Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
United Medical Home Care, Inc.,	DATE: August 28, 2008
Petitioner,	App. Div. Docket No. A-08-61
- v. -	Decision No. 2194
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

United Medical Home Care, Inc. (United), a California home health agency (HHA), appeals the December 31, 2007 decision of Administrative Law Judge Keith W. Sickendick (ALJ), which upheld the termination of United's Medicare provider agreement by the Centers for Medicare & Medicaid Services (CMS) effective August 30, 2005. United Medical Home Care, Inc., DAB CR1713 (2007) (ALJ Decision). The ALJ upheld the termination based on a finding that United was not "primarily engaged" in providing skilled nursing and other therapeutic services between February 9 and August 23, 2005 and thus failed substantially to meet the Medicare statute's definition of a "home health agency" during that period. Because we conclude that this finding is supported by substantial evidence and not legally erroneous, and because failing substantially to meet the statutory definition of an HHA is a legally sufficient ground upon which to terminate a Medicare provider agreement, we affirm the ALJ Decision with a modification of the ALJ's findings regarding the date of the notice of termination and the termination's effective date.

Legal Background

Title XVIII of the Social Security Act (Act) establishes the Medicare program, which reimburses health care "providers" and

"suppliers" for the medical care and services they furnish to Medicare beneficiaries. Act §§ 1811-12, 1831-32. The program is administered by CMS and its contractors on behalf of the Secretary of Health and Human Services (Secretary).

In order to participate in the Medicare program, an HHA or other provider[1] must execute a "provider agreement" and undergo surveys to certify its compliance with program requirements. 42 C.F.R. §§ 488.20, 489.11. The provider agreement contains assurances that the provider meets, and will continue to meet, applicable conditions for Medicare participation and also reflects CMS's acceptance of the provider's eligibility to participate in the program. Id. §§ 489.11(a), 489.20.

A provider agreement may be terminated by either the provider or by CMS. Termination by the provider (an event that the parties refer to as "voluntary termination") is governed by 42 C.F.R. § 489.52, which provides:

> **§ 489.52 Termination by the provider.**
>
> (a) *Notice to CMS*. (1) A provider that wishes to terminate its agreement must send CMS written notice of its intent.
>
> (2) The notice may state the intended date of termination which must be the first day of the month.
>
> (b) *Termination date*. (1) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the provider's notice of intent.
>
> . . .
>
> (3) 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.
>
> (c) *Public notice*. (1) The provider must give notice to the public at least 15 days before the effective date of the termination.

(Emphasis added.)

[1] The term "provider of services" is defined in the Medicare statute to include a home health agency. Act § 1861(u).

Section 1866(b) of the Act sets out the conditions under which the Secretary or CMS may terminate a provider agreement. Section 1866(b)(2)(B) provides that the Secretary may, "upon such reasonable notice to the provider and to the public as may be specified in regulations," terminate the provider agreement if he determines that the provider "fails substantially to meet the applicable provisions of section 1861." (Emphasis added.)

In this case, the "applicable provision" of section 1861 is section 1861(o), which provides in relevant part:

> The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which —
>
> (1) is primarily engaged in providing skilled nursing services and other therapeutic services; . . .

The statutory definition in section 1861(o) contains seven other enumerated elements, none of which is implicated here.

Title 42 C.F.R. § 489.53(a)-(c) implements the statutory provisions governing termination by the Secretary. Section 489.53(a)(1) provides that CMS may terminate a provider agreement if it finds that the provider "is not complying with the provisions of title XVIII and the applicable regulations of this chapter or with the provisions of the agreement." Section 489.53(c)(1) states that CMS "gives the provider notice of termination at least 15 days before the effective date of termination[.]" Section 489.53(c)(3) states that the notice of termination "states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date[.]" Section 489.53(d) states that a provider may appeal the termination of its provider agreement by CMS in accordance with 42 C.F.R. Part 498.

Case Background

The following undisputed facts are drawn from the ALJ Decision and the record below.

United was first certified to participate in Medicare in 1996. P. Ex. 12, at 1.

