Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

A.M. Home Health Services, Inc.
Docket No. A-10-91
Decision No. 2354
December 27, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

A.M. Home Health Services, Inc. (AMHHS), which participated in the Medicare program as a home health agency (HHA), appeals the August 20, 2010 decision of Administrative Law Judge Steven T. Kessel (ALJ) upholding the termination of AMHHS's Medicare provider agreement by the Centers for Medicare & Medicaid Services (CMS). *A.M. Home Health Services, Inc.*, DAB CR2225 (2010) (ALJ Decision). The ALJ granted summary judgment to CMS on the ground that the undisputed facts demonstrated that AMHHS was not "primarily engaged" in providing skilled nursing and other therapeutic services, as required for HHAs participating in the Medicare program.

For the reasons discussed below, we conclude that the ALJ properly granted summary judgment in favor of CMS.

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, 1812, 1831, 1832 (42 U.S.C. §§ 1395(c), (d), (j), (k)). The program is administered by CMS and its contractors on behalf of the Secretary of Health and Human Services (Secretary). An HHA is a Medicare "provider of services." Act § 1861(u). To have a Medicare provider agreement as a home health agency, an agency must, among other things, meet the requirements of section 1861(o) of the Act, the institutional planning requirements of section 1861(z) of the Act, and the other conditions of participation at section 1891(a) of the Act, and the implementing regulations at 42 C.F.R. Part 484.

Section 1861(o) of the Act 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**; . . . .

(Emphasis added.) HHAs' compliance with Medicare participation requirements is determined through surveys performed by state agencies under agreements with CMS. 42 C.F.R. § 488.10.

Background and ALJ Decision

CMS terminated AMHHS's provider agreement on the ground that AMHHS was not "primarily engaged in providing skilled nursing services and other therapeutic services" to patients, as required by section 1861(o) of the Act. The ALJ granted summary judgment sustaining the termination on that basis. The ALJ set out the following, as the facts that CMS had asserted:

> On November 4, 2009, a surveyor went to [AMHHS's] office at 12626 Riverside Drive, Valley Village, California, to conduct a compliance survey of [AMHHS's] operations (November 4 Survey). No one was present at this location, and the door to the facility was locked with the type of lock that real estate agencies put on vacant facilities that are for sale or lease. The manager of the premises told the surveyor that [AMHHS] had moved from the premises about six months previously.
>
> On that same morning, another surveyor went to 1420 N. Claremont Blvd., Suite 110A, Claremont, California. This location is the address that [AMHHS] had on the check that it used to pay for its license renewal. The surveyor spoke with Janet Marcelin, [AMHHS's] administrator. Ms. Marcelin told the surveyor the [AMHHS] had not provided services to patients since December 2008, or for about 10 months. According to Ms. Marcelin, [AMHHS] was in the process of recruiting professional staff. Ms. Marcelin stated that, as of the survey date, [AMHHS] had no registered nurses, or other professional personnel on its staff, who could provide patient care.

ALJ Decision at 3 (citations omitted).[1] The ALJ also stated that CMS had "offered corroboration for the surveyors' findings, consisting of information from the California Outcome & Assessment Information Set system [OASIS], which shows that [AMHHS]

[1] The surveyor who visited the Claremont office actually found, based on a statement by the Administrator, that AMHHS had "no current **field** registered nurses." CMS Ex. 1, at 2 (emphasis added); CMS Ex. 5 ¶ 5. The omission of the word "field" by the ALJ is harmless, however. AMHHS proffered no evidence regarding any nurses it had at the time of the survey other than a document dated October 2009 identifying one nurse as its Director of Patient Care Services (DPCS). That evidence created no genuine dispute about whether AMHHS failed to provide skilled nursing and other services to patients for an extended period between when it left the Valley Village location and the survey. Indeed, AMHHS's own evidence shows that the nurse whom AMHHS identified as its DPCS did not even apply to work for AMHHS until October 4, 2009. P. Ex. 8 (Gipson application). AMHHS proffered no evidence about when, if ever, this individual actually started working for it.

had not submitted any data concerning patient care since December 10, 2008." ALJ Decision at 3, *citing* CMS Ex. 7, at ¶¶ 3, 5.

