S&C: 12-15-HHA, Revised Initial Certification Process for Home Health Agencies (HHAs), issued by CMS's Office of Clinical Standards and Quality/Survey & Certification Group, dated Dec. 23, 2011. In this S&C Letter, CMS stated that an "additional step" – a "second review" of enrollment criteria by the Regional Home Health Intermediary (RHHI) or the Medicare Administrative Contractor (MAC) – was being added to the enrollment review process for prospective HHAs. The CMS Regional Office would hold the issuance of a CMS certification number (CCN) and provider agreement until the RHHI or the MAC re-reviews certain Medicare enrollment requirements (e.g., site visit verification, capitalization requirements and Medicare exclusion check) following the initial survey that is performed by either the state survey agency or an approved accreditation organization. If the RHHI or the MAC determines that the prospective HHA continues to remain in compliance with the enrollment requirements following the initial survey, the CMS Regional Office would then proceed with completing the initial certification of the HHA.[3]

Pursuant to section 6401(a) of the Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, which amended section 1866(j) of the Act by adding a new section 1866(j)(7) of the Act, the Secretary of Health and Human Services is authorized to impose temporary moratoria on the enrollment of new Medicare (title XVIII), Medicaid

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[3] The S&C Letter, S&C: 12-15-HHA, was discussed in CMS's briefing below and before the Board. CMS's Motion for Summary Disposition or, in the Alternative, Motion for Decision on Submission & Supporting Brief (CMS Br.), filed with the ALJ, at 4; CMS's Response to UpturnCare's Request for Review, at 4, 18-19. CMS S&C Letters are available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/.

(title XIX), or Children's Health Insurance Program (CHIP, title XXI) providers and suppliers, including categories of providers and suppliers, if the Secretary determines that moratoria are necessary to prevent or combat fraud, waste or abuse under the programs. Act § 1866(j)(7)(A). There "shall be no judicial review" of the imposition of a temporary moratorium imposed under section 1866(j)(7)(A) of the Act. Act § 1866(j)(7)(B).

The Secretary published proposed regulations to implement the ACA amendments, including those concerning temporary moratoria on new enrollments of Medicare providers and suppliers. 75 Fed. Reg. 58,204, 58,242-43 (Sept. 23, 2010). Under the final regulations effective March 25, 2011 (76 Fed. Reg. 5862 (Feb. 2, 2011)), CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. 42 C.F.R. § 424.570(a)(1)(i). CMS will announce the temporary enrollment moratorium in a Federal Register document that includes the rationale for imposition of the moratorium. *Id.* § 424.570(a)(1)(ii). "The temporary enrollment moratorium does not apply to any enrollment application that has been approved by the enrollment contractor but not yet entered into PECOS at the time the moratorium is imposed." *Id.* § 424.570(a)(1)(iv).[4]

Under the final regulations, CMS may impose a temporary moratorium if, among other reasons, CMS determines that there is significant potential for fraud, waste or abuse with respect to a particular provider or supplier type or particular geographic area or both, or, CMS, in consultation with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) or the U.S. Department of Justice or both and with the approval of the CMS Administrator, identifies either a particular provider or supplier type or a particular geographic area, or both, as having a significant potential for fraud, waste or abuse in the Medicare program. 42 C.F.R. §§ 424.570(a)(2)(i)-(iv). CMS may deny a provider's or supplier's enrollment if the provider or supplier "submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium." *Id.* § 424.530(a)(10). A moratorium on enrollment may be imposed for a six-month period and, if CMS deems necessary, may be extended in six-month increments. *Id.* § 424.570(b). "A Medicare contractor denies the enrollment application of a provider or supplier if the provider or supplier is subject to a moratorium as specified in [section 424.570(a)]." *Id.* § 424.570(c).

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[4] The Provider Enrollment, Chain and Ownership System (PECOS) is an internet-based Medicare enrollment system through which providers and suppliers can submit enrollment applications, view, print, and update enrollment information, and track the status of submitted enrollment applications. https://pecos.cms.hhs.gov.

CMS announced new and extended temporary moratoria, including a new temporary moratorium on the enrollment of HHAs in the Dallas, Texas metropolitan area, effective January 30, 2014. 79 Fed. Reg. 6475, 6479-80 (Feb. 4, 2014). This Federal Register announcement states in part that, beginning January 30, 2014, "no new HHAs will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Texas Counties of Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant unless their enrollment application has already been approved but not yet entered into PECOS or the State Provider/Supplier Enrollment System at the time the moratorium is imposed." *Id.* at 6479; *see also* PIM, Ch. 15, § 15.19.3 ("Temporary Moratoria") (revised effective June 3, 2014).

A prospective provider or supplier denied billing privileges based on the imposition of a temporary moratorium may appeal the denial in accordance with the appeal procedures in 42 C.F.R. Part 498, subpart A. 42 C.F.R. § 424.545(a); 79 Fed. Reg. at 6476. But the scope of any such appeal is limited to determining whether the temporary moratorium applies to the provider or supplier appealing the denial. The basis for imposing a moratorium is not subject to review. 42 C.F.R. § 498.5(l)(4); 79 Fed. Reg. at 6476.

Background and Procedural History[5]

In December 2011, UpturnCare filed an application, Form CMS-855A, to enroll in the Medicare program as a new HHA. CMS Exhibit (CMS Ex.) 9. By letter dated February 3, 2014, Palmetto GBA (Palmetto), a CMS MAC, informed UpturnCare that its application was denied based on the imposition of a temporary moratorium on the enrollment of HHAs and HHA subunits in the "county" in which UpturnCare proposed "to enroll a practice location." CMS Ex. 4, at 1, *citing* 42 C.F.R. §§ 424.530(a)(10) and 424.570(c). The letter informed UpturnCare that the moratorium "took effect on July 30, 2013"; that it "will" remain in effect for six months; and "may be extended in 6-month increments." *Id.*[6]

UpturnCare requested reconsideration of the denial. CMS Ex. 5. In its April 1, 2014 reconsidered determination, CMS referred to the moratorium that took effect on January 30, 2014 and was to remain in effect for six months, and stated that UpturnCare's

[5] The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision and undisputed facts in the record and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact.