In September 2004, Trust Solutions, LLC (TSL), a CMS contractor, suspended Medicare payments to United pending an audit of prior program payments. CMS Ex. 5. The payment suspension continued for approximately one year (until August 25, 2005). P. Ex. 1, at

2. The payment suspension did not prohibit United from continuing to provide services to Medicare beneficiaries and submitting coverage claims to Medicare for those services; the suspension instead withheld Medicare payment on pending or future coverage claims until the audit was completed. CMS Ex. 5, at 4.

On May 25, 2005, United faxed a letter to the California Department of Health Services (CDHS) which stated:

> Please be informed that our agency, United Medical Home Care, Inc., is not actively admitting patients up to the current period and do[es] not have any active patients at this time because we were placed into suspension by . . . a CMS Program Contractor since September 1, 2004.

CMS Ex. 2, at 1. Attached to (and faxed with) the May 25 letter was a document entitled "Active Patient Report . . . Covering Period from: 01/25/2005 thru 02/02/2005." Id. at 2. This document lists a single patient whom United discharged on February 8, 2005. Id.

On June 2, 2005, United sent a letter to CMS which stated that "[t]he last client we serviced was discharged in February of this year." CMS Ex. 2, at 3.

On August 15, 2005, CMS sent United a termination notice letter which began by summarizing United's May 25 and June 2 correspondence. CMS Ex. 1. The August 15 notice letter then stated:

> Based on information you furnished . . ., it is evident that United voluntarily terminated its Medicare provider agreement due to the cessation of services in February [2005]. See 42 C.F.R. § 489.52(b)(3) . . . . United's voluntary termination was effective on February 9, 2005 (the day after February 8, 2005, which was the last day United provided services, according to the information furnished by [United] . . . .

Id.

On August 20, 2005, United advised CMS that it "never ceased" or "intended to cease" providing home health services to the community. CMS Ex. 3, at 1. United asserted that its focus had been on meeting demands of the TSL payment audit and that it had taken steps to remain in business despite the lack of Medicare revenue, including: (1) continuing to educate staff and sources

of referral; (2) advising the medical community of its readiness to accept clients; (3) maintaining and updating patient records; and (4) holding "regular meetings . . . in anticipation of favorable results" of the audit. Id. at 1-2.

On August 25, 2005, TSL lifted the payment suspension and notified United that its audit had found approximately $3.5 million in Medicare overpayments to United for the period January 1, 2002 to September 30, 2004. P. Ex. 1. That same day, CMS informed United of its intent to recoup the overpayment, indicating that $1,849,041 in suspended payments would be applied toward the overpayment, leaving a balance due of $1,733,358. P. Ex. 2.

On August 24, 2005 and September 1, 2005, United informed CMS by letter that it had admitted a Medicare patient on August 23, 2005. CMS Ex. 3, at 3-4.

On September 15, 2005, CMS sent United a second notice letter. The September 15 notice reaffirmed CMS's original conclusion that United had terminated its provider agreement because it had ceased providing services to the community after February 8, 2005. CMS Ex. 4. In this notice, CMS also cited two ALJ decisions, including one cited for the proposition that "where provision of services is a necessary prerequisite to Medicare certification, it is insufficient for an entity to contend it is willing to provide such services, or that it has the ability to provide them; CMS demands proof that the facility is actually providing the services." Id. at 2.

On February 3, 2006, United requested an ALJ hearing to contest CMS's notice of "voluntary termination." CMS responded with a motion to dismiss the hearing request, asserting that United had never made an appealable "initial determination" under 42 C.F.R. Part 498. CMS's Motion to Dismiss (March 10, 2006) (MTD) at 9. CMS also contended that regardless of the ALJ's authority to hear the dispute, termination was justified because once United stopped providing services to patients on February 9, 2005, it was no longer "primarily engaged in providing skilled nursing services and other therapeutic services" and thus no longer met the statutory definition of an HHA in section 1861(o)(1) of the Act. Id. at 8.

On October 26, 2006, the ALJ issued a ruling on the motion to dismiss. Suggesting that United would not have challenged the termination had it been "voluntary," the ALJ held that CMS had "mischaracterized the nature of the termination" and "involuntarily" terminated United's provider agreement pursuant

to section 489.53. Accordingly, the ALJ concluded that United had a right to a hearing on the legality of the termination.

