Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Community Home Health Care of Western Michigan, Inc.,
(NPI: 1477891380; PTAN: 23-9100),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-356

Decision No. CR4921

Date: August 15, 2017

DECISION

The Medicare enrollment of a branch of Petitioner, Community Home Health Care of Western Michigan, Inc., is denied pursuant to 42 C.F.R. § 424.530(a)(10),[1] because a temporary moratorium pursuant to 42 C.F.R. § 424.570 applied to Petitioner's new branch location for its home health agency.

I. Procedural History and Jurisdiction

National Government Services (NGS), a Medicare administrative contractor (MAC), notified Petitioner by letter dated August 29, 2016, that Petitioner's application to enroll its branch location in Medicare as a home health agency (HHA) was denied. CMS Exhibit (Ex.) 1 at 51. NGS advised Petitioner that the Centers for Medicare & Medicaid Services (CMS) imposed a temporary moratorium for HHAs and HHA subunits in Michigan effective July 29, 2016. CMS Ex. 1 at 51.

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[1] The 2015 revision of the Code of Federal Regulations (C.F.R.) is cited, unless otherwise stated.

On October 27, 2016, Petitioner requested reconsideration of the enrollment denial. CMS Ex. 1 at 7-11. A CMS hearing officer issued a reconsidered determination dated January 31, 2017. The hearing officer concluded that Petitioner was subject to the moratorium and that Petitioner's application to add a new practice location was properly denied. CMS Ex. 1 at 1-4.

Petitioner filed a request for hearing before an administrative law judge (ALJ) on February 10, 2017. The case was assigned to me for hearing and decision on February 17, 2017, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. No issue has been raised as to the timeliness of Petitioner's request for hearing; the parties do not challenge my authority to decide this case; and I conclude that I have jurisdiction.

On March 20, 2017, CMS filed a combined prehearing brief and motion for summary judgment (CMS Br.), with CMS Exs. 1 through 3. On April 18, 2017, Petitioner submitted a brief and cross-motion for summary judgment (P. Br.). On May 3, 2017, CMS filed its reply brief (CMS Reply) with an amended exhibit list and CMS Ex. 4. Petitioner has not objected to my consideration of CMS Exs. 1 through 4 and they are admitted as evidence.

II. Discussion

A. Applicable Law

Sections 1811 through 1821 of the Social Security Act (the Act) (42 U.S.C. §§ 1395c-1395i-5) establish the hospital insurance benefits program for the aged and disabled known as Medicare Part A. Section 1831 of the Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B.[2] Administration of both the Part A and B programs is through the MACs. Act §§ 1816, 1842(a) (42 U.S.C. §§ 1395h, 1395u(a)). Payment under the programs for services rendered to Medicare-eligible beneficiaries may only be made to

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[2] In the case of Medicare-eligible beneficiaries not enrolled in Medicare Part B, home health services are paid under Part A subject to the limitations specified in section 1812(a)(3) of the Act. Home health services are also covered under Medicare Part B for those enrolled. Act § 1832(a)(2)(A). Thus, HHAs, which are defined as providers by section 1861(u) of the Act, may be reimbursed under Part A or Part B depending upon the facts of the particular case.

eligible providers of services and suppliers.[3] Act §§ 1815, 1817, 1834(j)(1) (42 U.S.C. §§ 1395g, 1395i, 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a HHA, is a provider.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary. The Act sets forth requirements for HHAs participating in the Medicare and Medicaid programs, and authorizes the Secretary to promulgate regulations implementing the statutory provisions. Act §§ 1861(m) and (o), and 1891 (42 U.S.C. §§ 1395x(m) and (o), and 1395bbb).