[6] Palmetto did not specify whether the moratorium that took effect on July 30, 2013 applied to the geographic area(s) in which UpturnCare sought to have its practice location(s). According to the S&C Letter, S&C:13-53-HHA, July 30, 2013 was the date on which CMS stopped the enrollment of new HHAs and HHA branch locations in the Miami, Florida and Chicago, Illinois metropolitan areas.

application was properly denied because it was subject to this moratorium. CMS Ex. 7, at 1. On April 14, 2014, CMS issued an amended notice of reconsidered determination, which was substantially similar to the April 1, 2014 reconsidered determination, but which added that UpturnCare's application was "impacted by the moratorium that took effect on January 31, 2014 for Tarrant County, Texas." CMS Ex. 8, at 1.[7]

On March 27, 2014, UpturnCare filed a request for hearing before an ALJ, arguing chiefly that its application was not subject to the moratorium or that its application "should not be covered by" the moratorium because it had "successfully completed each and every step" of the application process "long before the moratorium extension was announced." Request for Hearing (RFH) at 1, 4. According to UpturnCare, Palmetto had recommended approval of its application; UpturnCare was accredited by the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) following a survey performed between August 13-15, 2013; and UpturnCare was only awaiting the entry of the approval into PECOS. *Id.* at 2-4. UpturnCare also argued, in the alternative, that it had detrimentally relied on verbal statements made to UpturnCare, over the telephone, by an individual from CMS, who informed UpturnCare that CMS had completed the re-review of UpturnCare's application on December 16, 2013 (RFH at 3; UpturnCare's brief headed "Cause to Appeal" at 1 (not paginated)). However, on page 5 of its Request for Hearing, UpturnCare asserted that the "secondary review was complete[d] on December 12, 2013[.]"[8]

On May 2, 2014, CMS moved for summary disposition or, in the alternative, a decision on the written submissions, arguing that there is no genuine dispute of material fact and that summary judgment in its favor is appropriate. CMS argued that UpturnCare was not excepted from the moratorium because the contractor had not completed its review of UpturnCare's application: Palmetto had not performed a final re-review and site visit, also called a "pre-tie-in review," of UpturnCare's application in accordance with Chapter 15, Section 15.26.3 of the PIM. CMS Br. at 10-11, 12. Only after the re-review and site visit are performed and the prospective HHA is found to be in compliance does the contractor make its final determination on whether the prospective HHA may be enrolled.

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[7] Page 2 of the April 1, 2014 reconsidered determination, admitted as CMS's Exhibit 7 and UpturnCare's Exhibit (P. Ex.) I, referred to a legal business name of another HHA applicant, in error. The April 14, 2014 amended notice of reconsidered determination, however, correctly referred to "Upturn" as the legal business name of the applicant, but incorrectly referred to January <u>31</u>, 2014 as the effective date of the moratorium. CMS Ex. 8, at 1; P. Ex. J. The ALJ admitted all of UpturnCare's exhibits, A through P and SM A through SM E. ALJ Decision at 3. The documents that comprise UpturnCare's exhibits are not marked or paginated.

[8] UpturnCare's references to dates are not entirely consistent. For instance, on page 1 of its "Cause to Appeal," UpturnCare indicated that the telephone conversation with CMS occurred on January 7, 2014; its Request for Hearing, page 3, indicates that the call took place on December 12, 2013. UpturnCare does not clearly explain whether two calls took place on two different days.

Id. at 11, *citing* PIM, Ch. 15, §§ 15.4.1.6, 15.19.2, 15.26.3. With respect to UpturnCare's assertions of detrimental reliance, CMS argued that UpturnCare mistakenly believed that a second review had been performed; CMS stated that, "in fact, ***the request*** for the second review was issued on January 8, 2014." *Id.* at 11-12 (emphasis in original).

The ALJ noted that UpturnCare had not waived its right to oral hearing or otherwise consented to a decision based only on the documentary evidence or pleadings and, accordingly, disposition of this case based only on the written record would not be permissible unless the ALJ granted CMS's motion for summary judgment. ALJ Decision at 4. The ALJ concluded that there was no genuine dispute as to any material fact in this case that required a hearing, and that the issues in this case that require resolution were issues of law related to the interpretation and application of the regulations that govern Medicare enrollment and billing privileges and the application of the law to the undisputed facts of this case. *Id.* at 6. The ALJ therefore concluded that disposition by summary judgment would be appropriate. *Id.*

The ALJ found that:

> [UpturnCare's] application was received by Palmetto on December 12, 2011. Palmetto completed processing the application on August 9, 2012, and recommended approval of [UpturnCare] to participate in Medicare as a provider. CMS Ex. 1. [UpturnCare] was advised of the Palmetto recommendation on August 9, 2012, and that the application was forwarded to the state agency and CMS for further action, including a survey. CMS Ex. 2. The survey of [UpturnCare] was completed and [UpturnCare] received accreditation and a recommendation for Medicare certification by The Joint Commission effective October 1, 2013. CMS Ex. 3.

ALJ Decision at 6.