The parties then proceeded to exchange documentary evidence and to brief the merits of the case. During this process, United waived its right to an in-person evidentiary hearing and agreed to allow the ALJ to resolve any outstanding issues based on the parties' documentary evidence and written legal arguments.

On December 31, 2007, the ALJ issued his final decision upholding termination of United's provider agreement effective August 30, 2005. Finding it undisputed that United had no patients between February 9 and August 23, 2005, the ALJ held that United was not "primarily engaged in providing skilled nursing services and other therapeutic services" and thus was in "substantial" violation of section 1861(o)(1) during that period. ALJ Decision at 6-7. The ALJ also held that CMS has the discretion under the Act and regulations to terminate a provider agreement when the provider no longer meets the definition of an HHA under section 1861(o)(1), and that it was "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." Id. at 7. In addition, the ALJ rejected United's assertion that it had cured any violation of the Act by admitting a patient on August 23, 2005. Id. He also found that the payment suspension levied on United was not an extraordinary circumstance, noting that United "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." Id. Finally, the ALJ held that United had received "adequate notice" of its "involuntary termination" in accordance with 42 C.F.R. § 489.53(c), and that the effective date of the termination was August 30, 2005. Id. at 5, 8.

United then filed its request for review, contending, on various grounds, that termination of its provider agreement was legally invalid. Along with its request for review, United submitted a copy of a March 9, 2007 Office of Medicare Hearings and Appeals (OMHA) decision. In that decision, which was admitted to the record below as Petitioner's Exhibit 17, an administrative law judge with OMHA invalidated the statistical sampling upon which TSL's overpayment determination was based and concluded that CMS was entitled to recover only $14,276 of the $3.5 million that TSL had deemed to be an overpayment. CMS objected below to the admission of Petitioner's Exhibit 17 and renews that objection in its response to the request for review.

In addition to submitting a copy of Petitioner's Exhibit 17, United submitted two new exhibits, which it labeled Petitioner's Exhibits 18 and 19. Petitioner's Exhibit 18 contains the "affidavit" of Erlinda De Joya (United's director of patient care services), telephone logs, correspondence, and other documentation which, according to United, collectively show that during the second half of the Medicare payment suspension (February to August 2005), United "continued to maintain core home health agency operations and responded to inquiries regarding former patients even though it was no longer financially unable [sic] to provide care until the financial suspension was lifted." Reply Br. at 4.

Petitioner's Exhibit 19 is a copy of a check issued to United by National Government Services, Inc. (NGS), United's Medicare fiscal intermediary, for $1,908,236.20. According to United, this check represented the amount of Medicare payments withheld by CMS between August 2004 and August 2005 and was issued "as a direct result of" the March 9, 2007 OMHA decision. United Br. at 8; Reply Br. at 4.

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision or ruling is supported by substantial evidence in the record. The standard of review on a disputed issue of law is whether the ALJ decision or ruling is erroneous. *Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (*Guidelines*), available on the DAB website at http://www.hhs.gov/dab/guidelines/ prov.html).

Discussion

In this discussion, we first address certain evidentiary issues raised by the parties on appeal. Next, we make a finding on what constitutes the operative notice of termination for purposes of this case. We then consider United's objections to the ALJ's conclusion regarding the legality of its termination from the Medicare program.

1. *Evidentiary matters*

We decline to admit Petitioner's Exhibits 18 and 19 into the record. The Board may admit evidence into the record in addition to the evidence introduced at the ALJ hearing if the additional evidence is relevant and material to an issue before it. 42 C.F.R. § 498.86(a). In considering whether to admit additional

evidence, the Board considers whether the proponent of the new evidence has shown good cause for not producing it during the ALJ proceeding. See *Guidelines*. Regarding the telephone logs and other documentation in Petitioner's Exhibit 19, United's patient care director stated that United "did not submit [them] to administrative law judge Sickendick because we did not know that they existed until we finished our clinical patient chart audit in February, 2008." However, the records in Petitioner's Exhibit 18 were all created prior to the ALJ proceeding and were in United's custody. Furthermore, United gives no reason for not performing its "patient chart audit" until after the ALJ issued his decision. In addition, United has provided no explanation for failing to produce the document in Petitioner's Exhibit 19, which is a copy of a Medicare contractor's check issued in July 2007, five months before the ALJ issued his decision. For these reasons, we decline to admit Petitioner's Exhibits 18 and 19 into the record. We note that their contents would not have altered our decision because they do not undercut the ALJ's central conclusion that United was not primarily engaged in providing home health services between February and August 2005.

