Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Great Lakes HealthCare, LLC
Docket No. A-16-143
Decision No. 2777
March 22, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE RULING

Petitioner Great Lakes HealthCare, LLC (Petitioner) is a Home Health Agency (HHA) that participated in the Medicare program until December 23, 2015, the date the Centers for Medicare and Medicaid Services (CMS) terminated Petitioner's Medicare provider agreement. Petitioner requests review of an administrative law judge (ALJ) ruling dismissing Petitioner's February 8, 2016 request for a hearing. *Great Lakes HealthCare, LLC*, ALJ Ruling No. 2016-14 (July 25, 2016)(ALJ Ruling). The ALJ dismissed Petitioner's hearing request under 42 C.F.R. § 498.70(b) after concluding that Petitioner had no right to a hearing on the issues raised in its hearing request. On appeal, Petitioner does not directly challenge this conclusion but reiterates its argument that CMS was required to respond to its plan of correction (POC) and, according to Petitioner, failed to do so. Request for Review (RR) at 1, 2; Reply to CMS Response to Petitioner's Request for Review (Reply) at 1, 2, 3. Petitioner also argues that its hearing request was timely filed or that there was "good cause" for late filing. RR at 3; *see also* Reply at 3. Finally, Petitioner argues that "42 C.F.R. § 488.830(a) does not support the ALJ's finding that CMS is not required to afford a provider time to correct a deficiency before imposing termination." RR at 3.

We conclude that the ALJ correctly dismissed Petitioner's hearing request under section 498.70(b) because it failed to raise an issue that a provider is entitled to appeal or that an ALJ may review. In light of this conclusion, the other issues raised by Petitioner do not provide a possible basis for reversing the ALJ, as we discuss in the last section of our decision.

Applicable Law

An HHA is eligible to enter into a provider agreement with CMS to provide certain in-home health services – such as skilled nursing services – to Medicare beneficiaries in their places of residence when the beneficiaries are under the care of a physician. Section 1861(m) of the Social Security Act (Act), 42 U.S.C. § 1395x(m).[1] To become and remain a Medicare provider of home health services, an HHA must meet the statutory definition for HHAs in section 1861(o) and the conditions of participation in section 1891(a) of the Act, as well as the Secretary's requirements at 42 C.F.R. Part 484 (sections 484.10 to 484.55). HHAs participating in Medicare are subject to periodic surveys, conducted by state survey agencies, under agreements with CMS, to determine whether they are in compliance with the conditions and other requirements of participation. Act § 1891(c); 42 C.F.R. § 488.10. The state survey agency makes and documents findings with respect to an HHA's compliance with each of the conditions, and each of the standards in the conditions, governing Medicare participation. 42 C.F.R. §§ 488.11, 488.12, 488.18 – 488.26. CMS may terminate an HHA that it finds noncompliant with one or more condition of participation. Act §§ 1866(b)(2)(B), 1861(o)(6), 1891(e); 42 C.F.R. § 489.53(a)(3).

If CMS decides to terminate an HHA's Medicare provider agreement based on noncompliance with a condition of participation, the HHA has a right to appeal that decision pursuant to section 1866(h) of the Act and 42 C.F.R. Part 498. 42 C.F.R. §§ 489.53(e), 498.1, 498.3(b)(8). The right of appeal includes a hearing before an ALJ of the Departmental Appeals Board (subpart D of Part 498), and, if sought, review of the ALJ decision by the Departmental Appeals Board (subpart E of Part 498). The hearing request must be filed in writing within 60 days from receipt of the notice of initial . . . determination unless that period is extended "[f]or good cause shown." 42 C.F.R. § 498.40(a)(2),(c)(2). An ALJ may dismiss a hearing request that is not timely filed. 42 C.F.R. § 498.70(c). An ALJ also may dismiss a hearing request where there is no right to a hearing. 42 C.F.R. § 498.70(b).

[1] Hereafter, citations will be only to the Act. The current version of the Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table, and the U.S.C.A. Popular Name Table for Acts of Congress.