The ALJ found that UpturnCare acknowledged, and did not dispute, that CMS did not notify Palmetto until January 8, 2014 that Palmetto should proceed with its "pre-tie-in review," i.e., "the final re-reviews and site visit," nor did UpturnCare dispute that Palmetto had not performed the "pre-tie-in review" and had 45 days from January 8, 2014 do so. *Id.* at 8.[9] The ALJ also found that, "before the re-reviews and site visit could be performed by Palmetto, CMS announced the moratorium." *Id.* Therefore, the ALJ found, "[UpturnCare's] application was not 'approved' because not every step required to

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[9] The reference to the 45-day period the contractor would have to perform the "pre-tie-in review" (ALJ Decision at 8) is taken from PIM, Ch. 15, § 15.7.7.2.1 (effective Oct. 9, 2012). This PIM section states that, for "Form CMS-855A transactions that require a post-tie-in notice/approval site visit" (in other words, enrollment applications like UpturnCare's), the applicable time period is 45 days. As the PIM states, "This is to account for the additional time needed for the site visit to be performed." PIM, Ch. 15, § 15.7.7.2.1.

be fully approved and accepted into the Medicare program had been completed prior to 12:00 a.m. on January 30, 2014, when the moratorium became effective." *Id.* The ALJ concluded that UpturnCare's enrollment application was subject to the temporary moratorium imposed pursuant to section 424.570(c) and that the application was properly denied pursuant to section 424.530(a)(10). *Id.* The ALJ therefore concluded that CMS was entitled to summary judgment. *Id.* Finally, the ALJ stated that, to the extent UpturnCare's arguments may be construed as a request for equitable relief, he had no authority to grant such relief. *Id.*

UpturnCare timely requested review of the ALJ Decision by the Board.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address *de novo*. *Lebanon Nursing & Rehabilitation Ctr.*, DAB No. 1918, at 7 (2004); *Andrew J. Elliott, M.D.*, DAB No. 2334, at 4 (2010). The moving party bears the initial burden of demonstrating that there are no genuine issues of material fact in dispute and that it is entitled to judgment as a matter of law. *Celotex v. Catrett*, 477 U.S. 317, 322-325 (1986); *Everett Rehab. & Medical Ctr.*, DAB No. 1628, at 3 (1997). If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (italics omitted) (quoting Rule 56(e) of the Federal Rules of Civil Procedure).[10] To defeat an adequately supported motion for summary judgment, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Id.* at 586 n.11; *Celotex*, 477 U.S. at 322 (moving party is entitled to summary judgment if the party opposing the motion "fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial"). In order to demonstrate a genuine issue of material fact, the opposing party must do more than show that there is "some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is 'no genuine issue for trial.'" *Matsushita*, 475 U.S. at 586-87. In deciding whether summary judgment is appropriate, the tribunal must view

[10] Effective December 10, 2010, Rule 56 was "revised to improve the procedures for presenting and deciding summary-judgment motions and to make the procedures more consistent with those already used in many courts." Committee Notes on Rules – 2010 Amendment, available at http://www.law.cornell.edu/rules/frcp/rule_56. The revisions alter the language of the rule, but the "standard for granting summary judgment remains unchanged." *Id.* The Federal Rules of Civil Procedure are not directly applicable to administrative proceedings as in this case, but Rule 56 and related case law provide guidance for determining whether summary judgment may be appropriate in administrative proceedings. The ALJ's April 2, 2014 Acknowledgment and Prehearing Order, page 5, notified the parties that "[t]he standards that have been developed related to Fed. R. Civ. P. 56, including those articulated and/or applied by the federal courts and the Departmental Appeals Board (ALJs and Appellate Panels), will be applied in ruling upon a motion for summary judgment filed in this case."

the entire record in the light most favorable to the non-moving party, drawing all reasonable inferences from the evidence in that party's favor. *Madison Health Care, Inc.*, DAB No. 1927, at 6-7 (2004).

The Board's standard of review on a disputed conclusion of law is whether the decision below is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (*Guidelines*). The *Guidelines* are available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Discussion

The Board affirms the ALJ's decision on summary judgment to uphold CMS's denial of UpturnCare's application for enrollment in Medicare as a new HHA because the undisputed facts establish that UpturnCare was subject to the temporary moratorium on the enrollment of HHAs under section 424.570(c). Before we discuss the reasons why we affirm the ALJ's decision, we first address UpturnCare's filing headed "Petitioner's Board Review Exhibit List," submitted with three attachments that UpturnCare refers to as Exhibits 1, 2 and 3.

The attachment offered as Exhibit 1 is a duplicate copy of UpturnCare's Exhibit E, which we will discuss elsewhere in our decision. It is not clear why UpturnCare is offering another copy of Exhibit E when it is of record. The Board decides provider enrollment appeals like this case based on the evidentiary record on which the ALJ based his or her decision. *See* 42 C.F.R. § 498.86(a); *Guidelines*. The attachment offered as Exhibit 1 is not admitted.

The attachment UpturnCare offers as Exhibit 2 is CMS's initially filed Exhibit 9 (bearing CMS's exhibit marking), which is a printout of an email exchange on January 8, 2014 between an individual at CMS and an individual at Palmetto, in which CMS (Dallas Regional Office) informed Palmetto that it received and agreed with the state survey agency's recommendation for initial certification of certain identified home health agencies, including UpturnCare (the names of the HHAs, other than UpturnCare's, are redacted). CMS later submitted another document as its amended Exhibit 9, which is a copy of UpturnCare's completed enrollment application, Form CMS-855A. The ALJ stated that he would treat CMS's filing of the new document identified as CMS's Exhibit 9 as a substitution for and withdrawal of the offer of the document previously filed and marked as CMS Exhibit 9. ALJ Decision at 2-3. Before the Board, UpturnCare asserts that CMS improperly "remov[ed]" "important eviden[ce]" and "conveniently withdr[e]w" the initially filed CMS Exhibit 9. Request for Review (RR) at 14. UpturnCare also asserts that CMS's amended Exhibit 9, UpturnCare's Form CMS-855A, is irrelevant evidence. *Id.*