The ALJ concluded that "the core of CMS's contentions – that [AMHHS] was not actively engaged in providing services to patients and that it had not done so for about 10 months as of November 2009 – is simply not challenged" by AMHHS. In reaching this conclusion, the ALJ did not discuss any specific evidence proffered by AMHHS.[2] ALJ Decision at 3-4. The ALJ did, however, set out what he referred to as "arguments and contentions" by AMHHS. *Id.* at 4. The ALJ rejected what he referred to as AMHHS's "objection to some of CMS's facts on the ground that some of them may be based on hearsay," explaining that AMHHS had "not actually challenged those facts" and "offered nothing to show that the surveyors' findings are, or may be, incorrect." *Id.* at 4. The ALJ also concluded that assertions that AMHHS "had a business license, was renting offices, or had satisfied [Clinical Laboratory Improvement Act] and other requirements" does not constitute any challenge to CMS's findings because they do not show that AMHHS "was providing actual care to patients through licensed professional staff." *Id.*

CMS also said termination was authorized because AMHHS had refused to permit the surveyor to examine records necessary for verification of information furnished as a basis for Medicare payment, and had refused to permit photocopying of records or other information necessary to determine or verify compliance with participation requirements, as required by 42 C.F.R. §§ 489.53(a)(5) and (13). The ALJ concluded that AMHHS's assertion that it could have produced the requested records from storage raised a fact dispute as to whether AMHHS complied with section 489.53, and declined to enter summary judgment as to these bases for the termination. ALJ Decision at 5.

AMHHS timely requested review of the ALJ Decision. With its request, AMHHS also submitted additional exhibits, which it referred to as "exhibits A-1, 2, 3 pages & B-1, 2, 3 pages."

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Andrew J. Elliott, M.D.*, DAB No. 2334, at 2 (2010); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Everett Rehabilitation and Medical Cente*r, DAB No. 1628, at 3 (1997). If a moving party carries its initial 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*, 474 U.S. 574, 587 (1986) (quoting Fed. R. Civ. Pro. 56(e)). In deciding a summary judgment motion, a tribunal must view the

[2] The ALJ noted that AMHHS twice failed to mark and paginate its exhibits as required by the ALJ's instructions to the parties, but did not state that he was rejecting the exhibits on that basis. ALJ Decision at 1-2. We generally refer to AMHHS's documents within an exhibit by description, since there are no page numbers.

entire record in the light most favorable to the nonmoving party, drawing all reasonable inferences from the evidence in that party's favor. *Madison Health Care, Inc.*, DAB No. 1927 (2004). Our 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*) at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

Below, we address the arguments AMHHS made on appeal. We conclude that AMHHS did not show that there is a genuine dispute of fact material to the issue of whether AMHHS was in substantial compliance with Medicare requirements. Thus, we conclude that summary judgment in favor of CMS is appropriate.

1. The evidence AMHHS proffered to the ALJ did not create a genuine dispute of material fact about whether AMHHS was "primarily engaged" in providing services to patients, even when viewed in the light most favorable to AMHHS.

AMHHS asserts that it "was in fact operating an active home health agency, providing patient care services at [its] new address at the time of [the] survey visit . . .." RR at 1. According to AMHHS, "CMS has not proven that services were not being provided, nor is there evidence submitted by CMS that AMHHS was not engaged in providing Home Health services." *Id.*

We disagree. CMS presented evidence, including the survey report and an affidavit by the first surveyor, that AMHHS had not occupied the office in Valley Village for about six months prior to November 4, 2009. CMS Exs. 1, 3. The second surveyor, who visited the new office in Claremont, also attested that the Administrator, Janet Marcelin, admitted that AMHHS had "not provided services to patients since December 2008, or for about 10 months." CMS Ex. 5, at 2; CMS Ex. 1, at 1.