We also reject CMS's request to overturn the ALJ's admission of Petitioner's Exhibit 17. Because the exhibit is relevant to what United calls its "public policy" argument (which we discuss below), the ALJ did not err or abuse his discretion in admitting the exhibit.

2. *Notice of termination*

While (as discussed below) we reject United's position that it never received adequate notice of involuntary termination, we conclude that CMS's September 15, 2005 notice letter, not the August 15 notice letter, is the operative notice of termination in this case. Given that United's cessation of services in February 2005 was the basis for CMS's statement in the August 15 notice letter that United had "voluntarily" terminated its provider agreement, United could reasonably have believed that termination was avoidable if it showed that it never intended to cease doing business as an HHA. After receiving the August 15 notice, United informed CMS that it did not intend to leave the program, that it continued to perform certain administrative functions in order to maintain its readiness to provide services, and that it expected to resume providing services when the payment suspension was lifted. CMS Ex. 3, at 1. In spite of this information, CMS reaffirmed the termination in its September 15 notice. By indicating that CMS considered the provider agreement to be terminated despite receiving information that United did not intended to terminate its provider agreement, CMS

implied that the termination was, in fact, involuntary. Moreover, in the September 15 notice letter CMS referred for the first time to the provision of services as a prerequisite to certification (and therefore to program participation). Contrary to what the ALJ concluded, the August 15 notice cannot reasonably be viewed as informing United that it was being terminated against its will and the reason why.

For these reasons, we conclude that the September 15, 2005 notice letter is the initial notice of termination under section 1866(b)(2) of the Act.

3. *Legality of the termination*

As a preliminary matter, neither party has challenged the ALJ's October 2006 ruling that the termination which occurred in this case was "involuntary." In articulating their respective positions, the parties assume that section 1866(b)(2) of the Act, which authorizes the Secretary to terminate a provider agreement under certain circumstances, is the ostensible legal basis for the challenged termination.

The ALJ concluded that there was a valid and sufficient basis for termination pursuant to section 1866(b)(2) because United failed to meet section 1861(o)(1)'s definition of an HHA between February 9 and August 23, 2005. United's arguments concerning that conclusion present two key issues: (1) whether, as a matter of law, failure to meet the definition of an HHA in section 1861(o)(1) constitutes a valid and sufficient basis for terminating an HHA's provider agreement; and (2) whether the ALJ's conclusion that United failed to meet the definition of an HHA between February 9 and August 23, 2005 is legally correct and based on substantial evidence in the record.

On the first issue, section 1866(b)(2)(B) authorizes the Secretary to terminate a provider agreement when he has determined that the provider "fails substantially to meet the applicable provisions of section 1861." The "applicable provision" of section 1861 is section 1861(o), which defines an HHA as entity that has or meets eight enumerated elements or criteria, the first of which is that the entity be "primarily engaged in providing skilled nursing services and other therapeutic services." Reading sections 1866(b)(2)(B) and 1861(o) together, we hold that an HHA's provider agreement may be terminated by the Secretary if the provider "fails substantially to meet" one or more of the definitional elements or criteria in section 1861(o), including the "primarily engaged" criterion in section 1861(o)(1).

United contends that section 1861(o)(1)'s "primarily engaged" criterion is merely a "descriptive definition of a home health agency," not a statutory requirement for participation in the Medicare program. Reply Br. at 8. We disagree. Section 1866(b)(2)(B) authorizes the Secretary to terminate a provider agreement if the provider fails to "substantially meet" an "applicable provision" of section 1861. United would have us find that the "primarily engaged" criterion in section 1861(o)(1) is not an "applicable provision" within the meaning of section 1866(b)(2)(B), but we see nothing in the statutory text to support that view, nor do we discern any factual basis for concluding that section 1861(o)(1) is not "applicable" to this case.[2] Because an entity is subject to termination of its provider agreement for failing to meet one or more elements of the definition of an HHA in section 1861(o), those elements – including the "primarily engaged" criterion – are requirements of Medicare participation.