This case is an appeal of the denial of UpturnCare's application for enrollment in the Medicare program. UpturnCare's enrollment application is relevant evidence. As for the initially filed CMS Exhibit 9 (January 8, 2014 email between CMS and Palmetto), it was the *ALJ's decision* to substitute the amended CMS Exhibit 9 for the initially filed CMS Exhibit 9. Before the Board, UpturnCare does not assert that the ALJ's decision to do so was error. The ALJ did not specifically inform the parties that he would treat CMS's amended Exhibit 9 as a substitution for and withdrawal of the initially filed CMS Exhibit 9 before he issued his decision. But UpturnCare had notice of CMS's filing of an amended Exhibit 9 and an opportunity to raise a dispute about the amended Exhibit 9 before the ALJ issued his decision, but did not avail itself of that opportunity. The ALJ's April 2, 2014 Acknowledgment and Prehearing Order, page 5, informed UpturnCare that it "should make any objections to exhibits submitted by CMS when [UpturnCare] files an opposition or a motion or cross-motion for summary judgment" and "should file any objection to exhibits submitted by CMS with its reply within ten days of the date of service of the exhibits." On June 16, 2014, CMS filed its amended pre-hearing exhibit and witness list, which identified amended CMS Exhibit 9 and the amended CMS Exhibit 9 itself. On the same day, CMS filed its reply to UpturnCare's opposition to CMS's motion for summary judgment. On July 21, 2014, UpturnCare filed its sur-reply, but raised no dispute about either the initially filed CMS Exhibit 9 or the amended CMS Exhibit 9. Then, on August 11, 2014, UpturnCare filed what appears to be a duplicate copy of its July 21, 2014 sur-reply, but still raised no dispute about the initially filed CMS Exhibit 9 or the amended CMS Exhibit 9. *See* ALJ Decision at 3 & 3 n.4. Nor did UpturnCare amend its own exhibit list or offer any additional exhibits to the ALJ. During the ALJ proceedings UpturnCare took no action to have the document CMS initially offered as its Exhibit 9 included in the record before the ALJ.

The attachment offered to the Board as Exhibit 2 is not admitted. Even if we were to admit it, it would not alter our ultimate conclusion that UpturnCare was properly denied enrollment. It does not aid UpturnCare in establishing that there is a genuine factual dispute about whether the review of UpturnCare's application was completed before the moratorium went into effect on January 30, 2014. UpturnCare does not accurately characterize the contents of the document (January 8, 2014 email between CMS and Palmetto) initially offered as CMS Exhibit 9.[11]

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[11] UpturnCare asserts that the email is important evidence because it "shows that CMS review was done 12/15/2013." RR at 14. UpturnCare refers to a "phone conversation" with a person at CMS, who purportedly informed UpturnCare that "CMS completed its review [on] December 12, 2013." *Id.* But there is absolutely nothing in the email indicating that CMS performed a review, let alone completed a review, on December 12 or December 15, 2013, or on any date before the date of the email, January 8, 2014. In the email, CMS informed Palmetto that it would await the email notification of the results of Palmetto's re-review (i.e., the pre-tie-in review discussed in the ALJ Decision and mentioned in UpturnCare's Exhibit E), which would indicate that, as of January 8, 2014, review of UpturnCare's application was not completed. This evidence – if admitted – would undercut UpturnCare's position.

The attachment offered as Exhibit 3 is a double-sided page, the reverse side of which is UpturnCare's May 12, 2014 fax inquiry addressed to "CMS FOIA Regional Officer" in the CMS Regional Office in Dallas, Texas, asking that UpturnCare be provided "access to" "information" concerning the "agency documents process and documents submitted to Palmetto GBA for the certification process in December 2013." The front side is CMS Regional Office's September 4, 2014 reply, informing UpturnCare that the documents UpturnCare requested pursuant to the Freedom of Information Act (FOIA) are not "directly releasable by [the Regional Office]" and that CMS's response has been forwarded to the Acting FOIA Officer in CMS's central office in Baltimore, Maryland, "for final disposition." UpturnCare refers to this FOIA request and CMS response, RR at 4, but does not explain why it is submitting it or how it supports its appeal. Even if we were to admit the documents offered as Exhibit 3, they would not alter our ultimate conclusion that UpturnCare was properly denied enrollment. Exhibit 3 is excluded.

Lastly, in its filing headed "Petitioner's Board Review Exhibit List," UpturnCare indicates that it would be willing to provide its "[c]orporate tax return forms" to the Board "on [B]oard request." We do not see the relevance of UpturnCare's tax records to this appeal.

We now turn to the merits of UpturnCare's appeal. We, like the ALJ, find that CMS's denial of UpturnCare's application for enrollment in Medicare as a new HHA was proper because the undisputed facts establish that UpturnCare was subject to the temporary moratorium on the enrollment of HHAs under section 424.570(c).

A. *The ALJ did not err in concluding that there is no genuine dispute of material fact with respect to CMS's determination that UpturnCare's enrollment application had not been approved as of January 30, 2014.*

The question presented here is whether UpturnCare was subject to the moratorium. If so, then, there is no dispute that, under section 424.530(a)(10), CMS is authorized to deny UpturnCare's application. The basic factual issues determinative of whether UpturnCare's enrollment application was subject to the temporary memorandum that went into effect on January 30, 2014 are:

(1) whether UpturnCare's application was an initial application for enrollment in the Medicare program as a new HHA;
(2) whether UpturnCare was seeking to practice in a geographic area for which the moratorium on enrollments was in effect; and
(3) whether UpturnCare's enrollment application had been "approved" when the moratorium went into effect (because the moratorium does not apply to applications that have been "approved," as section 424.570(a)(1)(iv) provides).