AMHHS did not show there is a genuine dispute of fact regarding either of these findings that is material to the basis for the termination. AMHHS apparently would have us disregard CMS's evidence that it had left the office in Valley Village about six months before the survey. AMHHS objected to the ALJ that CMS was relying on hearsay for this finding, specifically what the first surveyor was told by a parking attendant. ALJ Decision at 4. The first surveyor also relied on a statement from the building manager, however, which the surveyor said was confirmed by the parking attendant. CMS Ex. 1, at 1; CMS Ex. 4. AMHHS does not appear to understand that hearsay is admissible in this proceeding and may constitute substantial evidence in support of a finding, especially, in circumstances such as this where the opposing party had an opportunity to seek to subpoena the declarants and did not do so. 42 C.F.R. § 498.61; *Richardson v. Perales*, 402 U.S. 389, 402 (1971). What weight should be given to the hearsay is

irrelevant, moreover, given that AMHHS proffered **no** evidence to rebut the declarants' statements.[3]

Nor did AMHHS directly dispute at the ALJ level the surveyor's testimony that AMHHS's Administrator had admitted to the surveyor that the agency had not provided patient services since December 2008. Although AMHHS submitted to the ALJ affidavits by the Administrator and by an Administrative Assistant (who was present for the conversation between the second surveyor and the Administrator), neither affidavit contests the surveyor's attestation about this admission by the Administrator to the surveyor. P. Ex. 5. The Administrator's affidavit mainly addresses the surveyor's request for records for the last two patients to whom AMHHS provided services. The Administrator attests:

> I told her that we had just moved in the office but I could get those files for her if she could wait for about 30 minutes (inactive files are stored . . .). She declined and suggested that she will return after lunch . . . [but] did not return . . . .

P. Ex. 5 (Marcelin Affidavit). This statement, even viewed in the light most favorable to AMHHS, does not undercut the survey findings. If the files for the last two patients were considered "inactive" and therefore stored offsite, this would confirm that AMHHS had no active patients at the time of the November 4, 2009 survey. *See also* RR at 2 (asserting that AMHHS did not have space on site to store inactive files). We also note that AMHHS submitted as a proposed exhibit an October 4, 2009 letter addressed to the California Department of Health Services, notifying the Department that patient files were stored at the Claremont address. P. Ex. 9. The Administrator's acknowledgment that she needed to get patient files from storage at the time of the survey therefore tends to support the finding that AMHHS had no active patients at that time. It does not show there is a genuine dispute regarding that finding.

The affidavit of the Administrative Assistant also attests that the surveyor said she would return, but does not state that AMHHS had any patient records available at the Claremont address at the time of the survey. This affidavit does state that employee files and contractor contracts were "in the agency at the time of the . . . visit," but does not identify any specific employees or contractors or assert that they were providing services at the time of the survey. P. Ex. 5 (Sinchich Affidavit).

AMHHS also argues that we should conclude that it was "engaged" because it was in the "ready mode" to provide services. RR at 2. According to AMHHS, it is impossible to consider AMHHS to be "dormant" after viewing its documentation. *Id*. This argument is apparently a response to the ALJ's statement that an "an entity that is dormant" does **not** meet the statutory definition in section 1861(o). ALJ Decision at 3. The argument takes the word "engaged" out of context. Section 1861(o) requires that an HHA be "primarily

[3] AMHHS concedes that it had just opened the office in Claremont at the time of the survey. RR at 2; *see* P. Ex. 2 (lease for Claremont office starting October 1, 2009).

engaged in providing skilled nursing services and other therapeutic services." While AMHHS proffered documentation that shows that AMHHS may have been engaged in some activities at the time of the survey, that documentation does not show that AMHHS was primarily engaged in providing skilled nursing services and other therapeutic services, even if read in the light most favorable to AMHHS.

The documentation that AMHHS submitted shows at most that beginning in late September 2009 it was engaged in activities such as opening a bank account in its new name (Arise Home Care), renting the Claremont office, informing various entities about its new name and location, appointing a Medical Director, and obtaining contracts for nurse aides and therapists. None of the documentation shows, however, that AMHHS was actually providing services at the time of the survey.

Moreover, while AMHHS asserted to the ALJ that the documents showed it had completed all of these activities by October 4, 2009, after moving into the Claremont office on October 1, many of the documents are dated after the date of the survey, November 4, 2009. For example, the email notification to CMS of the changes in name and location included in proposed Exhibit 2 is dated November 4, 2009, and the California license at Exhibit 6 has an effective date of January 31, 2010. A few emails dated in June 2009 relate to AMHHS's late filing of a utilization review report to the state. P. Ex. 2. AMHHS did not, however, submit a copy of the report ultimately filed, which presumably would show whether any services were being provided. We also note that the document AMHHS submitted to show it was accredited relates to accreditation of Duramed Homecare Services, Inc, and that a Tax Registration Certificate and a Business License Certificate are also for Duramed, at a Meridian Street address. P. Ex. 7. AMHHS does not explain how these documents are relevant.

