Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Caretenders Visiting Services of Columbus, LLC,
(CCN: 36-8136),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-213

Decision No. CR2311

Date: January 19, 2011

DECISION

Through a convoluted – but ultimately unsuccessful – series of maneuvers, Petitioner's parent company, Almost Family, Inc. (AFAM), tried to establish Petitioner, Caretenders Visiting Services of Columbus, LLC (Petitioner or Caretenders), as a Medicare-certified home health agency (HHA) in Columbus, Ohio. To achieve its goal, AFAM purchased an already-certified HHA that served the Cleveland area (Broadview Heights). AFAM then fired Broadview Heights' entire staff and discharged all its patients. Five months later, AFAM opened Caretenders of Columbus and, relying on Broadview Heights' provider agreement and billing number, began admitting Medicare patients. CMS subsequently terminated Caretenders' program participation. Petitioner here challenges its termination.

The parties agree that this case can be decided based on the written record. Order Following Prehearing Conference (June 14, 2010); CMS Cl. Br. at 4; P. Cl. Br. at 1. They have filed opening briefs (CMS Br.; P. Br.) and closing briefs (CMS Cl. Br.; P. Cl. Br.). CMS submitted 18 exhibits (CMS Exs. 1-18), and Petitioner submitted two exhibits (P. Exs. 1-2).

For the reasons set forth below, I find that CMS properly terminated Caretenders' Medicare participation.

I. Discussion

A. CMS properly terminated Caretenders' Medicare participation because Caretenders failed to meet the statutory definition of an HHA after it fired its staff and discharged all its patients.[1]

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) § 1861(o). It may participate in the Medicare program as a provider of services if it meets the statutory definition and complies with certain requirements, called conditions of participation. Act §§ 1861(o), 1891; 42 C.F.R. Part 484; 42 C.F.R. § 488.3. 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 the provisions of section 1861 or the regulations governing its program participation. Act § 1866(b)(2); 42 C.F.R. § 489.53(a)(1).

To assure an HHA's compliance with statutory and regulatory requirements, CMS contracts with state agencies to conduct periodic surveys. Act § 1864(a); 42 C.F.R. §§ 488.10, 488.11, 488.20. The regulations generally require that each provider be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. § 488.20. In lieu of an annual state survey, however, an HHA may be "deemed" to meet Medicare requirements based on its accreditation by an approved national accreditation program (such as The Joint Commission). Act § 1865; 42 C.F.R. § 488.6.

With limited exceptions not applicable here, a prospective Medicare provider must be surveyed and meet all conditions of participation before the effective date of its provider agreement. 42 C.F.R. § 489.13.

In this case, AFAM owned and operated a business that provided unskilled, in-home personal care services in Columbus, Ohio. CMS Ex. 11 at 1; P. Ex. 1 at 2 (Lyles Decl. ¶ 3). It sought to expand this business to include a Medicare-certified HHA. Accordingly, on April 20, 2007, it applied for Medicare certification, but it never completed the

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

application process. CMS Exs. 4, 5; P. Ex. 2 at 1-2 (Hawkins Decl. ¶¶ 2, 3); P. Ex. 1 at 2 (Lyles Decl. ¶ 7).[2]

Instead, on or about October 13, 2007, AFAM purchased, from Alliance Care, an already-certified HHA, which was based in Broadview Heights, Ohio and operated in and around Cleveland. CMS Ex. 6. But AFAM already owned a Medicare-certified HHA in Cleveland (Caretenders of Cleveland, LLC), and it neither needed nor wanted a second one in that service area. P. Ex. 1 at 2 (Lyles Decl. ¶ 3); CMS Ex. 11. Almost immediately after it acquired Broadview Heights, AFAM fired all of the staff and discharged all of the patients, readmitting them "as necessary" to Caretenders of Cleveland. CMS Ex. 11 at 3; P. Ex. 2 at 3 (Hawkins Decl. ¶¶ 10, 11, 12). At the same time, AFAM "began the process" of hiring staff for Caretenders at Columbus. According to Rachel Hawkins, AFAM's Director of Clinical Affairs, the Columbus operation was finally adequately staffed in March 2008, at which time it admitted its first Medicare patients. P. Ex. 2 at 3 (Hawkins Decl. ¶ 12).

