Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Hugo Health and Rehabilitation Center (CCN: 37-5492),	)	Date: July 18, 2007
	)	
Petitioner,	)	
	)	
-v.-	)	Docket No. C-06-492
	)	Decision No. CR 1625
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

For reasons set forth below, the Centers for Medicare & Medicaid Services's (CMS) Motion to Dismiss the request for hearing filed by Petitioner, Hugo Health and Rehabilitation Center, is granted.

I. Background

Hugo Health and Rehabilitation Center (Petitioner), a skilled nursing facility (SNF) located in Hugo, Oklahoma, was certified as a Medicare provider in April 1995. CMS Ex. 1. Petitioner's Medicare provider agreement was involuntarily terminated on December 1, 2000, by CMS due to Petitioner's failure to maintain substantial compliance with Medicare participation requirements for skilled nursing facilities. CMS Ex. 2. Petitioner was unsuccessful in its appeal of CMS's decision to terminate its provider agreement. *See Homestead of Hugo*, DAB CR819 (2001).

Petitioner sought re-entry into the Medicare program and was dissatisfied with the re-certification date established by CMS. Petitioner now appeals the re-certification date of November 17, 2005. Petitioner's request for hearing, dated June 5, 2006, was docketed as C-06-492 and assigned to me for hearing and decision. In its request for hearing, Petitioner asserts that it was entitled to reinstatement at the close of the second reasonable

assurance survey, April 12, 2001, rather than the date when CMS found compliance, November 17, 2005. Additionally, Petitioner challenges the effect of certain survey findings that had been cited by CMS as its rational for establishing an effective date later than April 12, 2002, and CMS's denial of an opportunity to present oral arguments and briefs with respect to Petitioner's objection to the initial determination at the time of reconsideration.

Pursuant to my Order of June 20, 2006, Petitioner filed a Report of Readiness and CMS filed its Notice of Issues. Following review of the written submissions, I directed the parties to brief the issue outlined by CMS in connection with matters appealable pursuant to 42 C.F.R. Part 498 which governs appeal procedures for determinations that affect Medicare program participation.

On September 19, 2006, CMS filed its Motion to Dismiss and its Brief in Support of the Motion accompanied by five exhibits (Exs.) marked CMS Ex. 1- CMS Ex. 5. On October 23, 2006, Petitioner filed a response brief accompanied by six exhibits. I have marked these exhibits as P. Ex. 1 - P. Ex. 6 to conform to Civil Remedies Division procedures. Both parties filed reply briefs. CMS's reply brief was accompanied by two additional exhibits marked CMS Ex. 1 and CMS Ex. 2, which I have remarked as CMS Ex. 6 and CMS Ex. 7.

II. Issue

The sole issue before me is whether Petitioner is entitled to a hearing to challenge CMS's decision to reinstate it as a Medicare provider effective November 17, 2005.

III. Relevant Authority

Under section 1866(b)(2) of the Social Security Act (Act) and 42 C.F.R. § 489.53(a)(3) of the regulations, the Secretary of Health and Human Services (Secretary) may terminate an agreement with any skilled nursing facility if CMS finds that the provider no longer meets the appropriate conditions of participation or requirements. Section 1866(c)(1) of the Act provides that: "[w]here the Secretary has terminated or has refused to renew an agreement under this title with a provider of services, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination or non-renewal has been removed and that there is reasonable assurance that it will not recur."

When CMS terminates a provider agreement pursuant to section 489.53 of the regulations, a new agreement with that provider will not be accepted unless CMS finds:

> (a) That the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and
>
> (b) That the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

42 C.F.R. § 489.57.

Therefore, before a provider can be reinstated in the Medicare program following an involuntary termination of its provider agreement, it must apply for re-entry and must satisfy CMS that the reason or reasons for termination of the previous agreement have been removed, and that there is reasonable assurance that the reason or reasons would not recur. Act § 1866(c)(1); 42 C.F.R. § 489.57. Consequently, a provider attempting to re-enter the Medicare program has to establish its ability to maintain substantial compliance with Medicare requirements by successfully completing a reasonable assurance process.

The reasonable assurance process requires the provider seeking re-entry to undergo two surveys, one at the beginning and one at the end of a specified reasonable assurance period. *See* State Operations Manual § 7321 B. Reinstatement is granted only if the results of these surveys show that the facility was in substantial compliance with the nursing home requirements at the beginning and the end of the reasonable assurance period. *Id.*

There is no statutory or regulatory reasonable assurance period imposed by states, thus a provider can seek immediate re-entry as a Medicaid-only facility following acceptable findings from the state survey. State Operations Manual § 7321 B. CMS does have discretion to accept the Medicaid re-entry survey as the initial reasonable assurance survey; however, if the facility is not found to be in substantial compliance during either reasonable assurance survey, the re-entry is denied and the provider's Medicaid provider agreement is subject to termination. *Id.*

The regulations at 42 C.F.R. Part 498 implement the appeals provisions of the Act that are relevant in this case. Section 498.5 of the regulations addresses appeal rights of providers and prospective providers.