The only document proffered that even mentions patients receiving services from AMHHS is a letter dated April 29, 2009 from the Administrator to Trust Solutions, LLC, that asserts that by January 2009, her license was suspended and the agency "financially bankrupt," and that she had personally paid for the discharge of the 100 patients that the agency serviced on January 9, 2009. P. Ex. 3. AMHHS makes a similar assertion on appeal, except that it refers to 80 patients, rather than 100, and asserts that the discharge process took over six months after January 2009 to complete. Reply Br. at 3. Although the Administrator signed both the April 2009 letter and AMHHS's brief, neither document is a sworn statement.[4] The Administrator made no such assertion in her affidavit submitted to the ALJ. In any event, these assertions at most suggest that AMHHS provided some services in the first half of 2009, while it was discharging the 80 or 100 patients. This still leaves an extended period of about five months when AMHHS was providing no patient services.

[4] The ALJ's Pre-Hearing Order informed the parties that any witness statements "must be submitted in the form of an affidavit made under oath or as a written declaration that is signed by the witness under penalty of perjury for false testimony."

In sum, none of the proffered documents raises a genuine dispute of fact material to determining whether AMHHS failed to meet the requirement that it be primarily engaged in providing services to patients at the time of the survey and for many months prior to that time. [5]

2. The evidence AMHHS submitted with its request for review does not show a genuine dispute of material fact.

On appeal, AMHHS now asserts that what "the surveyor asked the administrator for were the last two patients seen by the agency under the Medicare participation program" and "those patient charts are in storage."[6] RR at 1. AMHHS contends that the evidence it submitted on appeal shows that it had received three patient referrals. Reply Br. at 1. AMHHS also contends that it paid a nurse to "open two cases" before the survey and that "the current patient referrals [AMHHS] received were not Medicare, they were still being visited, [and AMHHS's] nurse was in the process of patient assessment and evaluation." *Id.* at 3. AMHHS's reply brief, submitted by the Administrator, also states that "I admitted only to the fact that I had not provided skilled or therapeutic services to patients that qualify for Medicare." *Id*.

The Board may admit new evidence on appeal in a proceeding under 42 C.F.R. Part 498. 42 C.F.R. § 498.86(a). The Board generally does not do so unless the submitting party gives a reason why it did not produce the evidence to the ALJ. *See Guidelines.* Although CMS's response to the request for review objected to the new evidence on this ground, AMHHS's reply still did not give any reason why AMHHS did not submit the evidence to the ALJ. We need not decide whether to admit the evidence, however, since it would not make a difference, in any event.

We note first that AMHHS did not submit any additional testimonial evidence in the form of an affidavit or declaration to support its assertion that the Administrator admitted only to not having served **Medicare** patients since December 2008, an assertion that AMHHS did not make before the ALJ. Nor did AMHHS submit evidence that it had in fact employed or contracted with a nurse to provide skilled nursing care. As noted above, AMHHS did submit to the ALJ a copy of an application for employment from a Registered Nurse and a form identifying this individual as its Director of Patient Care Services (using her middle name). P. Ex. 8. AMHHS proffered no evidence, however, that it had in fact employed this individual to provide skilled nursing services to patients, much less that she was in fact providing such services prior to the survey or even that she

[5] Our analysis of these documents is solely for the purposes of summary judgment – we express no opinion on whether ALJ could have excluded the proposed exhibits and testimony for failure to meet requirements in his order, nor any opinion on the authenticity of the documents.

[6] AMHHS reports that its Medicare billing privileges were twice suspended for a total of one year, from January 2009 to January 2010. RR at 3; P. Reply at 2, 3. The record shows, however, that Medicare **payments** were suspended, not AMHHS's billing privileges. (See our discussion below.)

was assessing and evaluating the non-Medicare patients AMHHS now asserts were referred to it.

