**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Best Florida Homecare, Inc.,
(NPI: 1679820989),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-665

Decision No. CR4962

Date: October 31, 2017

# DECISION

The Centers for Medicare & Medicaid Services (CMS) did not err in denying Medicare enrollment to Best Florida Homecare, Inc. (Petitioner), because a temporary moratorium pursuant to 42 C.F.R. § 424.570 applied to Petitioner's application to participate in Medicare as a new home health agency (HHA). Therefore, as explained more fully below, I affirm CMS's reconsidered determination denying Petitioner enrollment in the Medicare program.

## I. Background and Procedural History

The following facts are undisputed. Petitioner is an HHA, licensed in Florida, located in Winter Park, Orange County, Florida. CMS's Motion for Summary Judgment/Pre-hearing Brief (CMS Br.) at 1; Petitioner's Cross-Motion for Final Summary Judgment/Pre-hearing Brief and Opposition to Respondent's Motion for Summary Judgment (P. Br.) at 2. Petitioner submitted an application to enroll in Medicare as a

provider of services.[1] CMS received Petitioner's application on December 7, 2014. CMS Br. at 2; P. Br. at 3.

In a letter dated September 24, 2015, the Medicare Administrative Contractor (MAC), Palmetto GBA (Palmetto), informed the health services and facilities consultant for the Florida Agency for Healthcare Administration (state agency) that Palmetto was issuing a "Recommendation for Approval" of Petitioner's application. CMS Exhibit (Ex.) 6; *see also* P. Br. at 3. Also by letter dated September 24, 2015, Palmetto informed Petitioner that Petitioner's application was forwarded to the state agency and to the CMS Regional Office for further review. CMS Ex. 5. Palmetto's letter to Petitioner explained, "The next step will be a survey or site visit conducted by a State Survey Agency or a CMS approved deemed accrediting organization to ensure compliance with required Conditions of Participation." *Id.* Finally, Palmetto's letter stated, "Once the CMS Regional Office confirms that these conditions are met, we will send you our decision." *Id.*

In June 2016, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) surveyed Petitioner and concluded that it met the requirements to be certified to participate in Medicare. P. Br. at 3. Effective July 29, 2016, CMS imposed a statewide moratorium on the enrollment of new HHAs in Florida. 81 Fed. Reg. 51,120, 51,123 (August 3, 2016). By letter dated September 29, 2016, Palmetto notified Petitioner that Petitioner's application to enroll in Medicare as an HHA was denied. CMS Ex. 1. Palmetto advised Petitioner that its application was denied pursuant to 42 C.F.R. §§ 424.530(a)(10) and 424.570(c), because CMS had imposed a moratorium on enrolling new HHAs and subunits in the state where Petitioner's practice was located. *Id.*

Petitioner requested reconsideration. CMS Ex. 2. CMS, through its Provider Enrollment & Oversight Group, issued an unfavorable reconsidered determination dated March 17, 2017.[2] CMS Ex. 3. In its reconsidered determination, CMS concluded that the moratorium applied to Petitioner and, accordingly, Petitioner's application for enrollment was properly denied. *See, e.g.,* CMS Ex. 3 at 2-3.

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[1] The Social Security Act (Act) defines "provider of services," commonly shortened to "provider," to include hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, HHAs, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)).

[2] CMS initially rejected Petitioner's reconsideration request as untimely, but upon further review determined that the request was timely filed and issued a reconsidered determination on the merits. *See* P. Exs. 5, 6.

Petitioner submitted a hearing request dated May 4, 2017, which was received on May 9, 2017. The case was assigned to me, and I issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order) on May 15, 2017. On June 19, 2017, CMS submitted its motion for summary judgment, along with six exhibits (CMS Exs. 1-6). On July 21, 2017, Petitioner filed its cross-motion for summary judgment, along with seven exhibits (P. Exs. 1-7).[3] Neither party objected to the exhibits offered by the opposing party. Accordingly, in the absence of objection, I admit CMS Exs. 1-6 and P. Exs 1-7 into the record.

Neither party proposed to call any witnesses. As I informed the parties in my Pre-Hearing Order, a hearing is only necessary if a party offers the written direct testimony of a witness and the opposing party requests to cross-examine the witness. Pre-Hearing Order ¶ 10. Although the parties cross-moved for summary judgment, because an in-person hearing to cross-examine witnesses is not necessary, I decide this case based on the written record, without considering whether the standards for summary judgment are satisfied.

## II. Issue

The sole issue which I may decide in this case is "whether the temporary moratorium applies to the provider or supplier appealing the denial." 42 C.F.R. § 498.5(*l*)(4). CMS's basis for imposing the temporary moratorium is not reviewable. *Id.*

## III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(*l*)(2); *see also* Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)).