On the second main issue, we find no error in the ALJ's conclusion that United was not primarily engaged in providing skilled nursing and other therapeutic services between February 9 and August 23 and thus did not meet the definition of a HHA during that period. In Arizona Surgical Hospital, LLC, DAB No. 1890 (2003), the Board considered whether a hospital met Medicare's definition of a "hospital" in section 1861(e)(1). That provision defines a hospital in relevant part as an entity "primarily engaged" in providing health care services to "inpatients." The Board held in Arizona that in order to be "primarily engaged" in providing inpatient services, the hospital had to be actually "engaged" in that activity. It was undisputed that the hospital in question had not been engaged in providing inpatient services in the 39-day-period between two Medicare complaint surveys. DAB No. 1890, at 6-7. We concluded that the "length of Petitioner's failure to engage in providing services to inpatients . . . support[ed] the ALJ's conclusion that Petitioner failed substantially to meet the provisions of section 1861(e) of the Act." Id. at 7.

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[2] CMS regulations likewise fail to support United's reading. "In order to be approved for participation in or coverage under the Medicare program, a prospective [HHA] . . . . must . . . [m]eet the applicable statutory definition in section . . . 1861 . . . and . . . [b]e in compliance with the applicable conditions . . . prescribed in . . . part 484[.]" 42 C.F.R. § 488.3(a). The requirement that the provider "meet the applicable statutory definition" provides no exception for any particular element of that definition.

The material facts in this case are similar. There is no dispute that United performed no skilled nursing or other therapeutic services for six months between February 9 and August 23, 2005. Because it was not engaged at all during that period in providing the types of services described in section 1861(o)(1), we see no basis to disturb the ALJ's conclusion that United was not primarily engaged in providing those services during that period. Furthermore, we find that a six-month period in which an entity fails to provide any home health services is a manifestly "substantial" failure to meet the statutory definition of an HHA.

United points out that, unlike the hospital in Arizona, it maintained its state license to provide services. But United's own evidence shows that its financial situation clearly hampered its ability to obtain and serve patients. P. Exs. 5, 7, 14. The mere possession of a license, in the absence of a demonstrated capacity to actually provide services, cannot overcome evidence of substantial failure to meet the statutory definition of an HHA.

United contends that in order to determine whether it substantially failed to meet section 1861(o)(1)'s definition of an HHA, its entire history must be considered, not just the period from February 9 to August 23, 2005. Reply Br. at 5-7. United asserts that it operated continuously as a Medicare-certified HHA for several years prior to February 9, 2005, and that, even after the financial suspension went into effect, United continued to provide skilled nursing and other therapeutic services for six months until it "ran out of money and exhausted sources for borrowing money." Id. In addition, United suggests that its inability to continue operating after February 9, 2005 was not its fault and stemmed from TSL's "wrongful" payment suspension. United Br. at 32.

United's reliance on its pre-February 9, 2005 activity is unpersuasive. Once it is accepted into the program, a provider must continue to meet requirements and conditions for program participation or risk termination. Cf. 42 C.F.R. § 489.53(a)(1) (authorizing termination of a provider agreement when the provider is no longer complying with the provisions of title XVIII or with provisions of the provider agreement). CMS has a legitimate interest in ensuring that a provider which has been accepted into the program have the financial and other resources to meet its obligations to Medicare beneficiaries and the program. United failed to demonstrate that, as of September 15, 2005, it possessed sufficient resources and clientele to maintain itself as a viable, compliant health care enterprise. We note that the sustained period of inactivity would have impaired the

ability of the state health agency to verify that United remained compliant with other program requirements, including requirements relating to quality of care.[3]

We agree with the ALJ that the circumstances of United's financial difficulty are not extraordinary. Because program regulations expressly authorize CMS to suspend and audit a provider's payments for up to one year, see 42 C.F.R. §§ 405.371-.372, a provider should expect the possibility of having to operate temporarily without Medicare payment. CMS is under no legal obligation to maintain the participation status of a provider or supplier that is financially unable to operate during a payment suspension. Whether or not the suspension in this case was proper or warranted is an issue that is beyond the scope of our inquiry and that could not in any event have been resolved based on the evidence before us.

