Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
AccentCare Home Health of Phoenix, Inc.,	)	Date: November 28, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-467
	)	Decision No. CR1869
Centers for Medicare & Medicaid Services.	)	

DECISION

I consider here whether the Centers for Medicare and Medicaid Services (CMS) may properly terminate the Medicare provider agreement of a home health agency that has stopped providing services.

Petitioner, AccentCare Home Health of Phoenix, (Petitioner or AccentCare) is a home health agency (HHA) based in Phoenix, Arizona, that, until its May 15, 2008 termination, was certified to participate in the Medicare program. But when surveyors from the Arizona Department of Health Services (State Agency) attempted to survey the HHA on March 13, 2008, they discovered that it was not operational. CMS therefore determined that AccentCare no longer met the statutory definition for HHAs and terminated its Medicare participation. Petitioner here challenges its termination. The parties have filed cross motions for summary judgment.[1]

[1] CMS's motion is accompanied by one attachment (CMS Exhibit (Ex.) 1) and Petitioner's motion is accompanied by nine attachments (P. Exs. 1-9).

For the reasons set forth below, I find that CMS was authorized to terminate AccentCare's Medicare provider agreement, and I grant CMS's motion for summary judgment.

I. Discussion

A. CMS is entitled to summary judgment because the undisputed facts establish that AccentCare did not meet the statutory definition of "home health agency"; CMS is therefore authorized to terminate its provider agreement.[2]

Summary judgment is appropriate here because this case turns on a question of law and presents no genuine dispute as to any material fact. *Anderson v. Liberty Lobby*, 477 U.S. 242, 247-48 (1986); *Livingston Care Center v. United States Department of Health and Human Services*, 388 F. 3d 168, 173 (6th Cir. 2004).

An HHA is a public agency or private organization that "is primarily engaged in providing skilled nursing services and other therapeutic services" to patients in their homes. Social Security Act (Act), section 1861(o). It may participate in the Medicare program as a provider of services if it meets that statutory definition and complies with certain requirements, called Conditions of Participation. Act, sections 1861(o), 1891; 42 C.F.R. Part 484; 42 C.F.R. § 488.3. On the other hand, CMS, acting on behalf of the Secretary of Health and Human Services, may terminate a provider agreement based on the provider's failure to comply with provisions of section 1861 or the regulations governing its program participation. Act, section 1866(b)(2); 42 C.F.R. § 489.53(a)(1).

In this case, the undisputed facts establish the following:

- on or about May 1, 2007, Petitioner, an HHA operating in Yuma, Arizona, notified its Medicare Fiscal Intermediary that it was relocating to Phoenix. P. Ex. 7, at 2;

- AccentCare stopped transmitting OASIS (Outcome and Assessment Information Set) data to CMS on July 16, 2007.[3] CMS Ex. 1, at 1.

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[2] My findings of fact and conclusions of law are set forth, in italics and in bold, in the discussion captions.

[3] An HHA must conduct an initial assessment of each new patient within 48 hours of referral or the physician-ordered start of care date. No later than 5 calendar days after starting care, it must complete a comprehensive patient assessment. 42 C.F.R. § 484.55.

- On March 13, 2008, State Agency surveyors went to AccentCare's new location but were unable to survey the HHA because it was not then providing services. CMS Ex. 1.

- AccentCare assessed its first patient at the Phoenix location on April 7, 2008; it assessed a second patient on April 16, 2008. P. Ex. 1, at 3, 4; P. MSJ at 3.

- By notice letter dated April 22, 2008, CMS advised AccentCare that its provider agreement would terminate effective May 15, 2008. P. Ex. 6.

Aside from an oblique reference to the "summer of 2007," Petitioner has been conspicuously silent as to the specific date it stopped providing services to patients. Hearing Request at 6. Nevertheless, based on the OASIS data, which Petitioner has not challenged, I can reasonably infer that Petitioner stopped providing services to patients in July 2007. Moreover, as CMS accurately points out, even assuming that AccentCare saw a patient on the last day of summer (September 23, 2007, according to CMS's interpretation of autumnal equinox data), the HHA would still have gone more than six months without seeing a patient. In CMS's view, an HHA that is not providing services to any patients does meet the statutory definition of HHA, which requires that it be "primarily engaged in providing skilled nursing and other therapeutic services," so CMS is authorized to terminate its provider agreement. Act, sections 1861(o)(1); 1866(b)(2). I agree.

The Departmental Appeals Board (Board) definitively resolved this question in a recent decision, *United Medical Home Care, Inc.*, DAB No. 2194 (2008). There, an HHA declined to serve patients for six months while its payments were suspended pending the outcome of an audit. The Board ruled that CMS could terminate its provider agreement under section 1866(b)(2), since the HHA "substantially failed" to meet the statutory definition that it be "primarily engaged" in providing services. *United Medical*, DAB No. 2194, at 9-11.