## IV. Discussion

### A. Statutory and Regulatory Background

Congress authorized the Secretary of Health and Human Services (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 supplier's enrollment in the Medicare program if the supplier submits an enrollment application for a practice location in a geographic area

[3] As filed in the Departmental Appeals Board E-Filing system, Petitioner's exhibits are identified with the initials "BFHC" for Best Florida Homecare. In this decision, I refer to the exhibits as "P. Ex." followed by the number assigned by Petitioner.

where CMS has imposed a temporary moratorium. 42 C.F.R. § 424.530(a)(10); 42 C.F.R. § 424.570. However, the temporary enrollment moratorium "does not apply to any enrollment application that has been approved by the enrollment contractor but not yet entered into PECOS[4] at the time the moratorium is imposed." 42 C.F.R. § 424.570(a)(1)(iv). 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 administrative law judge of denials related to a temporary moratorium is limited to the issue of whether the temporary moratorium applies to the denied provider. The basis for imposing a temporary moratorium is not subject to review by an administrative law judge. 42 C.F.R. § 498.5(*l*)(4).

**B. Findings of Fact, Conclusions of Law, and Analysis**[5]

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

The sole issue in this case is whether Petitioner's application was already "approved by the enrollment contractor" on July 29, 2016, when CMS expanded the moratorium on enrolling new HHAs to include the entire state of Florida. If the application was approved at that time, then, pursuant to 42 C.F.R. § 424.570(a)(1)(iv), the moratorium does not apply to Petitioner's application. On the other hand, if the application was not yet approved, then CMS properly denied Petitioner's application to enroll in Medicare. Because I conclude that the application was not yet approved, I find that the moratorium applies to Petitioner's application.

There is no dispute as to the pertinent facts. On July 29, 2016, when CMS expanded the Florida moratorium on enrolling new HHAs, Petitioner had applied for enrollment in Medicare, Palmetto had "recommended approval" of Petitioner's application, and Petitioner had been surveyed by the Joint Commission, which also recommended approval of Petitioner's application. However, nothing in the record indicates that the CMS Regional Office had approved the application or directed Palmetto to approve the application. As an appellate panel of the Departmental Appeals Board (DAB) has observed:

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[4] The Provider Enrollment, Chain and Ownership System (PECOS) is an internet-based Medicare enrollment system through which providers and suppliers can submit enrollment applications, view, print, and update enrollment information, and track the status of submitted enrollment applications. https://pecos.cms.hhs.gov.

[5] My findings of fact/conclusions of law appear as numbered headings in bold italic type.

> That an enrollment contractor *recommended* approval does not mean that *CMS* has endorsed that approval as a final determination on approval status. It is CMS, not Palmetto or any other CMS contractor, which ultimately decides whether a prospective provider or supplier meets the requirements for participation in Medicare and may be enrolled in Medicare.

*UpturnCare Co.*, DAB No. 2632 at 12 (2015) (italics in original). Thus, without action or endorsement by CMS, a contractor's recommendation to approve an enrollment application does not mean that the application is "approved" within the meaning of 42 C.F.R. § 424.570(a)(1)(iv).

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); CMS Pub. 100-08, Medicare Program Integrity Manual (MPIM), § 15.19.2.1C (Rev. 556, effective Dec. 29, 2014). Because of the potential for fraud, the enrollment process for new HHAs includes an additional step for a second review of enrollment criteria performed by either the Regional Home Health Intermediary or the MAC after CMS's Regional Office completes its review. MPIM § 15.26.3 (Rev. 492, effective Jan. 7, 2014); CMS Survey & Certification Letter (S&C) 12-15-HHA, Revised Initial Certification Process for Home Health Agencies (HHAs) (Dec. 23, 2011) (CMS Ex. 4). This second review by the contractor occurs once the CMS Regional Office notifies the contractor by email that the Regional Office has completed its review. CMS Ex. 4 at 2. 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. MPIM § 15.26.3. The contractor then performs a site visit. *Id.* It is only after successful completion of this final re-review by the contractor that the HHA will be certified by CMS for enrollment and entered into PECOS. *Id.*

Section 15.26.3 of the MPIM describes a five-step review process for enrollment of new HHAs. As far as the record reveals, as of July 19, 2016, Petitioner's application had passed only the first two steps of review. That is, the contractor (Palmetto) had recommended approval to the state agency/CMS Regional Office, and an accrediting organization had performed a survey and made its recommendation. There is no indication that the CMS Regional Office had reviewed and concurred in the recommendations, nor that Palmetto had completed its re-review and notified CMS that Petitioner was still in compliance with the enrollment requirements. Finally, CMS had not yet issued a CMS Certification Number, signed a provider agreement, or sent a tie-in notice or approval letter to Palmetto. *See* MPIM § 15.26.3. Therefore, Petitioner's application had not yet been approved. *See UpturnCare*, DAB No. 2632 at 13

(“approved” means that CMS has made “a determination to allow enrollment following successful completion of the entire review process”).

***2. CMS had a legal basis to deny Petitioner’s Medicare enrollment pursuant to 42 C.F.R. § 424.530(a)(10).***

Petitioner’s application for enrollment in Medicare was not approved when CMS implemented a temporary moratorium on enrolling new HHAs throughout Florida on July 29, 2016. Accordingly, the exception described in 42 C.F.R. § 424.570(a)(1)(iv) does not apply. Because Petitioner’s application is not exempt from the moratorium, CMS had a legal basis to deny Petitioner’s Medicare enrollment pursuant to 42 C.F.R. § 424.530(a)(10).