Medicare regulations require that parties to a change of ownership (CHOW) submit new enrollment applications (CMS Form 855A). 42 C.F.R. §§ 424.550(b), 489.18(b). Petitioner submitted to its fiscal intermediary (Palmetto GBA) the required CMS Form 855A, signed by Director Hawkins and AFAM's Compliance Officer, Senior Vice President Patrick Todd Lyles. CMS Ex. 7. I agree with CMS that the information Petitioner provided in this document does not accurately reflect the transaction. According to the form, Petitioner had acquired a "parent" HHA located in Columbus, Ohio, with a service area that included counties in and around Columbus. CMS Ex. 7 at 9, 12. In fact, Petitioner acquired a Cleveland-based HHA with a service area that included counties in and around Cleveland. CMS Ex. 6 at 1. Nor did Petitioner disclose that it would stop providing services in Cleveland. The form directs the provider to specify those areas to which it would no longer provide services, and Petitioner left that section blank. CMS Ex. 7 at 13.

Although it took some time for CMS to catch up with all these events, it ultimately denied the request for a CHOW. In a letter dated April 30, 2009, CMS told Petitioner that it could not reassign the provider agreement and certification number to an entity that served different patients in a different geographic location from that served by the original owner. CMS Ex. 10. In August 2009, CMS advised Alliance Care – the original owner – that its provider agreement was terminated because it no longer primarily engaged in providing services. CMS Exs. 12, 13. Alliance Care was understandably disturbed (apparently not wanting on its record an involuntary termination for an entity it thought it had long since sold). CMS Ex. 18 at 6 (Potjeau Decl. ¶ 45). Following

[2] As CMS points out, the Columbus operation did not then qualify for certification. By its own admission, the operation did not reach adequate staffing levels for an HHA prior to March 2008. CMS Cl. Br. at 7-8; P. Ex. 2 at 3 (Hawkins Decl. ¶ 12).

negotiations among Petitioner, Alliance Care, and CMS, Petitioner eventually filed an amended CMS Form 855A, acceptable to CMS, acknowledging that it acquired an HHA operating in what had been Broadview Heights' service area at the time of the transaction – Cleveland and environs. CMS Ex. 14. CMS then approved the CHOW, but again terminated the provider agreement because the Cleveland facility had stopped providing services. CMS Exs. 15, 16.

Without regard to rules governing CHOWs or relocation (which I discuss below), these facts establish that, in October 2007, the Medicare-certified HHA (Broadview Heights/Caretenders) stopped treating patients. It was therefore no longer "primarily engaged" in providing skilled nursing, therapeutic, or any other services, and no longer met the statutory definition of an HHA. CMS therefore properly terminated its program participation. Act § 1866(b)(2), 42 C.F.R. § 489.53(a)(1); *United Med. Home Care, Inc.*, DAB No. 2194 (2008) (holding that CMS properly terminated the Medicare participation of an HHA that treated no patients between February 9 and August 23, 2005); *see Cornerstone Family Healthcare*, DAB No. 2319 (2010) (affirming Medicare termination of a rural health clinic that was no longer providing services); *Arizona Surgical Hosp., LLC*, DAB No. 1890 (2003) (upholding Medicare termination of a hospital that did not provide in-patient services for 39 days and therefore did not meet the provisions of section 1861(e) of the Act).

B. Aside from its billing number (which cannot be sold), Caretenders of Columbus bore no resemblance to Broadview Heights, and CMS may appropriately require it to demonstrate that it meets the statutory definition of an HHA and complies with all Medicare conditions of participation before certifying it to participate in the Medicare program.

Petitioner claims that it merely took a five-month hiatus and had resumed providing services by the time CMS terminated its program participation. Whether a provider can ultimately avoid termination by resuming services after a significant period of inactivity is questionable. I am aware of no situation (and Petitioner cites none) in which the Departmental Appeals Board (Board) has reversed a termination based on the provider's claim that it resumed services. In fact, the Board has repeatedly rejected such arguments. *United Med. Home Care, Inc.*, DAB No. 2194 at 12; *Cornerstone*, DAB No. 2319 at 6.