Case Background[2]

The Illinois Department of Public Health, the state survey agency, completed a recertification survey of Petitioner on May 8, 2015 and found six condition-level deficiencies. ALJ Ruling at 3, citing CMS Exhibits (Exs.) 1, 6. In an August 6, 2015 letter, CMS informed Petitioner that a revisit survey on June 19, 2015 found Petitioner remaining out of substantial compliance with one condition-level deficiency and that CMS would terminate Petitioner's Medicare provider agreement effective December 19, 2015 and impose a $2,000 per day civil money penalty beginning June 19, 2015. *Id*., CMS Ex. 6, at 1, 2; *see also* CMS Ex. 5 (Statement of Deficiencies for June 19, 2015 revisit). Under a heading "prominently captioned '**Appeal Rights**,'" CMS's August 6, 2015 letter also gave Petitioner notice of its right to request a hearing before an ALJ within 60 days of Petitioner's receipt of the August 6 letter. ALJ Ruling at 3, citing CMS Ex. 6, at 4 (emphasis in original and ALJ quotation). The letter instructed Petitioner how to file a hearing request and cited the regulations governing appeals. *Id*., citing CMS Ex. 6, at 4-5.

CMS sent the letter by overnight mail. *Id*., citing CMS Ex. 6, at 1. "No one disputes that the HHA received its notice on August 7, 2015, which means that its hearing request was due no later than October 6, 2015. Petitioner did not request review of CMS's findings of substantial noncompliance, and the deadline . . . passed." *Id*.

CMS's August 6, 2015 letter had also informed Petitioner that any plan for correcting the deficiencies found during the survey should be submitted within 10 calendar days of the date of the letter and set out the criteria that such a plan must meet. CMS Ex. 6, at 3. Great Lakes submitted a corrective action plan (POC) on August 17, 2015.[3] CMS Ex. 16 (Para Declaration), at 1-2¶¶ 4, 5; *see also* CMS Ex. 7 (emails scheduling POC delivery to CMS). CMS found the POC unacceptable. CMS Ex. 16, at 1-2¶¶ 4, 5. A state survey agency supervisor who oversaw the May 8 and June 19 surveys stated that she phoned

[2] The facts stated here are from the ALJ Decision and the record and are undisputed unless otherwise noted. We make no new findings of fact. We include facts regarding the history of communications between the parties regarding a POC. The ALJ did not discuss many of these facts, presumably because they were not germane to her Ruling. They also are not germane to our analysis or decision. However, given Petitioner's principal argument, we thought it appropriate to set out these facts here in order to provide context.

[3] Petitioner claimed in its hearing request that it submitted "another POC" on August 12, 2015, and the ALJ noted Petitioner's claim that a POC was submitted on that date. Hearing Request at 2; ALJ Decision at 3. A letter signed by Petitioner's attorney also refers to a POC having been "hand-delivered" on August 12, 2015. *See* CMS Ex. 11, at 2. However, there is no POC dated August 12, 2015 (or showing delivery on that date), in the record, and Petitioner's Request for Review identifies no POC with a submission date other than August 17, 2015.. *See* RR at 1, 2, 3. Since the parties agree that a POC was submitted on some date in August 2015 and neither the submission of the POC nor the date of submission makes a difference to our decision, we refer in our decision only to the POC submitted on August 17, 2015.

Petitioner on August 17, 2015 to inform it that the POC was unacceptable and instructed Petitioner to send additional information. CMS Ex. 14 (Varghese declaration), at 2¶ 10. Petitioner concedes the conversation but denies being informed that the POC was unacceptable. Reply at 2.

Petitioner submitted additional documents on September 16, 2015, but on September 17, 2015, CMS found the POC still unacceptable. CMS Exs. 8, 9; CMS Ex. 14, at 2-3¶¶ 11, 12. Petitioner and its attorney had additional communications with CMS on November 24, 2015. CMS Ex. 16, at 2¶¶ 6, 7; CMS Ex. 14, at 3¶ 13.