***3. Petitioner’s arguments regarding statutory construction are without merit.***

Petitioner argues that application of the temporary moratorium to its pending application violates several canons of statutory construction. P. Br. at 5-6, 9-12. In particular, Petitioner argues that application of the moratorium to it contravenes the presumption against retroactivity and that the plain meaning of the statute and regulations demonstrates that it is not covered by the moratorium. Neither argument has merit.

First, Petitioner argues that CMS should not apply the moratorium “to retroactively affect applications already submitted and in the process prior to the effective date of the moratorium.” P. Br. at 9. According to Petitioner, this is because Congress did not provide for retroactive application of moratoria when it enacted section 1866(j)(7)(A) of the Act. *Id.* Petitioner misunderstands the presumption against retroactive application. As the U.S. Supreme Court stated in *Landgraf v. USI Film Products*, 511 U.S. 244, 265 (1994), “Elementary considerations of fairness dictate that individuals should have an opportunity to know what the law is and to conform their conduct accordingly; settled expectations should not be lightly disrupted.” Thus, the general principle that laws should not be applied retroactively absent a clear expression of intent is intended to protect persons or entities from being subject to unexpected consequences for conduct that occurred prior to the enactment of prohibitions or limitations on such conduct.

In the present case, neither the statute nor the regulation was applied to Petitioner retroactively. Congress enacted section 1866(j)(7)(A) of the Act in 2010, as part of the Patient Protection and Affordable Care Act (Pub. L. 111-148, § 6401(a)). The Secretary of Health and Human Services proposed regulations to implement the statutory changes on September 23, 2010. 75 Fed. Reg. 58,204 (Sep. 23, 2010). The proposed regulations included 42 C.F.R. §§ 424.530(a)(10) and 424.570 governing temporary moratoria. *Id.* at 58,242-43. The regulations became final on March 25, 2011. 76 Fed. Reg. 5862 (Feb.

2, 2011).[6] The point to be made here is that the statute and regulations authorizing temporary moratoria on enrollment of new HHAs were in effect well before Petitioner submitted its enrollment application in 2014. Petitioner had the opportunity to consult the Federal Register and the Code of Federal Regulations to inform itself of the rules that would apply to its Medicare enrollment. Had it done so, Petitioner would have been aware that the Secretary would treat in-process applications as subject to temporary moratoria.[7] Thus, neither the statute nor regulation has retroactive effect as applied to Petitioner. *See Robert F. Tzeng, M.D.*, DAB No. 2169 at 13 (2008) (challenged regulation was not retroactive because it did not invalidate actions or impose additional requirements on circumstances existing before its effective date).

Second, Petitioner argues that the plain meaning of 42 C.F.R. § 424.530(a)(10) requires a conclusion that, to be subject to a moratorium, a Medicare application must be submitted after the effective date of the moratorium. P. Br. at 6, 10-11. Petitioner argues additionally that section 1866(j)(7)(A) of the Act does not make a distinction between "final approval" and "preliminary approval" and, accordingly, either type of approval should invoke an exception to the moratorium. P. Br. at 11-12. The plain meaning of the statutory and regulatory language does not support Petitioner's interpretation.

As Petitioner implicitly concedes, the statute is silent on the question of whether a moratorium applies to applications that are in process on the date the moratorium is imposed. Thus, the Secretary was free to issue regulations on this point. The Secretary did so, promulgating both 42 C.F.R. § 424.530(a)(10) and § 424.570(a)(1)(iv). It is a maxim of statutory construction that statutory and, by extension, regulatory language should be interpreted to give effect to all provisions. *See, e.g., Hibbs v. Winn*, 542 U.S. 88, 101 (2004). Interpreting 42 C.F.R. § 424.530(a)(10) as meaning that moratoria apply only to applications filed after the effective date of the moratorium would render section 424.570(a)(1)(iv) superfluous. It is apparent then, that the Secretary intended moratoria to apply to applications that are pending, but not yet approved, on the effective date of the moratorium.

***4. I am without authority to reverse the denial of Petitioner's Medicare enrollment based on equitable considerations.***

Petitioner argues that it spent two years and over $250,000 in its effort to become enrolled as a Medicare provider. *See, e.g.*, P. Br. at 9. To the extent Petitioner's

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[6] Section 424.570(a)(1)(iv) was added when the final rule with comment period was promulgated. *See* 76 Fed. Reg. at 5919, 5965.

[7] Indeed, the preamble to the final rule with comment period explicitly states that CMS interprets the Affordable Care Act's temporary moratorium provision as applying to pending enrollment applications. 76 Fed. Reg. at 5919.

arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302, at 8 (2010) ("[n]either the [administrative law judge] nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements"). 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 (2009) ("[a]n [administrative law judge] is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground").

## V. 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 was properly denied pursuant to 42 C.F.R. §§ 424.530(a)(10).

/s/
Leslie A. Weyn
Administrative Law Judge