Congress authorized the Secretary to impose temporary moratoria on the enrollment of new Medicare and Medicaid providers and suppliers, including categories of providers and suppliers, if the Secretary determines such moratoria are necessary to prevent or combat fraud, waste, or abuse under the programs. Act § 1866(j)(7)(A) (42 U.S.C. § 1395cc(j)(7)(A)). Under the applicable regulations, CMS may deny a provider's enrollment in the Medicare program if the provider submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium. 42 C.F.R. §§ 424.530(a)(10), 424.570. Congress has provided that there will be no judicial review of the Secretary's determination to impose a temporary moratorium. Act § 1866(j)(7)(B). The scope of review by an ALJ of denials related to a temporary moratorium is limited to the issue of whether the temporary moratorium applied to the denied provider. The basis for imposing a temporary moratorium is not subject to review by an ALJ. 42 C.F.R. § 498.5(*l*)(4).

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[3] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

B. Issues

Whether summary judgment is appropriate; and

Whether the temporary moratorium that was cited as the basis for denial of Petitioner's enrollment as a provider applied to Petitioner.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate in this case.

A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866(h)(1) and (j)(8); *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing. Accordingly, disposition on the written record alone is not permissible, unless either CMS's motion for summary judgment or Petitioner's cross-motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g., Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure (Fed. R. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment, and an ALJ's decision-making in deciding a summary judgment motion, differ from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

Petitioner agrees that there is no genuine dispute as to any material fact in this case. P. Br. at 1. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment in the Medicare program and application of the law to the facts of this case. In reviewing the evidence of this case in the light most favorable to Petitioner, the issues in this case must be resolved against Petitioner as a matter of law because the evidence shows that the temporary moratorium did apply to Petitioner's application to enroll its new branch in Medicare. Accordingly, CMS's motion for summary judgment is granted and Petitioner's cross-motion for summary judgment is denied. Petitioner's challenge to the validity of 42

C.F.R. § 424.570(a) to the extent it extends to the application of a temporary moratorium to a new practice location is, as discussed hereafter, not within my jurisdiction to decide.

2. The temporary moratorium applies to Petitioner's enrollment application because the application was pending but not approved when the moratorium became effective.

3. There was a basis for denying Petitioner's Medicare enrollment pursuant to 42 C.F.R. § 424.530(a)(10).

a. Facts

There is no genuine dispute as to the pertinent facts.

On February 5, 2016, NGS received Petitioner's application (CMS-855A) dated February 1, 2016, changing its Medicare information to reflect the addition of a new practice location of its HHA at 102 S. Whittacker Street, New Buffalo, Michigan, effective February 15, 2016. CMS Ex. 2 at 13, 27; P. Br. at 1. NGS confirmed receipt of Petitioner's CMS-855A and requested corrections by letter dated February 9, 2016. CMS Ex. 3 at 2-5. Petitioner submitted the corrections on March 2, 2016. CMS Ex. 3 at 1.

NGS informed Petitioner by letter dated March 8, 2016, that it had assessed Petitioner's CMS-855A and forwarded it to the Michigan Department of Licensing Regulatory Affairs for review. The notice also informed Petitioner that a copy of the application was sent to the CMS Regional Office in Chicago for review and that the next step would be a site visit or survey conducted by the state survey agency or a CMS-approved accrediting organization to ensure Petitioner complied with the conditions of participation. NGS advised Petitioner that once CMS confirmed that Petitioner met the conditions of participation, NGS would send Petitioner its decision. NGS further advised Petitioner that Medicare billing privileges would not begin before the survey and certification process was completed and there was a determination that all requirements were met. CMS Ex. 4.

It was announced in the Federal Register on August 3, 2016, that effective July 29, 2016, CMS extended a temporary moratorium on HHAs in some counties in Michigan to all counties in Michigan. The Federal Register notice specified:

> CMS has determined that it is necessary to expand these moratoria to be statewide. Accordingly, beginning on the effective date of this document, no new HHAs will be enrolled in Medicare, Medicaid, or CHIP with a practice location in Florida, Illinois, Michigan, or Texas unless their enrollment application has already been approved but not yet

> entered into PECOS [Provider Enrollment Chain and Ownership System] for Medicare or the State Provider/Supplier Enrollment System for Medicaid and CHIP as of the effective date of this document.