The only evidence that AMHHS submitted on appeal consists of two facsimile cover sheets to Arise Home Health (one version of AMHHS's new name) from a physician, dated October 10, 2009 (allegedly transmitting information regarding several "HMO patients"), and the physician's Progress Notes for two patients. The Progress Notes for one patient (initials A.S.) are dated October 15, 2009, which undercuts any inference from the order of the documents that the patient was referred to AMHHS on October 10. P. Ex. A, at 2d page. The Progress Notes for the second patient (initials J.W.) are dated October 13, 2009, again undercutting any inference from the facsimile cover sheet regarding the date of any referral. P. Ex. B, at 2. Even if we accepted these documents as showing that two non-Medicare patients had been referred to AMHHS in October 2009, no rational trier of fact could find that these documents showed that AMHHS actually provided services to the patients.

AMHHS also suggests that records regarding these patients were not in the Claremont office at the time of the survey because the nurse doing the assessment and evaluation has "48 hours to receive the order, complete the assessment and evaluation and return the OASIS back to the office." Reply Br. at 3. AMHHS provides no evidence about **when** any nurse received the "order," however. If, in fact, the patients were referred in October, the nurse should have had ample time to complete the assessment and evaluation and return it by November 4, 2009, the date of the survey.

3. The undisputed facts show that AMHHS was not in substantial compliance with section 1861, and, therefore, CMS was authorized to terminate AMHHS's Medicare provider agreement.

Section 1866(b)(2) of the Act authorizes the Secretary to terminate a provider agreement after the Secretary has "determined that the provider fails substantially to meet the applicable provisions of section 1861."

Based on the provisions of section 1861(o), the Board has determined that a provider fails substantially to meet the definition of a "home health agency" for Medicare purposes if it has provided no skilled nursing services and other therapeutic services to patients for an extended period of time. *United Medical Home Care, Inc.*, DAB No. 2194, at 9-12 (2008). As the Board has noted, moreover, a home health agency is subject to a survey to ensure that the agency meets the Medicare conditions of participation, including requirements intended to ensure the quality of the care provided and the protection of patients' rights. Act, § 1891(c); 42 C.F.R. Part 488, subpart A. If the agency is not providing any services to patients, it is not possible to conduct a survey according to the statutory and regulatory requirements.

Here there is no genuine dispute of fact regarding whether, during an extended period of time, AMHHS failed to be primarily engaged in providing such services.

Accordingly, we conclude that termination of AMHHS's provider agreement was authorized.

4. AMHHS's other arguments are irrelevant and/or have no merit.

AMHHS raises a number of other arguments on appeal that are irrelevant, in light of our conclusions above. For example, AMHHS argues that many providers will admit some patients in order to get surveyed and then discharge them while waiting for final approval to bill for services. AMHHS further contends that its Administrator expended a significant amount of funds to get it in "ready mode," and that requiring providers to actually be serving patients places too high a burden on providers. RR at 2-3. What other providers do or the wisdom of the policy to require that a home health agency be primarily engaged in providing services in order to qualify for Medicare would not provide a basis for overturning the termination, which is based on a statutory requirement that AMHHS was obligated to meet if it wished to participate in the Medicare program. We note, moreover, that, in section 1861(z) of the Act, Congress imposed institutional planning requirements on home health agencies that indicate that Congress intended that any agency participating in Medicare be sufficiently capitalized. *See also* 42 C.F.R. § 489.28 (special capitalization requirements for home health agencies).

AMHHS also argues that the termination is unfair (and even "callus") to its Administrator because she spent personal funds to provide services after Trust Solutions, LLC (which is identified in the record as a CMS Program Safeguard Contractor) suspended Medicare payments to AMHHS. Reply Br. at 2; P. Ex. 3, at 1st to 6th pages. AMHHS suggests that the contractor's findings that 18 patients reviewed were not "homebound" (as Medicare requires) were not well-founded and should not have resulted in suspension. AMHHS's own proposed exhibit, however, show that AMHHS had an opportunity under 42 C.F.R. § 405.372(b)(2) to contest the contractors' findings by providing information that the patients were homebound and did not do so, arguing only for a shorter suspension. P. Ex. 3.

In sum, none of the arguments provides a basis for reversing the termination.

Conclusion

For the reasons stated above, we sustain the termination of AMHHS's provider agreement.

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Leslie A. Sussan

_____/s/_____
Judith A. Ballard
Presiding Board Member