IV. Discussion

I make findings of fact and conclusions of law to support my decision in this case. I set forth each finding below, in bold, as a separate heading.

A. CMS's determination to re-certify Petitioner as of the November 17, 2005 survey date was not an initial determination subject to my review.

It is undisputed that on December 1, 2000, Petitioner's provider agreement to participate in the Medicare program was terminated. CMS Ex. 2; CMS Brief (Br.) at 2; P. Br. at 3. Thereafter, Petitioner appealed the initial determination to the Departmental Appeals Board (DAB) and an unfavorable decision was rendered in *Homestead of Hugo*, DAB CR819 (2001).

On December 15, 2000, Petitioner applied for reinstatement. Although Petitioner avers that at the time it thought it was applying for re-entry into the Medicare and Medicaid programs, it is clear from the record before me that Petitioner applied for re-entry into the Medicaid program only. CMS Ex. 7.

Pursuant to a December 21, 2000 Medicaid re-certification survey, Petitioner was readmitted into the Medicaid program as a provider. CMS Ex. 7. On February 16, 2001, Petitioner underwent a Medicaid complaint investigation survey which resulted in a finding of immediate jeopardy. CMS Ex. 3. On April 19, 2001, Petitioner entered into a settlement agreement with the Oklahoma State Health Department (Department) agreeing that the Department would not recommend to CMS an extension of a period of reasonable assurance. *Id.* at 2-3.

On June 29, 2005, Petitioner underwent an annual Medicaid recertification survey which found Petitioner not in substantial compliance with the requirements for skilled nursing home facilities at 42 C.F.R. Part 483. CMS Ex. 4. Petitioner submitted a plan of correction to CMS, after which a review was conducted and CMS then accepted the plan as credible evidence of corrective action. *Id.* CMS determined that Petitioner had achieved substantial compliance with applicable program requirements as of August 1, 2005, thus satisfying the first part of the reasonable assurance period. CMS Br. at 3, n.3. On November 17, 2005, Petitioner underwent another survey where it was found to be in

substantial compliance with the requirements at 42 C.F.R. Part 483. CMS Ex. 5. According to CMS, the reasonable assurance period was therefore satisfied and under the governing regulations of 42 C.F.R. § 489.13, the effective date of Petitioner's reinstatement was November 17, 2005. P. Ex. 1.

Petitioner disagrees and asserts that it should have been found to be in substantial compliance as of the December 21, 2000 (the first Medicaid survey) and again as of April 12, 2001 (the second Medicaid survey). Petitioner states that since no plan of correction was needed at that time, CMS was not faced with an issue of using its discretion to determine if a reasonable assurance period had been met. P. Br. at 2. Therefore, according to Petitioner, CMS's decision as to the effective date of its reinstatement into the Medicare program was an "initial determination."

Petitioner further states that, acting in good faith that its provider agreement was in good standing based on representations from its fiscal intermediary, it billed for services provided to Medicare beneficiaries in residence during a period of time CMS is now asserting that Petitioner's provider status was not approved. Petitioner states that it is now faced with CMS demanding an overpayment refund of $2,502,787.02 for payments to Petitioner made prior to the Medicare recertification date of November 17, 2005, and it seeks relief through this appeal. *Id.* at 3.

CMS argues that its decision is not an initial determination and therefore Petitioner does not have a right to a hearing. Petitioner asserts that the determination made by CMS as to Petitioner's qualification to be a provider as of a particular effective date was an initial determination subject to appeal pursuant to the regulations at 498.3(b)(1) and (15).

I find Petitioner's assertion unavailing. The provision Petitioner relies on pertains only to the effective date of an agreement sought by a "prospective provider" and has no application in the case of a provider, such as Petitioner, that has been involuntarily terminated as a Medicare provider. This point is clarified in the Notice of Proposed Rulemaking (NPRM) which was published on October 8, 1992. The NPRM explains that the change to the regulation at 42 C.F.R. Part 498, was intended to "specifically provide the appeal rights specified in sections 498.3(b)(1) and (4) and 498.5(a) and (b) to prospective providers and suppliers who are dissatisfied with a finding of noncompliance . . . as of the date of the initial survey." 57 Fed. Reg. 46363 (Oct. 8, 1992). In the matter before me, Petitioner is not a prospective provider, rather, Petitioner is a provider that had its provider agreement terminated, and was required to successfully undergo a reasonable assurance period before being certified to re-enter the Medicare program.