It is undisputed that UpturnCare's application was an initial application for enrollment as a new HHA. In its application, signed by UpturnCare's Owner and President on December 8, 2011, UpturnCare indicated that it was seeking to enroll in Medicare as a HHA. CMS Ex. 9 (UpturnCare's enrollment application, Form CMS-855A), at 15 (box for "You are a **new enrollee** in Medicare" is checked) and 19 (box for "Home Health Agency" is checked for "Type of Provider"). In its August 9, 2012 letter to Texas Department of Aging & Disability Services (TDADS), Palmetto stated that it had completed processing UpturnCare's application for "initial enrollment." CMS Ex. 1, at 1. It also is undisputed that UpturnCare was seeking to practice at least in one of multiple counties in the Dallas, Texas metropolitan area, to include Tarrant County. Its own enrollment application so states. CMS Ex. 9, at 60-65. UpturnCare's address is in Bedford, Texas. *Id.* at 29. The ALJ found that "the practice location listed in the application was . . . [in] Bedford, Texas" and that UpturnCare "does not dispute that its practice location is in Tarrant County, Texas." ALJ Decision at 6.[12]

The dispute lies elsewhere – what it means to be "approved" for enrollment. UpturnCare has argued below, and continues to argue before the Board, that it had completed "each and every" requisite step for enrollment because Palmetto recommended approval of its application on August 9, 2012 and The Joint Commission accredited UpturnCare and recommended certification before the moratorium went into effect on January 30, 2014. Therefore, UpturnCare's argument goes, its application was "approved" and all that needed to be done was to enter the approval status into PECOS and, accordingly, its application was not subject to the moratorium. RFH; RR. CMS, however, maintained, and the ALJ agreed, that UpturnCare had not completed all of the steps for approval and, specifically, had not undergone final re-review and site visit, or "pre-tie-in review," a step that precedes final approval. ALJ Decision at 8.

In essence the dispute centers on *when* (or more specifically at what stage of the multi-step review process) an application is considered "approved" for the purposes of determining whether the moratorium applies to UpturnCare's application. We agree with the ALJ that UpturnCare has raised no genuine dispute of fact material to the issue of whether UpturnCare's application had been approved.

But we will first address a more basic, though related, issue raised by UpturnCare's arguments below and before the Board, which concerns *who* actually approves the enrollment application. This issue, like the issue of what "approved" means, calls for an examination of section 424.570(a)(1)(iv), which states (italics added):

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[12] The ALJ also found that UpturnCare "seeks to operate in Tarrant and Denton Counties, Texas." ALJ Decision at 6. Before the Board, UpturnCare does not dispute the ALJ's finding that it was seeking to operate in Tarrant and Denton Counties, which are two Dallas, Texas metropolitan area counties affected by the moratorium that went into effect on January 30, 2014. *See* 79 Fed. Reg. at 6479; ALJ Decision at 6.

> The temporary enrollment moratorium does not apply to any enrollment application that has been approved *by the enrollment contractor* but not yet entered into PECOS at the time the moratorium is imposed.

UpturnCare stated below, and restates before the Board, that "the MAC" (referring to the enrollment contractor) recommended approval of its application, asserting that this recommendation meant that UpturnCare's application had been approved. *See, e.g.*, RR at 1, 2-3, 8-9; RFH at 1. But elsewhere in its Request for Review, it also states that "CMS completed its final review . . . prior to the Moratorium going into effect on January 30, 2014 in Tarrant County, TX" and "CMS had finished its review." RR at 13. In its reply to CMS's response to the request for review (Reply), UpturnCare repeatedly makes statements to the effect that CMS completed review, recommended approval, and determined that UpturnCare was eligible to participate in Medicare. Reply at 2, 6, 9. UpturnCare's statements suggest a misunderstanding or confusion about the approval process and, specifically, about who ultimately approves enrollment.

Section 424.570(a)(1)(iv) does state that "the enrollment contractor" approves the enrollment application. But the enrollment contractor (like Palmetto) acts with authority delegated by CMS. That an enrollment contractor *recommended* approval does not mean that *CMS* has endorsed that approval as a final determination on approval status. It is CMS, not Palmetto or any other CMS contractor, which ultimately decides whether a prospective provider or supplier meets the requirements for participation in Medicare and may be enrolled in Medicare. *See* 42 C.F.R. § 424.516(a); *see also id.* § 424.510(a) ("CMS enrolls the provider or supplier into the Medicare program.").

The regulations also confer on CMS "the right, when deemed necessary, to perform onsite review of a provider or supplier . . . to determine compliance with Medicare enrollment requirements." 42 C.F.R. § 424.517(a). UpturnCare relies, in part, on The Joint Commission's October 1, 2013 accreditation and recommendation for certification of UpturnCare as support for its argument that it complied with, and completed, the enrollment requirements. *See, e.g.*, RR at 3. However, contrary to UpturnCare's position, a successful accreditation outcome, as achieved by UpturnCare following The Joint Commission's survey performed between August 13-15, 2013 (*see* CMS Ex. 3), does not mean that CMS (though its contractor) has in fact determined that UpturnCare has met all of the requirements for enrollment, let alone that CMS must or should accept the accrediting organization's favorable recommendation. CMS is authorized to take other, or additional, action, like performing an onsite inspection(s), if it determines that such action is needed to determine compliance with the enrollment requirements. *See* 42 C.F.R. §§ 424.510(d)(8), 424.517(a); *see also id.* § 424.516(a). Here, CMS determined that a "pre-tie-in review" that includes a contractor site visit and the "additional step" discussed in the S&C Letter, S&C: 12-15-HHA – a "second review" of enrollment criteria by the RHHI or the MAC – would be needed to make that determination. In fact, The Joint Commission's October 3, 2013 letter notifying UpturnCare of its accreditation

status effective October 1, 2013 informed UpturnCare, "Please note that the [CMS] Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation . . . ." CMS Ex. 3, at 1. Similarly, UpturnCare's application, Form CMS-855A, which includes a summary of the basic sequential steps for "Obtaining Medicare Approval," stated that "[t]he CMS Regional Office makes the final decision regarding program eligibility." CMS Ex. 9, at 7. CMS has not made any such determination here.