The parties do not claim to have had any communications after November 24, 2015 until December 7, 2015. On December 7, 2015, CMS wrote Petitioner to notify it that the termination scheduled to take effect December 19, 2015 would instead take effect four days later (December 23, 2015) in order to comply with public notice provisions. CMS Ex. 10, at 1. The letter stated, "To date, we have not received an acceptable plan of correction for the survey completed on June 19, 2015," and referred to CMS's August 6, 2015 letter that had advised Petitioner of its hearing rights and the deadline for filing a hearing request. *Id*. at 1, 2. On December 11, 2015, Petitioner's attorney submitted to CMS a letter with an attachment that the letter described as a POC. CMS Ex. 11. However, on the same date, CMS notified the attorney that it "d[id] not see a plan of correction . . . within the attachment."[4] CMS Ex. 12; *see also* CMS Ex. 16, at 2¶ 8 (discussing the absence of the POC); CMS Ex. 14, at 3 ¶ 16.

Petitioner filed the hearing request that triggered this appeal.

Standard of Review

The standard of review for an ALJ's exercise of discretion to dismiss a hearing request is whether the discretion has been abused. *Penobscot Nursing Home*, DAB No. 2642, at 2 (2015), *citing, inter alia*, *High Tech Home Health, Inc*., DAB No. 2105, at 7-8 (2007), *aff'd, High Tech Home Health, Inc. v. Leavitt*, Civ. No. 07-80940 (S.D. Fla. Aug. 15, 2008). However, where an ALJ dismisses a hearing request addressing only issues that as a matter of law are not initial determinations, and, thus, are not matters within the ALJ's review authority, the standard of review is whether the ALJ erred in dismissing the hearing request. *Penobscot*, DAB No. 2642, at 2, citing *Riverview Psychiatric Ctr*., DAB No. 2586, at 4 (2014), *aff'd sub nom., Maine Dep't of Health & Human Servs. v. U.S. Dep't of Health & Human Servs.*, No. 1:14-cv-00391-JDL, 2015 WL 4872376 (D. Me. Aug. 13, 2015), citing *High Tech*, DAB No. 2105, at 12-13.

[4] In its hearing request, Petitioner claimed its counsel did not receive a response to this submission, but on page four of its Response to CMS's Motion for Summary Judgment, Petitioner acknowledged receiving the email.

Discussion

A. The ALJ correctly dismissed Petitioner's hearing request because the only issues raised in that request were not appealable as a matter of law.

Petitioner states as the issue on appeal: "Whether or not the . . . State Agency[] and CMS is required to answer when a Plan of Correction ("POC") is filed that timely addresses the survey finding(s) of noncompliance." RR at 1. Petitioner argues that this question must be answered in the affirmative and that the ALJ, therefore, should have reversed the termination because Petitioner received no formal response from CMS regarding the POC it submitted on August 17, 2015. Petitioner claims it only learned that CMS had not accepted its POC when it received CMS's December 7, 2015 letter notifying Petitioner that the previously imposed termination would take effect December 23, 2015 because CMS had not received an acceptable POC for the condition found unmet during the June 19, 2015 revisit. *See id*. at 3 ("There is Zero evidence in writing from either the [state agency] or CMS that the POC had been rejected until December 7, 2015"). Petitioner states, on the one hand, that the ALJ Ruling "basically ignores the issue" and, on the other, that "[t]he ALJ's finding that the [state agency] and CMS do not have to answer POCs when filed in these specific circumstances is error and has no support in the authorities cited in the ALJ's [ruling]." RR at 1, 2.

Aside from the inherent inconsistency of Petitioner's statements about the ALJ Ruling, neither statement is true. The ALJ neither ignored the issue nor found that the state agency did not need to respond to a POC. Rather, she concluded that as a matter of law she "may [not] review either the state agency's [or] CMS' determination to reject a provider's [POC] or their failure to act on the provider's [POC]" because "[t]hose actions (inaction[s]) are not listed as initial determinations and are therefore not reviewable." ALJ Ruling at 4, citing 42 C.F.R. § 498.3(b); 498.5 (case citations omitted). Thus, the issue before the Board is whether the ALJ correctly concluded that the issues raised by Petitioner are not subject to review, and we conclude that the ALJ was correct.