81 Fed. Reg. 51,120, 51,123 (Aug. 3, 2016).

On August 4, 2016, NGS advised Petitioner by letter that NGS had approved Petitioner's information change request, adding a practice location at 102 S. Whittacker Street, New Buffalo, Michigan effective February 15, 2016. However, it was noted that "CMS/State final approval and tie-in" was required. The letter further advised that for certain states, including Michigan, the change would not occur until approved by CMS. CMS Ex. 1 at 37.

On August 29, 2016, NGS notified Petitioner that its application (CMS-855A) to enroll a new practice location at 102 S. Whittacker Street, New Buffalo, Michigan was denied pursuant to 42 C.F.R. § 424.530(a)(10) due to a temporary moratorium on new HHAs and subunits in Michigan. NGS advised that the moratorium began on July 29, 2016. CMS Ex. 1 at 51. On reconsideration, the hearing officer concluded that the moratorium applied to the addition of a new practice location and that Petitioner's new practice location had not been approved before the moratorium went into effect. The hearing officer correctly noted that review of the application of a temporary moratorium is limited to determining whether the temporary moratorium applies to a provider or supplier or geographic location. 42 C.F.R. § 498.5(*l*)(4).

b. Analysis

Petitioner states its case as follows:

> Community is not attacking the moratorium per se. Instead, in light of the statute authorizing the moratorium, CMS' own regulations concerning the moratorium, and applicable law, Community is challenging the application of the moratorium to its branch application on two bases. First, Community pleads that its application should be found to comply with CMS' own exception to the moratorium for an application approved by the enrollment contractor but not yet entered into the PECOS system as provided in regulation that was properly promulgated. 42 C.F.R. § 424.570(a)(1)(iv). In addition, Community argues that the extension of the moratorium to include branch applications is not in accordance with the authorizing statute [sic] and is otherwise arbitrary and capricious because home health agencies'

> branches are not "new providers" otherwise subject to the moratorium. 42 U.S.C. §1395cc(j).

P. Br. at 4-5.

Petitioner argues that it is not subject to the moratorium because its application to add a branch office location in its existing service area in Michigan was approved by NGS on March 8, 2016, but not entered into PECOS. P. Br. at 1-2. Thus, Petitioner contends that its application falls within the exception to the moratorium established by 42 C.F.R. § 424.570(a)(1)(iv), which provides that the temporary moratorium does not apply to any enrollment application approved by the enrollment contractor, but not yet entered into PECOS. P. Br. at 4. Petitioner refers to CMS Ex. 3 to support its claim that the application was approved in March 2016. P. Br. at 1. CMS Ex. 3 is a notice addressed to Petitioner from NGS dated February 9, 2016, notifying Petitioner that the Medicare enrollment application was received and that additional information must be furnished within the requested time frame to avoid possible rejection of Petitioner's enrollment application. CMS Ex. 3. The March 8, 2016 notice Petitioner describes states that NGS assessed Petitioner's Medicare enrollment application and notified Petitioner of the next step, either a site visit or survey. CMS Ex. 4.

HHAs are subject to a rigorous multi-tiered screening process for initial enrollment applications because CMS has designated these providers as high risk. 42 C.F.R. § 424.518(c); Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, § 15.19.2.1C (eff. December 29, 2014). Because of the potential for fraud, the enrollment process for a new HHA includes an additional step for a second review of enrollment criteria performed by either the Regional Home Health Intermediary or the MAC after the CMS regional office's review process is completed. MPIM § 15.26.3 (eff. Jan. 7, 2014); CMS Survey and Certification Letter (S&C) 12-15-HHA, Revised Initial Certification Process for Home Health Agencies (HHA) (Dec. 23, 2011).[4] This review by the contractor occurs once CMS notifies the contractor by email to perform this second review. The contractor then re-reviews certain Medicare enrollment requirements, such as determining if the HHA has the required amount of capitalization and checking to make sure that each entity and individual listed in the enrollment application is reviewed again against the Medicare Exclusion Database and the System for Award Management. The contractor then performs a site visit. It is only after

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[4] CMS S&C letters are available at:

> https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html.

successful completion of this final re-review by the contractor that the HHA will be certified by CMS for enrollment and billing privileges and entered into PECOS.