We now turn to the issue of what "approved" means as this word is used in section 424.570(a)(1)(iv). The terms "approve," "recommendation for approval," and a slight variation, "recommendation of approval," have special meaning within the context of enrollment processes. In the preamble to the Final Rule and Interim Final Rules (published together on August 16, 2010), CMS described the provider/supplier enrollment process. 75 Fed. Reg. 50,042, 50,402 (Aug. 16, 2010). CMS wrote:

> A CMS contractor will review and conduct an initial assessment of a prospective provider's or supplier's enrollment. If the contractor finds that a prospective provider or supplier meets the basic enrollment requirements to participate in the Medicare program for its identified certified provider or supplier type, the contractor will notify the appropriate CMS Regional Office. *Essentially, the contractor's initial assessment means that it has concluded its preliminary review of the enrollment application and has concluded that the survey and certification process can be initiated, and, consequently, it issues a recommendation of approval.* In order to help ensure compliance with enrollment requirements throughout this process, the contractor may continue to perform a number of enrollment verification tasks even after it has issued a recommendation for approval. These include, but are not limited to, conducting onsite visits of the prospective provider or supplier to ensure that it is still operational; verifying an HHA applicant's compliance with the capitalization provisions in 42 CFR 489.28; and requesting the provider or supplier applicant to reaffirm the accuracy of information it furnished on its initial enrollment application. . .

Id. at 50,402 (italics added). Thus, a "recommendation for approval" means only that the application has cleared the initial step. It precedes the next step, the survey and certification process, which also must be cleared. And, as applicable to this case, that step precedes the next step, the re-review and site visit referred to in the ALJ Decision as the "pre-tie-in review."

The term "approved," in contrast, contemplates a determination to allow enrollment following successful completion of the entire review process. Section 424.502 defines the term "Approve/Approval" to mean that "the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare

billing number and be granted Medicare billing privileges," which, as we discussed elsewhere in this decision, is a determination that CMS makes. Also, CMS recently addressed the meaning of the term "approved" within the context of the applicability of the moratorium. On August 9, 2013, CMS's Center for Clinical Standards and Quality/Survey & Certification Group issued a S&C Letter, S&C: 13-53-HHA, addressed to all State Survey Agency Directors, explaining how CMS would apply a temporary moratorium that became effective on July 30, 2013 in the Miami, Florida and Chicago, Illinois areas. Although this S&C Letter was issued before the January 30, 2014 moratorium that went into effect for the counties in the Dallas, Texas area, it is nevertheless instructive on the meaning of the word "approved" as it relates to the applicability of the moratorium. The S&C Letter states (italics added):

> Prospective HHA applications within the affected areas which were **not approved** prior to July 30, 2013 will be denied by the [MAC]. *Approved means that by 12:00 AM July 30, 2013 the initial certification survey was completed; the second MAC review was completed; the CMS Regional Office (RO) sent the tie-in notice to the MAC; the MAC performed a site visit and the MAC decided to switch the HHA's [PECOS] record to an "approved" status.*

S&C Letter, S&C: 13-53-HHA (emphasis in original, italics added).[13]

Also, in response to comments to the proposed rule published on September 23, 2010 (75 Fed. Reg. 58,204) expressing concerns about the applicability of the moratorium on pending enrollment applications, what CMS would do with applications submitted by new providers when the moratorium is imposed, and whether pending applications will be processed or denied when the moratorium is imposed, CMS responded as follows:

> In the [proposed rule], we indicated both in the preamble and the proposed regulations that an application to enroll in Medicare from a provider or supplier that is subject to a temporary enrollment moratorium would be denied. *With regard to pending applications, we interpret the ACA as applying to pending applications.* If a temporary enrollment moratorium is deemed necessary for any provider or supplier type, or for any geographic area, then all enrollment applications from unenrolled providers and suppliers of the type subject to the temporary enrollment moratorium or in the geographic area subject to the moratorium would be denied. *However, we will not deny any enrollment for which the Medicare enrollment*

[13] This language from S&C Letter, S&C: 13-53-HHA, was quoted in page 9 of "CMS' Reply to [UpturnCare's] Motion for Reconsideration of the Denial of Medicare Provider Number & Supporting Brief" and in pages 19-20 of CMS's Response to UpturnCare's Request for Review.

> *contractor has completed review of the application and has determined that the provider or supplier meets all the requirements for enrollment and all that remains is to assign appropriate billing number(s) and enter the provider or supplier into PECOS.*

76 Fed. Reg. at 5919 (italics added).

CMS's statements in the rulemaking, quoted above, distinguish pending or incomplete applications, which may be subject to moratoria imposed in accordance with the ACA amendments, from applications that have undergone complete review, which will not be denied based on the application of a moratorium. *Id.* A "recommendation for approval" means only that the application has cleared the initial step. 75 Fed. Reg. at 50,402. Accordingly, Palmetto's August 9, 2012 letter recommending approval of UpturnCare's application (CMS Ex. 1) does not mean that CMS has determined that all enrollment requirements have been completed satisfactorily, as UpturnCare urges us to find. Palmetto "had not yet performed the additional re-review" (ALJ Decision at 8), which includes confirmation that no owners or managing employees of the prospective HHA are excluded and that the prospective HHA meets capitalization requirements, as well as the site visit, when the moratorium effective January 30, 2014 was announced. *See* P. Ex. F (copy of PIM, Ch. 15, § 15.26.3, effective Jan. 7, 2014). Furthermore, CMS clearly communicated to UpturnCare what was necessary for its application to be "approved" in the application form, Form CMS-855A. The Form CMS-855A includes a summary of the basic sequential steps for "Obtaining Medicare Approval," which would include review of the application and "recommendation for approval or denial" by a CMS fee-for-service contractor, then survey by a state agency or approved accreditation organization, which makes a "recommendation for approval or denial" to the CMS Regional Office, and then possibly a second contractor review when deemed necessary. CMS Ex. 9, at 7.