The ALJ cited section 498.5, and the relevant portion of that regulation states as follows:

> **Section 498.5 Appeal rights.**
>
> * * *
>
> (b) Appeal rights of providers. Any provider dissatisfied with an *initial determination* to terminate its provider agreement is entitled to a hearing before an ALJ.

(Emphasis added.) Thus, section 498.5 limits appeal rights to CMS actions that qualify as "initial determinations." Section 498.3, also cited by the ALJ, defines what actions qualify as "initial determinations," providing as follows:

> (a) *Scope*. (1) This part sets forth procedures for reviewing initial determinations that CMS makes with respect to the matters specified in paragraph (b) of this section . . . .
>
> (b) *Initial determinations by CMS*. CMS makes initial determinations with respect to the following matters . . . .

The matters listed as "initial determinations" include "[t]he termination of a provider agreement in accordance with § 489.53 of this chapter . . . ." 42 C.F.R. § 498.3(b)(8). Section 489.53(a)(3) authorizes CMS to terminate an HHA that fails to comply with the conditions of participation applicable to HHAs. *See also* 42 C.F.R. § 488.865(b)(failure to comply with the conditions of participation is a basis for terminating an HHA's provider agreement); 488.865(d)(CMS terminates the provider agreement "in accordance with procedures set forth in § 489.53 of this chapter"); 488.865(e)(appeal of section 488.865(b) HHA terminations is "in accordance with part 498 of this chapter"). CMS terminated Petitioner's provider agreement based on CMS's finding that during the June 19, 2015 revisit survey Petitioner remained out of compliance with the condition of participation at 42 C.F.R. § 484.14. CMS Ex. 6, at 1-2.

Applying the cited regulations, Petitioner would have been entitled to have the ALJ review CMS's finding of noncompliance with the condition of participation at 42 C.F.R. § 484.14. In an August 6, 2015 letter, CMS notified Petitioner of that appeal right and the need to file any appeal within 60 days of receiving that letter. CMS Ex. 6, at 4-5. Petitioner does not dispute the ALJ's finding that it did not file a hearing request within 60 days of receiving the August 6, 2015 letter. Petitioner also does not dispute the ALJ's finding that the hearing request Petitioner filed in February 2016 did not challenge CMS's finding of noncompliance with the condition of participation. ALJ Ruling at 3; Hearing Request at 1. Indeed, as CMS notes, Petitioner acknowledges here, "Great Lakes has never argued that the [state agency] finding that Great Lakes[']non-compliance had not been cured was error." CMS Response at 11, quoting RR at 2.

Instead of challenging the finding of noncompliance on which the termination of its provider agreement was based, Petitioner challenged only CMS's failure to formally respond to the POC it submitted on August 12, 2015, arguing that this failure "effectively voids the [termination] process . . . ." ALJ Ruling at 3; Hearing Request at 1. The ALJ concluded that she had no authority to review CMS's actions or inactions with respect to Petitioner's POC because "[t]hose actions (inaction[s]) are not listed as initial determinations . . . ." ALJ Ruling at 4. The ALJ's conclusion is consistent with the

language of sections 498.5 and 498.3(b) and with decisions of this Board construing those regulations as limiting appeals to the initial determinations listed in section 498.3(b). *See, e.g*., *Capitol House Nursing and Rehab Ctr.*, DAB No. 2252, at 2 (2009) ("[A]dministrative actions that are not CMS initial determinations are not subject to appeal."); *Northridge Care Center*, DAB No. 1857, at 8 (2002) ("By its very terms, Part 498 provides appeal rights only for these listed actions."). In *Riverview Psychiatric Center*, the Board cited these decisions and upheld an ALJ dismissal of Riverview's hearing request which sought review of CMS's decision not to reopen or revise its initial determination to terminate Riverview's provider agreement under section 489.53 rather than the initial determination itself. *See also High Tech Home Health, Inc*, at 12 (upholding dismissal of hearing request that did not identify any cognizable depute regarding CMS' initial determination to terminate High Tech's Medicare provider agreement based on two surveys but instead raised claims that "[a]re [n]ot [m]atters [a]ppealable [u]nder [s]ection 498.3(b)").