On the other hand, I cannot conclude that the issue has been resolved for all situations, since the cases in which the Board has rejected the argument were narrowly decided. In *United Medical Home Care, Inc.*, the HHA argued that it had resumed services because it admitted a couple of patients following a six-month break in service. The Board found this insufficient and sustained the termination. *United Medical Home Care, Inc.*, DAB No. 2194 at 12. In *Cornerstone*, the Board rejected Petitioner's argument that CMS was

precluded from terminating a rural health clinic's provider agreement because services resumed after a change of ownership. However, in that case, the Board also pointed out that regulations governing rural health clinics allow – but do not require – termination based on a CHOW, so it is not clear whether the provider's status as a rural health clinic made a difference. DAB No. 2319 at 6 (*citing* 42 C.F.R. § 405.2404(b)(1)(iii)).

I need not decide this question here, however, because the Medicare-certified HHA that stopped providing services in October 2007 never resumed providing those services. The entity that reopened in March 2008 as Caretenders of Columbus was not the Medicare-certified entity that AFAM purchased in October 2007. The HHA staff were all different; the patients were different; the practice location was different; the service area was different. The HHA was apparently no longer accredited either; the Joint Commission withdrew its accreditation effective October 13, 2007, the date of the CHOW. CMS Ex. 17. All that remained the same was the provider billing number, which, by regulation, could not legally have been sold. 42 C.F.R. § 424.550(a); *see* 42 C.F.R. §§ 424.535(a)(7) and 424.535(b) (providing that CMS may revoke a Medicare provider's billing privileges and terminate its provider agreement if the provider sells or otherwise allows misuse of its billing number).

I reject Petitioner's suggestion that it did not change service areas because Broadview Heights' service area was the entire State of Ohio. When the HHA was initially certified in 2006, CMS designated its service area as Lorain County, Ohio, which is part of the metropolitan area surrounding Cleveland. CMS Ex. 1 at 3. In a letter dated August 7, 2006, Alliance Care announced that it was relocating the HHA to Broadview Heights. CMS Ex. 2 at 4, 13. Alliance Care filed the requisite CMS Form 855A, in which it described the HHA's service area as the State of Ohio. CMS Ex. 2 at 16. I see no evidence that it ever actually served the entire state. Moreover, at the time of the CHOW, its service area was unquestionably limited to the Cleveland area. As explained by Michael Potjeau, Regional Health Insurance Specialist for CMS, "[t]o claim a geographic area, the HHA must be able to provide supervision, administration and services throughout that service area on a daily basis." CMS Ex. 18 at 2 (Potjeau Decl. ¶ 11.) AFAM's Compliance Officer Lyles concedes that Broadview Heights was not providing services in Columbus, stating that, at the time AFAM purchased the Cleveland-based HHA, he was "not aware of any Medicare-certified home health agencies that were already serving the Columbus, Ohio service area and that were also available for purchase." P. Ex. 1 at 3 (Lyles Decl. ¶ 11). Finally, in describing the HHA's service area, the purchase agreement between Alliance Care and AFAM does not include Franklin County (where Columbus is located) or any of its surrounding counties. CMS Ex. 6 at 1.

Thus, without regard to the CHOW, CMS could not have allowed this entirely new operation to participate in the Medicare program without undergoing the certification process. When a CHOW occurs, the Medicare provider agreement is automatically

assigned to the new owner, and the assigned provider agreement is then subject to "all applicable statutes and regulations and to the terms and conditions under which it was originally issued. . . ." 42 C.F.R. § 489.18(c), (d).[3] However, a CHOW does not entitle the new owner to rights greater than those the old owner had to convey, and where, as here, a purported "relocation" is "far removed from the ordinary approved site," and involves different employees and patients, the relocation may constitute "a cessation of business at the provider's old location and a voluntary termination on the part of the provider." State Operations Manual (SOM) § 2702B.