Further, under the terms of the temporary moratorium, a HHA may not open a new subunit or branch within the moratorium area. 81 Fed. Reg. at 51,121 n.1. CMS instructed MACs that as of July 29, 2016, they must deny all applications for the addition of a practice location in the states subject to the moratorium, except those applications already entered into PECOS or those for which all review was completed and were simply awaiting entry into PECOS. S&C 16-36-HHA, Extension and Expansion of the Provider Enrollment Home Health Agency (HHA) Moratoria, at 2 (Aug. 26, 2016). Under the expansion of the moratorium, a HHA enrolled as of July 29, 2016, with an existing branch could change the location of the branch within the moratorium area but could not open a new branch in that area. S&C 16-36-HHA at 3.

There is no dispute that Petitioner's CMS-855A received by NGS on February 5, 2016, was submitted to open a new branch at 102 S. Whittacker Street, New Buffalo, Michigan and not simply to change the location of an existing branch of Petitioner. The February 9, 2016 NGS letter did not approve Petitioner's application to enroll its new branch location as the letter clearly states that the application required revision or additional information. CMS Ex. 3 at 2. The NGS letter dated March 8, 2016, was also not an approval of Petitioner's application to enroll its new branch. The letter clearly stated that the next step was a site visit or survey to ensure conditions of participation were met and, when CMS confirmed the conditions were met, NGS would send a decision on the application. The letter also advised that Medicare billing privileges would not begin before the survey and certification process was complete and all federal requirements were met. CMS Ex. 4. The steps required for approval of an application to enroll a home health agency or a new branch or subunit are provided by the MPIM § 15.26.3. NGS clearly advised Petitioner in its notice dated March 8, 2016, that the steps to enroll Petitioner's new branch at 102 S. Whittacker Street, New Buffalo, Michigan were not complete as of the date of that letter. The expansion of the temporary moratorium to cover all of Michigan was effective July 29, 2016. There is no evidence a survey or site visit was completed or that all the steps required by MPIM § 15.27.3 for approval of Petitioner's new home health agency branch were completed prior to July 29, 2016. It is not disputed that the NGS letter dated August 4, 2016, states that Petitioner's new practice location at 102 S. Whittacker Street, New Buffalo, Michigan was approved February 15, 2016, but subject to "CMS/State final approval and tie-in." CMS Ex. 1 at 37. Accordingly, I conclude that Petitioner's new branch was subject to the moratorium and Petitioner's enrollment application for that branch was properly denied pursuant to 42 C.F.R. § 424.530(a)(10).

Petitioner also argues that "the extension of the moratorium to include branch applications is not in accordance with the authorizing statute [sic] and is otherwise arbitrary and capricious because HHA branches are not 'new providers' otherwise subject

to the moratorium. 42 U.S.C. §1395cc(j)." P. Br. at 4-5. The authority of the Secretary to impose a temporary moratorium on the enrollment of new providers is found in section 1866(j)(7) of the Act (42 U.S.C. § 1395cc(j)(7)). Petitioner's argument that CMS exceeded its statutory authority by applying the moratorium to new branch locations of existing HHAs is beyond my authority to address. I am bound to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

There is no genuine dispute as to any material fact. Petitioner's application to add a new branch location of its HHA in Michigan was not processed through all required steps for approval prior to the moratorium going into effect in Michigan on July 29, 2016. Accordingly, Petitioner's new branch was subject to the moratorium and the application to enroll that branch was properly denied pursuant to 42 C.F.R. § 424.530(a)(10).

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's enrollment application was subject to the temporary moratorium imposed pursuant to 42 C.F.R. § 424.570(c), and the application is properly denied pursuant to 42 C.F.R. § 424.530(a)(10).

/s/
Keith W. Sickendick
Administrative Law Judge