In *HRT Laboratory, Inc*., DAB No. 2118, at 10 (2007), the Board specifically held "that the 'initial determinations' listed [in section 498.3(b)] do not include rejection of a POC." *Accord Hermina Traeye Mem'l Nursing Home*, DAB No. 1810, at 13 (2002); *aff'd sub nom., Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.*, 79 F. App'x 563 (4th Cir. 2003) The Federal District Court upholding the Board's *Riverview* decision specifically upheld the Board's conclusion that CMS's decision to reject a POC is not an "initial determination," explaining as follows:

> Here, by the State's own characterization, the . . . letter from CMS was a "determination that Riverview failed to implement the [plan of correction] properly." [citations omitted] Nowhere do the Medicare Act or its implementing regulations support a right to challenge a decision that a plan of correction was not properly implemented. *See* 42 U.S.C.A. § 1395cc(h)(1)(A); 42 C.F.R. § 498.3(b). While the regulations expressly authorize "plans of correction" and "revisit surveys" as tools for addressing deficiencies found by CMS, *see e.g*. 42 C.F.R. §§ 488.28, 488.30(a), neither is listed as an "initial determination" subject to administrative and judicial review.

2015 WL 4872376 at 4. Although Petitioner suggests we should distinguish between CMS's rejection of a POC, and CMS's failure to formally act on a POC, the latter of which Petitioner asserts is the issue here, we find no basis for such a distinction. The legal issue is the same regardless of whether CMS acts or fails to act on a proposed POC; neither administrative act is listed as an "initial determination" in section 498.3(b), therefore neither is subject to review by an ALJ or the Board.

Petitioner makes no attempt to discuss section 498.3(b) or to dispute the ALJ's conclusion that if an administrative action is not listed as an "initial determination" in that regulation, it carries no hearing rights. Instead, Petitioner cites another regulation, 42 C.F.R. § 498.70(b), the regulation authorizing dismissal of hearing requests that raise no issues for which there is a right to a hearing. Petitioner argues that section 498.70(b) "does not state that the [state agency] and CMS failure to respond to a timely filed POC cannot be the subject of an ALJ appeal." RR at 2. Petitioner is correct as to what section 498.70(b) does not state, but that is irrelevant here. Section 498.70(b) merely addresses an ALJ's authority to dismiss an appeal for which there is no right to a hearing. It does not address what administrative actions carry hearing rights. Section 498.3(b) establishes the administrative actions – initial determinations – for which the right to an ALJ hearing (and Board review) exists. As previously stated, the listed initial determinations do not include CMS's action or inaction on a POC, the only issue for which Petitioner sought ALJ review. Accordingly, the ALJ properly used her authority under section 498.70(b) to dismiss Petitioner's hearing request that sought a hearing solely on an issue that was not an initial determination.

B. In light of the fact that the hearing request Petitioner filed raised no appealable issue, Petitioner's other arguments provide no possible basis for reversing the ALJ Ruling.

Prior to concluding that she was not authorized to review CMS's rejection of or inaction on a POC because that administrative action (or inaction) was not an initial determination listed in section 498.3(b), the ALJ stated, "As a threshold matter, CMS is not required to afford a provider the opportunity to correct a condition-level deficiency before terminating its program participation."[5] ALJ Ruling at 3. The ALJ based her conclusion on 42 C.F.R. § 488.830(a) and Federal court and Board decisions.[6] *Id*. at 3-4. Petitioner

[5] It appears the ALJ addressed this "threshold matter" in response to Petitioner's claim in its hearing request, which we noted above, that CMS's alleged failure to formally respond to its POC "effectively voids the [termination] process . . . ." ALJ Ruling at 3, citing Hearing Request at 1. It was not necessary for the ALJ to do so, in our view, since Petitioner's claim did not alter the fact that the ALJ had no "initial determination" before her. In any event, Petitioner does not repeat that claim in its Request for Review.