A separate provision of the SOM specifically addresses situations involving a CHOW and relocation and achieves the same result as section 2702B. Section 3210.1B5 of the SOM mandates that, where, concurrent with the CHOW, a new owner relocates "to a site in a different geographic area serving different clients than previously served and employing different personnel to serve those clients," the provider "must be treated as a new applicant to the Medicare program." SOM § 3210.1B5.

I find these provisions of the SOM completely reasonable and wholly consistent with the spirit and the letter of the Act and regulations. They ensure that what is effectively a completely new entity is surveyed and demonstrates its substantial compliance with all Medicare requirements before it participates in the program. *See* 42 C.F.R. § 489.13.

C. Petitioner's purported reliance on misinformation from a state employee does not estop CMS from enforcing valid program requirements.

Vice President/Compliance Officer Lyles testifies that, notwithstanding his significant experience with CHOWs, he had "never experienced a situation that would entail an acquisition followed by a relocation of the agency to a new service area." P. Ex. 1 at 3 (Lyles Decl. ¶ 14). He asserts that he therefore instructed staff to contact the state survey agency "to inquire as to the permissibility of a CHOW and concurrent relocation of the agency to a new service area." P. Ex. 1 at 3 (Lyles Decl. ¶ 15). The task fell to Director

[3] Petitioner makes much of the "automatic" nature of the CHOW, arguing that the automatic assignment provisions of 42 C.F.R. § 489.18(c) are "controlling authority in the event of a CHOW and concurrent relocation." P. Cl. Br. at 2. But Petitioner overlooks other regulatory requirements for effectuating a CHOW. The buyer and seller must notify CMS and must submit new enrollment applications "before completion of the change of ownership." 42 C.F.R. § 424.550(b); 42 C.F.R. § 489.18(b). CMS may sanction or penalize the "current owner" for failing to submit an appropriate application "even after the date of ownership change." If the "prospective owner" fails to submit a complete enrollment application or its application contains "material omissions," CMS may deactivate the Medicare billing number. 42 C.F.R. § 424.550(b).

Hawkins, who says that she spoke to someone she knew at the state agency named Karen Cook who:

> gave me the impression that the CHOW and relocation would be permissible and was a matter of filing certain information with [the state agency] and the Medicare fiscal intermediary . . . . At no time during the call did she inform me that a Medicare State Operations Manual provision existed that impeded such an action.

P. Ex. 2 at 2 (Hawkins Decl. ¶ 8). Petitioner does not disclose Ms. Cook's exact status, simply describing her as "an [Ohio Department of Health] representative with whom [Director Hawkins] had worked in the past." P. Ex. 2 at 2 (Hawkins Decl. ¶ 7). Incredibly, according to both Mr. Lyles and Ms. Hawkins, based on this one conversation with a state employee, whose exact status Petitioner does not disclose, AFAM purchased Alliance Care's HHA. P. Ex. 1 at 3 (Lyles Decl. ¶ 17); P. Ex. 2 at 3 (Hawkins Decl. ¶ 10).

Whether the government can ever be estopped from enforcing valid regulations based on the misrepresentations of government employees or their agents is highly questionable. *See Heckler v. Cmty. Health Servs. of Crawford County*, 467 U.S. 51, 63 (1984); *Schweiker v. Hansen*, 450 U.S. 785 (1981). The Supreme Court has deliberately stopped short of establishing a flat rule to preclude estoppel against the government. It has nevertheless recognized that the arguments in favor of such a rule are "substantial."

> When the Government is unable to enforce the law because the conduct of its agents has given rise to an estoppel, the interest of the citizenry as a whole in obedience to the rule of law is undermined. It is for this reason that it is well settled that the Government may not be estopped on the same terms as any other litigant.

Cmty. Health Servs. of Crawford County, 467 U.S. at 60.