The situation of the petitioner in *Heartland Manor* is analogous to the present case. *Heartland Manor at Carriage Town*, DAB No. 1664 (1998). The appellate panel in *Heartland Manor* recognized that CMS determinations concerning reasonable assurance and readmission are considered not to be initial determinations subject to reconsideration and appeal. The appellate panel held that CMS's notice to petitioner, stating that petitioner did not meet the criteria for re-entry into the Medicare program, was an administrative action within the meaning of 42 C.F.R. § 498.3(d)(4), and was not an initial determination under 42 C.F.R. § 498.3(b). *Id.* at 24. Accordingly, the appellate panel concluded that the petitioner in *Heartland Manor* was not entitled to a reconsidered determination from CMS or a hearing before an ALJ on the action. *Id.* The appellate panel thus dismissed petitioner's hearing request since no review rights attached to CMS's determination. *Id.*

B. Petitioner does not have a right to a hearing.

In *Heartland Manor*, CMS treated petitioner's requests to participate in the Medicare program as requests by a once terminated facility attempting to re-enter the program. Thus, as with the present case, there arose no issue in *Heartland Manor* concerning prospective providers, and Heartland Manor's hearing request was dismissed. Determinations regarding reasonable assurance periods related to a provider's reinstatement into the Medicare program are classified as administrative actions over which CMS retains discretionary authority. *Heartland Manor at Carriage Town*, DAB No. 1664, at 4 *citing* 498.3(d)(4). Consequently, under section 498.3(d)(4) providers whose Medicare provider agreements have been terminated for failing to comply with the applicable participation requirements have no right to challenge CMS's denial of an application for reinstatement. Section 1866(h)(1) of the Act does not grant a provider a right to a hearing where CMS determines that the reason for the termination has not been removed or where CMS finds that there is no reasonable assurance that it will not recur.

Additionally, if an ALJ review of the denial of an application for reinstatement is not permitted, clearly an ALJ lacks jurisdiction to adjudicate the sub-issue of the effective date of reinstatement. The high level of scrutiny imposed on providers seeking re-entry is integral to the compliance scheme envisioned by Congress when it reformed the compliance and certification requirements for skilled nursing facilities in the late 1980s. *See* House Report on the legislation H.R. Rep. No. 100-391(I), 100th Cong., 1st Sess. (1987).

Accordingly, I reject Petitioner's arguments that it is entitled to a hearing. The findings made by CMS under section 1866(c)(1) of the Act to deny Petitioner re-entry to the Medicare program until November 17, 2005, are not subject to review in this forum. 42 C.F.R. § 498.3(d)(4). I conclude that Petitioner has no right to a hearing to challenge the Medicare certification effective date as set forth by CMS, or the effect of the findings that had been cited by CMS as its rationale for establishing an effective date later than April 12, 2001. 42 C.F.R. § 498.70(b).

Petitioner states that it reasonably relied upon the representations of the fiscal intermediary, Mutual of Omaha, that it qualified as a Medicare provider and that it then provided care for, billed for, and received reimbursement for services it provided to Medicare beneficiaries for several years. As a result, and to its detriment, it is now faced with having to repay Medicare for items billed and funds received when it was an uncertified provider with the Medicare program.

Here, Petitioner's assertions are essentially an estoppel argument. I cannot provide Petitioner with the relief it seeks as I do not have the authority to hear and decide claims based on equitable estoppel as the regulations at 42 C.F.R. Part 498 limit my authority to hearing and deciding only initial determinations. 42 C.F.R. §§ 498.3; 498.5; *see also Everett Rehabilitation and Medical Center*, DAB No. 1628 (1997); *Oasis Behavioral Health Center, Inc.*, DAB CR1085 (2003); *Lackawanna Medical Group Laboratories*, DAB CR957 (2003); *Danville HealthCare Surgery Center*, DAB CR892 (2002); *Marion Citrus Mental Health Center*, DAB CR864 (2002); *Palm Grove Convalescent Center*, DAB CR858 (2002).

V. Conclusion

For the reasons discussed above, the regulation at 42 C.F.R. § 498.3(d)(4) explicitly establishes that CMS's determinations concerning reasonable assurance and reinstatement do not trigger appeal rights. Therefore, CMS's decision to reinstate a provider following an involuntary termination is discretionary and not subject to my review. I find that I lack jurisdiction over Petitioner's hearing request and I therefore grant CMS's Motion to Dismiss pursuant to 42 C.F.R. § 498.70(b).

/s/
Richard J. Smith
Administrative Law Judge