[6] Section 488.830(a) provides as follows:

(a) *Noncompliance*. If the HHA is no longer in compliance with the conditions of participation . . . CMS will:

(1) Terminate the HHA's provider agreement; or
(2) Impose one or more alternative sanctions set forth in 488.820(a) through (f) of this part as an alternative to termination, for a period not to exceed 6 months.

does not address the court and Board decisions but asserts that while the ALJ's reading of section 488.830(a) "may certainly be true [it] is irrelevant here." RR at 3. Petitioner cites section 488.830(d) which it apparently reads as requiring CMS, absent immediate jeopardy, to give a provider six months to correct before terminating its provider agreement.[7] Since the ALJ, as a matter of law, correctly dismissed Petitioner's hearing request on the ground that it raised no issue subject to ALJ review, we must affirm the ALJ Ruling regardless of whether the ALJ also correctly concluded that CMS had the discretion to terminate Petitioner's provider agreement without giving it an opportunity to correct.

Nonetheless, we note that the ALJ's conclusion on this "threshold issue" was correct, as shown by the authorities she cited. The only one of those authorities Petitioner discusses – section 488.830(a) – clearly gives CMS the option of either imposing termination immediately when there is an unmet condition of participation or, instead, providing an opportunity to correct for no more than six months. As we noted, Petitioner does not dispute the ALJ's reading of that regulation but, instead, argues for application of section 488.830(d). Nothing in the language of section 488.830(d), however, limits or qualifies CMS's options provided in section 488.830(a). Instead, subsection (d) merely provides an outside limit of six months for keeping an HHA that has condition-level deficiencies (but no immediate jeopardy) in the Medicare program. We note incidentally that while CMS imposed the termination and gave Petitioner notice of the imposition of that remedy (and its right to appeal it) following the June 19, 2015 revisit survey, CMS did not effectuate the termination until December 23, 2015, which date was more than six months after the date of the revisit survey. Accordingly, the termination would have been lawful even under Petitioner's incorrect reading of section 488.830(d).

Also irrelevant in light of our decision is Petitioner's argument that its hearing request was not filed late or, alternatively, that there was "good cause" for filing it late based on CMS's alleged failure to respond in writing to its POC, which Petitioner contends "was at the heart of the delay . . . ." Reply at 3. The regulations require providers to file hearing requests within 60 days of receiving the initial determination for which they seek review, absent a finding of "good cause" for a late filing. 42 C.F.R. § 498.40(a)(2),(c). A hearing request that is filed late without a showing of "good cause" is subject to dismissal. 42 C.F.R. § 498.70(c). While acknowledging that rule and not disputing that its hearing request was not filed within 60 days of receipt of CMS's August 6, 2015

[7] Section 488.830(d) provides as follows:

(d) *Termination time frame when there is no immediate jeopardy*. CMS terminates an HHA within 6 months of the last day of the survey, if the HHA is not in compliance with the conditions of participation, and the terms of the plan of correction have not been met.

notice letter, Petitioner argues that the 60-day appeal period should begin with its receipt of CMS's December 7, 2015 letter (in which case its request for review would be timely) since that letter, according to Petitioner, was its first notice that CMS had rejected its POC. Reply at 3. Petitioner also spends a significant amount of time discussing the facts surrounding Petitioner's various POCs and its communications to and from CMS about them in an effort to support a later filing deadline or, alternatively, a finding of good cause for late filing. Reply at 2-4.

We need not discuss the facts cited by Petitioner or decide whether they support Petitioner's timeliness or "good cause" arguments since even finding for Petitioner on those issues would not alter our decision. Because the request for review Petitioner filed did not challenge CMS's findings of noncompliance but, instead, raised issues not subject to review, the hearing request was subject to dismissal regardless of whether it was filed on time or with "good cause" for late filing.

Conclusion

For the reasons stated above, we affirm the ALJ Ruling.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member