I note that, here, CMS was also authorized to terminate AccentCare's provider agreement because the HHA could not be surveyed in any meaningful way. To determine whether an HHA complies substantially with Medicare's statutory and regulatory requirements, the regulations require that it be surveyed at least once every twelve months. 42 C.F.R. §§ 488.10, 488.11, 488.20. CMS contracts with state agencies to conduct the surveys. Act, section 1864(a); 42 C.F.R. § 488.20. But, since AccentCare was not in operation and

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These assessments must incorporate OASIS items, which are electronically transmitted to CMS. 42 C.F.R. § 484.20; 64 Fed. Reg. 3748 *et seq*. (January 25, 1999).

was not providing services to patients, the state agency could not conduct a survey and could not determine that the HHA met the statutory and regulatory requirements. If a provider cannot be surveyed, it cannot participate in the Medicare program. *See*, *e.g.*, State Operations Manual, section 2008A; *Regency on the Lake*, DAB CR1760, at 3 (2008), *aff'd* DAB No. 2205 (2008).

B. After more than six months of inactivity, admitting one or two patients does not establish that AccentCare was "primarily engaged" in providing services.

Citing provisions from the State Operations Manual (SOM), Petitioner argues that its termination should have been halted when it began seeing patients again on April 7, 2008. In Petitioner's view, that single patient assessment corrected all of its purported deficiencies, so the termination should have been halted effective that date. *See* SOM § 3038A ("The RO stops the processing of an involuntary termination if it is positively ascertained that the provider now complies with all requirements and that termination is no longer appropriate.") I disagree.

First, the Board specifically rejected a similar contention in *United Medical*. Petitioner there also argued that it satisfied the statutory definition when it admitted two patients. The Board rejected Petitioner's contention, holding:

> [G]iven 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.

United Medical, DAB No. 2194, at 12.

Second, Petitioner wrongly assumes that its termination could be based solely on its failure to provide services, and that, so long as it began providing services, it could not be terminated. As noted above, an HHA must not only meet the statutory definition of an HHA, it must also demonstrate (generally during its annual survey) that it complies with all Medicare conditions of participation. Here, because the HHA could not undergo its annual survey, it failed to demonstrate its substantial compliance with *any* Medicare condition of participation. A provider that has not demonstrated substantial compliance with program requirements cannot participate in the Medicare program.

C. CMS complied with regulatory requirements for providing notice of termination, 42 C.F.R. § 489.53(d)(1).

Citing provisions of the SOM that strictly limit the notice given when a provider's conditions pose immediate jeopardy, Petitioner complains that, since its conditions did not pose immediate jeopardy, it was entitled to additional notice prior to its termination. First, as CMS correctly points out, I am bound by the statute and regulations, not by manual provisions. With limited exceptions that are not applicable here, the regulation governing notice of termination requires that CMS provide notice of termination "at least 15 days before the effective date of termination." 42 C.F.R. § 489.53(d)(1). CMS satisfied the regulatory notice requirements.

Moreover, the alternative provision of the SOM – which would have allowed Petitioner additional time – does not apply here. It sets forth a notice schedule beginning "on the date on which the entire survey is completed." SOM, § 3012. Since survey completion initiates the entire schedule, and no survey could be performed here, CMS justifiably did not follow that provision.

D. Petitioner was not entitled to an opportunity to correct.

Petitioner also complains that CMS did not afford it the opportunity to correct its deficiencies prior to termination.

The statutory and regulatory provisions that authorize termination do not include any opportunity to correct prior to termination. Act, section 1866(b)(2); 42 C.F.R. § 489.53(a)(1). Petitioner, however, argues that I should disregard section 1866(b)(2) and limit my analysis to section 1891(e) of the Act, which applies specifically to HHAs. Petitioner then claims that section 1891(e) affords it a six-month opportunity to correct prior to termination. Neither assertion is correct.

The two statutory provisions are wholly consistent and I must consider both. Section 1866(b) authorizes termination of any provider that fails to meet its statutory definition or fails to comply with applicable conditions of participation. Section 1891(e)(1) applies to immediate jeopardy situations, and requires that the Secretary "take immediate action" to remove the immediate jeopardy or to terminate an HHA's provider agreement. Section 1891(e)(2) applies to non-immediate jeopardy situations, and gives the Secretary the *discretion* to impose intermediate sanctions (not to exceed 6 months) instead of termination. Nothing in that section *requires* that the Secretary afford a deficient HHA the opportunity to correct.

By regulation, CMS describes the circumstances in which certain deficient providers, including HHAs, may be granted the opportunity to correct. Where deficiencies are at standard – not condition – level, CMS will allow a reasonable time to achieve compliance if the provider submits an acceptable plan of correction, and CMS determines that its deficiencies neither jeopardize the health and safety of patients nor "are of such character as to seriously limit the provider's capacity to render adequate care." 42 C.F.R. § 488.28.

I find that section 488.28 does not apply to providers such as AccentCare that have stopped providing services and have therefore not been subject to annual survey. Since the HHA has not been surveyed and could not be surveyed, CMS is not able to determine that it has the capacity to render adequate care. CMS may not, therefore, allow it the opportunity to correct.[4]

II. Conclusion

Because AccentCare no longer met the statutory definition for HHAs, CMS was authorized to terminate its provider agreement. I therefore grant CMS's motion for summary judgement, and deny Petitioner's motion for summary judgment.

/s/

Carolyn Cozad Hughes
Administrative Law Judge

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[4] Petitioner claims that CMS's alleged failure to comply with its regulations and the SOM is arbitrary and capricious and violates the due process clause. I have no authority to review constitutional claims. *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002). Nevertheless, I find no failure by CMS to comply with its regulations and the SOM, nor do I find any basis for Petitioner's claim that CMS's enforcement actions were arbitrary and capricious.