UpturnCare nevertheless invoked before the ALJ, and again on appeal, language in the PIM, Ch. 15, § 15.19.3, effective March 25, 2011 (Revision 371), that UpturnCare evidently reads to mean that the moratorium will not apply to applications like UpturnCare's, for which a recommendation for approval has been made. *See* UpturnCare's briefing below, headed "Cause to Appeal" at 3 (not paginated); RR at 6-7; P. Ex. N (copy of Revision 371). Revision 371 states, in relevant part:

> For initial and new location applications involving the affected provider and supplier type, the moratorium:
>
> • Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.

> • Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor shall deny such applications, using §424.535(a)(10) as the basis.

The language in the first bullet seems to suggest that an application for which a "recommendation for approval" has been made will be exempt from the moratorium and continue to be processed. Evidently, UpturnCare reads the language in the first bullet to mean that CMS has said that the moratorium will not apply to applications like UpturnCare's for which a recommendation for approval has been made, because UpturnCare circled the words "or a recommendation for approval has been made" in the first bullet and wrote an asterisk adjacent to the circled words. P. Ex. N. *See also* RR at 6-7 (quoting the language in the first bullet).[14]

The language in the second bullet creates ambiguity, however. On the one hand, it may be read to suggest that a pending application will be denied only if neither a "recommendation for approval" nor a "final" approval/denial decision has been made by the contractor. On the other hand, it may be read to apply the moratorium and deny any pending application that has not received final contractor approval/denial (where that step is required) or final recommendation for approval (where only that step is required).[15] Neither UpturnCare nor CMS addressed or even appeared to recognize the ambiguity of the manual's wording.

[14] Revision 371 was issued effective March 25, 2011, before the February 4, 2014 Federal Register announcement on the moratorium on new HHA enrollments in the Dallas, Texas area counties, and does not explicitly state that its provisions apply to moratoria imposed on new HHA enrollment applications. But UpturnCare does not dispute its relevance or applicability to its case. On the contrary, it asserts that the Revision 371 language supports its position. Section 15.19.3 of the PIM has since been revised. The current version of PIM, Ch. 15, § 15.19.3, in effect as of June 3, 2014, does not include the bulletized language in Revision 371. The current version reads, in its entirety:

> Under § 424.570(a), CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. The announcement of a moratorium will be made via the Federal Register, though the contractor will be separately notified of the moratorium.
>
> The contractor shall abide by all CMS directives and instructions issued pursuant to the imposition or lifting of a particular moratorium.

[15] The reference to section 424.535(a)(10) as the basis to cite for such denials is puzzling under either interpretation. Section 424.535(a)(10) concerns *revocation* of enrollment for the failure to furnish documentation or provide CMS access to documentation and refers to the failure to comply with the "documentation or CMS access requirements" in section 424.516(f), which holds certain providers and suppliers responsible for maintaining certain types of documentation and, on CMS's or a contractor's request, to provide access to the documentation in order to *enroll* in or maintain active enrollment in Medicare.

The apparent inconsistency between the first and second bullets may be best reconciled by reading the language in both bullets together to mean that pending applications will be denied unless the contractor has issued a recommendation for approval, or, if the contractor has determined that additional steps need to be taken before the application is ready for entry into PECOS, those steps have been completed and the final decision to approve (or deny) enrollment can be made. CMS's revision of section 15.19.3 of the PIM effective June 3, 2014 (Revision 514), which removed the bulleted language in Revision 371, supports that as CMS's intended construction. In any case, Revision 371 is at most sub-regulatory guidance, and should not be construed in a manner that would be inconsistent with explicit provisions in the February 2, 2011 final regulations (76 Fed. Reg. 5862 (Feb. 2, 2011)) or in the Federal Register announcement of the new moratorium on the enrollment of HHAs in the Dallas, Texas metropolitan area (79 Fed. Reg. 6475 (Feb. 4, 2014)). To the extent that Revision 371 is read to conflict with the final regulations and the Federal Register announcement, those authorities would prevail.[16]

UpturnCare further asserts that CMS "completed" its review and performed a "second review" on December 15 or December 16, 2013, and that a person from CMS informed UpturnCare about this in early January 2014. UpturnCare also appears to be asserting that it therefore should not have been required to undergo a "new" "pre-tie-in review" requirement in accordance with PIM section 15.26.3 provisions that became effective in January 2014. *See, e.g.*, RR at 4; Reply at 7, 9; P. Ex. F (PIM section 15.26.3 as revised Jan. 7, 2014). But, as we discussed earlier, there is no evidence that CMS or the contractor actually performed a re-review or completed its review on or around December 15, 2013 as UpturnCare asserts. UpturnCare has not offered evidence such as an affidavit in support of its contention concerning the purported telephone call(s) in early January 2014 between CMS and UpturnCare during which CMS is supposed to have informed UpturnCare that CMS had completed its review in December 2013. On the contrary, UpturnCare's own exhibit tends to indicate that no such review was completed in December 2013. UpturnCare's Exhibit E is a printout, apparently generated on February 22, 2014, of the search results of a web-based program maintained by Palmetto that provides information on the status of enrollment applications. The printout states, in part, that UpturnCare's application was received on January 8, 2014, "closed" on February 5, 2014, and, for "Application Type," notes "PTR – Pre-Tie-In Review." But neither the printout, nor any other evidence of record, indicates that any such pre-tie-in review or re-review was actually performed within 45 days after January 8, 2014.

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[16] In any case, UpturnCare could hardly claim to have relied to its detriment on any alternative interpretation of the bulleted language in Revision 371 (even if it could show it formed such an interpretation) because UpturnCare could done nothing differently during the period between the contractor's recommendation of the application for approval and the issuance of the denial of enrollment to change the outcome.