In *Cmty. Health Servs. of Crawford County*, a Medicare certified HHA asked its fiscal intermediary whether Medicare would reimburse the salaries of certain employees. Without first consulting the appropriate office of the Department of Health and Human Services (which would have been a predecessor to CMS), employees of the fiscal intermediary repeatedly – and wrongly -- assured the HHA that Medicare covered the costs. Relying on this erroneous advice, the HHA expanded its services and billed Medicare. HHS eventually learned of the error and recouped a substantial overpayment. In upholding the government's right to recoup, the Court emphasized that Medicare participants have a duty to familiarize themselves with the legal requirements for cost

reimbursement, and act with "scrupulous regard" for the requirements of the law. They may not rely on the conduct of government agents that is contrary to that law. 467 U.S. at 63, 64.

The Court also noted that, by consulting the fiscal intermediary, the provider showed that it "indisputably knew" that its entitlement was a "doubtful question," not clearly covered by existing policy statements. The fiscal intermediary's erroneous advice was, in itself, insufficient to raise an estoppel, as was the government's failure to anticipate the problem and make a clear resolution available to the respondent. 467 U.S. at 64.

Here, Petitioner's position is even weaker than that presented in *Cmty. Health Servs. of Crawford County*. Notwithstanding AFAM's considerable experience with the Medicare program, including CHOWs, Compliance Officer Lyles concedes that he was not aware of any provider ever having successfully avoided the certification process by acquiring and relocating an already-certified HHA. P. Ex. 1 at 3 (Lyles Decl. ¶ 14). From this, any reasonable person should have recognized that AFAM's plan was, at best, highly questionable. And, unlike the situation in *Cmty. Health Servs. of Crawford County*, the answer to AFAM's question was readily available. CMS explicitly articulated its rule in the SOM, which is easily accessible to anyone with a computer and internet access. Where a party exercising "reasonable diligence" can acquire program knowledge "so that it would be negligence . . . to remain ignorant by not using those means," it cannot claim to have been misled by relying on an agent's representation or concealment. *Wade Pediatrics*, DAB No. 2153 at 23 (2008) (*citing* 467 U.S. 51 at 61 n.10).

Further, a provider's reliance on statements from either the fiscal intermediary or a state employee – even one who, unlike Ms. Cook, could unquestionably be characterized as a "responsible government agent" – is simply unreasonable. As the Supreme Court explained, in administering a program such as Medicare, CMS cannot:

> be expected to ensure that every bit of informal advice given by its agents . . . will be sufficiently reliable to justify expenditure of sums of money as substantial as those spent [here]. Nor was the advice given under circumstances that should have induced respondent's reliance. As a recipient of public funds well acquainted with the role of a fiscal intermediary, respondent knew that [the fiscal intermediary] only acted as a conduit; it could not resolve policy questions. The relevant statute, regulations, and Reimbursement Manual, with which respondent should have been and was acquainted, made that perfectly clear. Yet respondent made no attempt to have the question resolved by the Secretary; it was satisfied with the policy judgment of a mere conduit.

467 U.S. at 64-65; *accord, Regency on the Lake*, DAB No. 2205 at 5 (2008) (finding a provider's reliance on statements of state employees "particularly unreasonable" because it should have known that neither a state agency nor its employees are empowered to find a facility eligible to participate in the Medicare program; only the Secretary has the final authority to make that determination).

Finally, Petitioner's reliance on oral advice weakens its case even more. The Supreme Court pointed out how inherently unreasonable such reliance is, and ruled that reliance on oral advice should not support an estoppel against the government:

> It is not merely the possibility of fraud that undermines our confidence in the reliability of official action that is not confirmed or evidenced by a written instrument. Written advice, like a written judicial opinion, requires its author to reflect about the nature of the advice that is given . . . and subjects that advice to the possibility of review, criticism, and reexamination. The necessity for ensuring that governmental agents stay within the lawful scope of their authority, and that those who seek public funds act with scrupulous exactitude, argues strongly for the conclusion that *an estoppel cannot be erected on the basis of . . . oral advice. . . especially . . . when a complex program such as Medicare is involved*, in which the need for written records is manifest.

467 U.S. at 65 (emphasis added).

II. Conclusion

Because it ceased providing services, Petitioner no longer met the statutory definition of an HHA, and CMS properly terminated its Medicare participation.

/s/
Carolyn Cozad Hughes
Administrative Law Judge