United's other contentions are meritless. United maintains that it remedied the violation of section 1861(o)(1) by "admitting" a patient on August 23, 2005. Reply Br. at 16. There is also evidence that United admitted a second patient on September 22, 2005. P. Ex. 5, at 8. However, given the length of United's prior inactivity (six months), we do not think the admission of one or two patients is sufficient to establish that United had become primarily engaged in providing skilled nursing and other therapeutic services. We note that United produced no evidence that it actually furnished skilled nursing and other therapeutic services to its recently admitted patients; United submitted only their plans of care and related physician orders. P. Ex. 16. Even if it did furnish such services, we have no basis to conclude that those services constituted United's primary activity during August and September 2005.

United contends that the termination should be declared invalid because CMS failed to provide notice of "involuntary" termination to United or to the public in accordance with 42 C.F.R. § 489.53(c)(1), (c)(3), and (c)(4). United Br. at 15-20. According to United, in his October 2006 ruling on CMS's motion to dismiss, the ALJ indicated that a key reason for his conclusion that United had not "voluntarily" terminated the provider agreement was that United had not given notice of

[3] Although the Board's decision in Arizona implied that a provider's operational history might be relevant in determining whether it failed substantially to meet the "primarily engaged" criterion, we think it was reasonable for the ALJ to conclude that a six-month failure to meet the definition was too long, regardless of United's history.

termination to CMS or the public. Id. at 19. "Since the ALJ invalidated the 'voluntary' termination . . . based on United's failure to adhere to the required 'voluntary' notice requirements" in 42 C.F.R. § 489.52, says United, "the ALJ should have invalidated the 'involuntary' termination . . . based on CMS's failure to adhere to the required 'involuntary' notice requirements of 42 C.F.R. § 489.53(c)." Id. at 19-20.

We disagree because nothing in section 489.53 indicates that failure to provide the required notices will, in itself, render CMS's termination action invalid or void. The chief purpose of section 489.53(c)'s notice requirements is to ensure that a provider is afforded due process to challenge a termination decision by CMS. Cf. 59 Fed. Reg. 56,116, 56,216 (Nov. 10, 1994) (noting that the "purpose of the notice [required by section 489.53(c)(1)] is not for a facility to make last minute corrections, but for the government to help fulfill its duty to provide due process to facilities before termination"). The Board has consistently held that a federal agency's failure to comply with formal pre-hearing notice requirements may be remedied by giving the adversely affected party an opportunity to challenge the agency's position in the ensuing administrative appeal. See, e.g., West Virginia Dept. of Health and Human Resources, DAB No. 2185, at 9 (2008); Recovery Resource Center, DAB No. 2063, at 7-8 (2007); District of Columbia Dept. of Human Services, DAB No. 1005, at 10 n.5 (1988); Alden Town Manor Rehabilitation & HCC, DAB No. 2054, at 17-18 (2006) (noting that the purpose of the Statement of Deficiencies generated by a nursing home survey is to give notice of the basis for CMS's imposition of enforcement remedies but that such notice may also provided in the course "pre-hearing record development"). The Board has also held that a due process violation will not be found absent a showing of prejudice from the allegedly insufficient notice. Livingston Care Center, DAB No. 1871, at 20 (2002), aff'd, Livingston Care Ctr. v. U.S. Dept. of Health and Human Servs., 388 F.3d 168 (6th Cir. 2004); see also St. Anthony Hospital v. Secretary, Dept. of Health and Human Services, 309 F.3d 680, 708 (10th Cir. 2002) ("To establish a due process violation [in an administrative proceeding], an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.").

Although CMS did not provide the notice of termination required by section 489.53(c), United did receive two notices (on August 15 and September 15, 2005) indicating that CMS considered its participation in the Medicare program to have been terminated, and, as discussed above, the September 15 notice made clear that CMS viewed the provider agreement as terminated, even if not

voluntarily so. Furthermore, United received a full opportunity before the ALJ (and the Board) to present legal argument and evidence to challenge CMS's assertion that the termination was justified under section 1866(b)(2) of the Act. United does not contend that the ALJ proceedings were inadequate in any respect, nor has it alleged or shown actual prejudice stemming from defects in the September 15, 2005 notice of termination. For these reasons, we reject any due process claim that United may be seeking to make in this appeal.