UpturnCare also relies on the regulations in 42 C.F.R. Part 489, subpart A and, in particular, section 489.13, in support of two arguments. RR at 4, 7, 8, 11-12, 13; Reply at 3, 9. First, UpturnCare appears to be arguing that, because section 489.12, which sets out the bases on which CMS may refuse to enter into an agreement with a provider, does not contemplate the applicability of a moratorium on new enrollments as a basis for denial of enrollment, the denial of UpturnCare's enrollment application based on the applicability of the moratorium was unlawful. RR at 12, 13. Second, UpturnCare invokes section 489.13, which addresses effective dates of provider agreements. UpturnCare apparently contends that, because it met all health and safety standards in accordance with section 489.13(b) as of October 1, 2013, the effective date of The Joint Commission's accreditation following a survey, it should not be subject to the moratorium. RR at 4, 7, 8, 11-12; Reply at 3, 9.

The Part 489 regulations govern, *inter alia*, the effective dates of provider agreements and the terms and termination of provider agreements. It is undisputed that CMS has not entered into a provider agreement with UpturnCare. Therefore, the Part 489 regulations are not even applicable where, as here, the provider has not been enrolled into the Medicare program and does not have a provider agreement in place. UpturnCare's application was properly denied based on the moratorium that was established in accordance with section 1866(j)(7) of the Act and the implementing regulations in 42 C.F.R. §§ 424.530(a)(10) and 424.570. CMS's imposition of the moratorium that went into effect on January 30, 2014 for the Dallas, Texas metropolitan area counties was a lawful exercise of the authority permitted by section 1866(j)(7).

As for the argument based on section 489.13(b), the inapplicability of the Part 489 regulations aside, UpturnCare seems to misread the regulation, or selectively reads a part of the regulation that it believes favors its position. *See, e.g.,* Reply at 9, ¶ 7. Section 489.13(b) states, in part:

> (b) *All health and safety standards are met on the date of survey.* The agreement or approval is effective on the date the State agency, CMS, or the CMS contractor survey (including the Life Safety Code survey, if applicable) is completed, or on the effective date of the accreditation decision, as applicable, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. . . . However, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met. Federal requirements include, but are not limited to–
>
> (1) Enrollment requirements established in part 424, subpart P of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met; . . . .

Therefore, before the effective date of any provider agreement or approval can be established, CMS must have first determined that all applicable federal requirements, to include the Part 424 enrollment requirements, were met. CMS has determined that the enrollment requirements were not fully met in this case.

UpturnCare has raised some general factual disputes concerning its approval status and, before the Board, repeats those arguments made below before the ALJ. But nothing that UpturnCare has said raises a genuine dispute on the only material question of whether UpturnCare's application has been "approved." UpturnCare's application was, as a matter of law, not "approved" when the moratorium went into effect even accepting UpturnCare's account of events. To defeat summary judgment against UpturnCare, UpturnCare must do more than rest on denials or unsubstantiated allegations. It must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita*, 475 U.S. at 587 (italics omitted) (quoting Fed. R. Civ. P. 56(e)). UpturnCare has not done so here.

B. UpturnCare's remaining arguments have no merit.

Before the Board, UpturnCare reiterates claims that Palmetto or CMS made representations concerning approval on which UpturnCare relied to its detriment, and that CMS and Palmetto unreasonably delayed the processing and review of its application, causing the review of its application to remain incomplete and later subject to the moratorium. RR at 1-2, 11, 12, 15. UpturnCare suggests that the delay might even have been intentional or the result of bad faith, as it writes, "[UpturnCare] feels that CMS and MAC was failed [*sic*] the continuation of the process in anticipation of the moratorium." *Id.* at 6.[17] As far as we are able to determine, these statements amount to a request for equitable relief – a matter the ALJ already addressed. ALJ Decision at 8, *citing US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither 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."). UpturnCare's claims that CMS or its contractor acted unreasonably lack foundation. Even if UpturnCare had any foundation for its assertions, the ALJ correctly informed UpturnCare that equitable relief is not available. UpturnCare's similar assertions that CMS made misleading statements or was "disingenuous" are vague and unsupported. *See, e.g.*, Reply at 8 (alleging that CMS "destroy[ed]" UpturnCare's "business"). Equally unavailing, UpturnCare states that the

[17] UpturnCare's repeated complaints about the unreasonable delay in completing review and suggestion that the delay was intentional "in anticipation of the moratorium" (RR at 6) undercut UpturnCare's alternative claim that it was already approved, by reinforcing that the re-review was not actually completed before the effective date of the moratorium.

denial of its enrollment application is "completely illegal," but, other than reasserting that CMS decided "not to process [UpturnCare's provider] agreement in anticipation of the moratorium," UpturnCare does not articulate specifically why the denial was illegal and cites no authority for its assertion. *See id.* at 9.

UpturnCare also states that it was discriminated against. RR at 14 ("This is true violation of the process and direct discrimination of the provider."). We have addressed UpturnCare's argument concerning the delay in processing of UpturnCare's application. To the extent that UpturnCare's claim of discrimination concerns CMS's initially filed Exhibit 9 and CMS's subsequent submission of amended CMS Exhibit 9, we have also addressed this matter earlier. In either case, UpturnCare has not shown how specifically CMS discriminated against UpturnCare and what authority CMS violated.

Finally, UpturnCare states that it is "currently in appeal status with Civil Rights Jurisdiction Court." RR at 5. As far as we can determine, UpturnCare is referring to a pending dispute it has against The Joint Commission concerning The Joint Commission's "removal" of UpturnCare's "deemed status" following the announcement of the moratorium. *Id.* at 5-6. But UpturnCare does not appear to raise an issue or matter related to its dispute with The Joint Commission that would properly be in the Board's jurisdiction, much less a dispute of material fact on the ultimate question of whether UpturnCare's application was approved. We need not further address this matter.

Conclusion

For the reasons stated above, we sustain the denial of UpturnCare's application for enrollment in Medicare as a new HHA.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member