United also complains that termination is an inappropriate or excessive remedy. Pointing to section 1891(e)(2) of the Act and its corresponding regulations at 42 C.F.R. 488.28, United asserts that CMS may apply an "intermediate" remedy, such as requiring the HHA to submit an acceptable plan of correction and providing the HHA with an adequate opportunity to carry out the plan. P. Br. at 18, 20-21, 24-27; Reply Br. at 3, 15-16. This contention is unavailing. Assuming for the sake of argument that section 1891(e)(2) and 42 C.F.R. § 488.28 are applicable here, and we make no finding that they are, we note that none of those provisions require CMS to impose an "intermediate" remedy in this or any other circumstance.[4] Section 1866(b)(2) provides that the Secretary "may terminate" a provider agreement when the applicable condition – "fail[ure] to substantially meet" the definition of an HHA in section 1861(o)(1) – is found to exist. In other words, if an entity fails substantially to meet the definition of an HHA – and we affirm the ALJ's conclusion that United did so – it is within the Secretary's discretion to terminate the provider agreement. We need not decide whether the Board has the authority to review CMS's choice of remedy (termination of the provider agreement) because we find no abuse of discretion by CMS given the substantial amount of time – six months – in which United was not primarily engaged in providing skilled nursing and other therapeutic services.

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[4] Section 1891(e)(2) states when "deficiencies" found during a compliance survey "do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services," the Secretary "may" impose an intermediate sanction "in lieu of terminating" an HHA's "certification." The Board has noted that section 1891(e)(2)'s text "clearly implies that the Secretary has discretion to terminate instead," and that "[t]his reading is supported by subparagraph 1891(f)(2)(B), which states that the intermediate sanctions specified in subparagraph 1891(f)(2)(B) 'are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies[.]'" Excelsior Health Care Services, DAB No. 1529, at 8 (1995).

Finally, United contends that the ALJ Decision is "contrary to public policy." Reply Br. at 19. "United's first public policy concern is that, in the light of [TSL's] financial suspension action, if CMS's 'involuntary' termination action is upheld by the DAB, it would send a very dangerous operational message to CMS, whereby CMS could literally financially starve a provider and then terminate that provider, with impunity, for failure to provide services, citing the United case as support." Id. (emphasis in original). United asserts: "What will prevent CMS from imposing 100% financial suspensions on home health agencies at will, causing those home health agencies to suspend patient services (due to lack of operating funds) and then terminating those home health agencies for violation of section 1861(o)(1) of the Act, even though, up to the date of the 100% financial suspension, those home health agencies were law abiding, compliant Medicare providers. Since the 100% financial suspension . . . is not appealable . . ., CMS could select any provider, impose 100% financial suspension and then terminate the provider, using the United decision as support." Id. at 3. "United's second public policy concern is that retroactive termination of United's provider agreement back to a date almost three years ago (August 30, 2005) is wholly improper . . . If anything, 'involuntary' termination of a provider should be implemented prospectively, not retroactively." Id. at 20 (emphasis in original).

We find these concerns unavailing because the ALJ and the Board are not empowered to make policy or to resolve disputes based on their conceptions of what is the best or most efficacious "public policy." Our review is limited to ascertaining whether there is a legally sufficient factual basis for the federal agency's decision.

We note that United's second "policy concern" is addressed in part by our conclusion above that the operative notice of termination was the September 15 notice. Termination of a provider agreement by CMS becomes effective no sooner than 15 days after the notice of termination is issued. 42 C.F.R. § 489.53(c). Because the operative notice of termination occurred on September 15, 2005, the effective date of termination was September 30, 2005. Since United had sufficient notice as of September 15 that its provider agreement was being involuntarily terminated, the effect of the action is prospective, not retrospective.

Conclusion

Based on discussion and analysis above, we modify the ALJ

Decision as follows. First, we add the following paragraph to the Findings of Fact in section II.A. of the ALJ Decision:

> 5. For purposes of this matter, CMS's notice of termination pursuant to 42 C.F.R. § 489.53 occurred on September 15, 2005.

Second, we modify paragraph five of the Conclusions of Law in section II.B. to read as follows:

> 5. CMS was authorized to terminate Petitioner's provider agreement effective September 30, 2005, 15 days after CMS's notice dated September 15, 2005.

We affirm the ALJ Decision in all other respects.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member