Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Hanover Home Health Care, LLC
Docket No. A-13-103
Decision No. 2545
December 2, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Hanover Home Health Care, LLC (Hanover), a home health agency (HHA), requests review of the June 12, 2013 decision of an Administrative Law Judge (ALJ). *Hanover Home Health Care*, DAB CR2823 (2013) (ALJ Decision). The ALJ sustained the October 22, 2012 reconsideration determination by the Centers for Medicare & Medicaid Services (CMS) denying Hanover's Medicare enrollment application because Hanover did not timely submit proof to CGS Administrators, LLC (CGS), a Medicare contractor, that Hanover met requirements for initial reserve operating funds.

For the reasons discussed below, we conclude that the ALJ Decision is supported by substantial evidence in the record and free from legal error. While Hanover asserts on appeal that a subsequent submission it made to CGS should be considered a timely filed corrective action plan (CAP), the Board does not have the authority to review actions or decisions involving the CAP process.

Background of the Case

The following facts from the ALJ Decision and the record are undisputed.

Hanover submitted a Medicare enrollment application in the spring of 2010. CMS Ex. 1. By letter dated June 29, 2010, Hanover was notified that its application had been recommended for approval. CMS Ex. 2. The notice stated that the enrollment process would continue and that "it could take 6 to 9 months (or longer) for the provider to obtain its billing number." *Id.*

In a letter dated June 7, 2012, CGS advised Hanover that Medicare regulations at 42 C.F.R. §§ 489.28(a) and 424.510(d)(9) require an HHA to have sufficient initial reserve operating funds "at the time of application submission and at all times during the enrollment process, to operate the HHA for the three-month period after Medicare billing privileges are conveyed . . . ." CMS Ex. 4, at 1. CGS stated that in order for Hanover to proceed with the enrollment process, CGS must receive by July 6, 2012, documentation

verifying that Hanover's initial reserve operating funds were still available. *Id.* CGS stated that the capitalization amount required for Hanover was $39,939 and that "[a]t least half of the funds must be the HHA's own funds; the rest may be borrowed, including a line of credit, from an unrelated lender . . . ." *Id.* at 2. CGS advised Hanover, "Acceptable funds include savings, checking, or other account(s) that contain the funds and/or cash equivalents (treasury bills, commercial paper, money market funds) that are readily convertible to cash in the first three months of operation." *Id.*

The CGS notice also stated:

> **If the home health agency fails to furnish adequate proof of capitalization by submitting the requested information within 30 days from the date of this letter, our previous approval recommendation will be revised and the State and the CMS Regional Office will be notified that your enrollment in the Medicare program is now denied.**

Id. at 1 (emphasis in original).

On July 3, 2012, Hanover faxed to CGS a letter from Essex Bank dated June 26, 2012, approving a line of credit to Hanover in the amount of $40,000. P. Supporting Documents at 9, 17-18; CMS Ex. 6. Hanover did not at that time submit any documentation of non-borrowed funds, nor did Hanover submit a current bank statement or an attestation that at least 50% of its initial reserve operating funds was non-borrowed. ALJ Decision at 2.

By letter dated July 19, 2012, CMS denied Hanover's enrollment application under section 424.530(a)(8) of the regulations on the ground that Hanover failed to meet the initial capitalization requirements of 42 C.F.R. § 489.28(a). CMS Ex. 3.

On August 10, 2012, Hanover requested reconsideration of the decision denying its Medicare enrollment application and submitted proof that it met the initial reserve operating funds requirements as of August 10, 2012. ALJ Decision at 2, *citing* P. Exs. 1, 3. CMS issued an unfavorable reconsideration determination on October 22, 2012, concluding that Hanover had not submitted the necessary initial reserve operating funds documentation within the 30-day period specified by CGS. CMS Ex. 5.

Hanover then requested an ALJ hearing. The ALJ sustained the denial of Hanover's enrollment application. The ALJ made the following findings of fact and conclusions of law:

1. Between June 7, 2012, and July 7, 2012, [Hanover] only submitted to CGS a letter indicating that [Hanover] had a line of credit of $40,000, as proof that it had initial reserve operating funds in the amount of $39,939.00.

2. CMS has a legal basis to deny [Hanover's] enrollment in the Medicare program as an HHA because [Hanover] was not able to provide documented proof to CGS that it met the initial reserve operating funds requirement within 30 days of CGS's request for such proof.

ALJ Decision at 3-4.

Standard of review

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Id.*

Analysis

1. Applicable regulations

To enroll and receive billing privileges in Medicare, an HHA must have sufficient "initial reserve operating funds" at the time it submits its enrollment application and "at all times during the enrollment process up to the expiration of the 3-month period following the conveyance of Medicare billing privileges . . . ." 42 C.F.R. § 489.28(a); *see also* 42 C.F.R. § 424.510(d)(9) (providing that "to obtain enrollment and to maintain enrollment for the first three months after Medicare billing privileges are conveyed," a HHA must "satisfy the home health 'initial reserve operating funds' requirement" at section 489.28). CMS, through its contractors, determines the amount of the initial reserve operating funds for each HHA using standards and methods prescribed by regulation. 42 C.F.R. §§ 489.28(b)-(c).

"The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds." 42 C.F.R. § 489.28(d). Such proof must "include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA." *Id.* At least 50 percent of an HHA's required initial reserve operating funds must be non-borrowed funds. *Id.*

Section 424.530(a) of the regulations describes the grounds on which CMS may deny a provider's enrollment in Medicare. Under section 424.530(a)(8)(i), CMS or its designated Medicare contractor may deny an HHA's billing privileges "if, within 30 days of a CMS or Medicare contractor request, a [HHA] cannot furnish supporting documentation which verifies that the HHA meets the initial reserve operating funds requirement" in section 489.28(a). Section 424.530(a)(8)(ii) provides that CMS may deny Medicare billing privileges upon an HHA applicant's failure to satisfy the initial reserve operating funds requirement found in 42 CFR 489.28(a).

2. The ALJ Decision is supported by substantial evidence in the record and free from legal error.

Applying sections 489.28 and 424.530(a)(8) to the evidence in this case, we conclude that the ALJ properly determined that CMS had a legal basis to deny Hanover's enrollment application. The record shows, and Hanover does not deny, that Hanover did not submit proof to CGS that it met the initial reserve operating funds requirements within 30 days of CGS's request for such proof. Specifically, in response to CGS's June 7, 2012 request for proof of Hanover's initial operating reserve funds, Hanover submitted a letter from Essex Bank dated June 26, 2012 showing that Hanover had a line of credit of $40,000. CMS Ex. 6; P. Supporting Documents at 9. Hanover submitted no documentation of any non-borrowed funds before the July 7, 2012 (30-day) deadline for its submission.

As the ALJ noted, Hanover alleges that it subsequently opened two bank accounts, one of non-borrowed personal savings in the amount of $20,000 and another line of credit for $20,000. ALJ Decision at 4, *citing* P. Supporting Documents at 1. Hanover did not provide any evidence that these accounts existed as of July 7, 2012, however, or that Hanover otherwise provided any proof of these accounts to CGS within 30 days of the June 7, 2012 request. *Id.*

Thus, CMS had a legal basis to deny Hanover's enrollment application because: 1) Hanover's June 26, 2012 submission did not prove that Hanover met the initial reserve operating funds requirements found in section 489.28(a); and 2) Hanover failed to furnish supporting documentation verifying that it met the initial reserve operating funds requirements within the 30-day period for an HHA to submit such documentation established under section 424.530(a)(8)(i).

3. The Board does not have authority to review actions or decisions involving the CAP process.

On appeal to the Board, Hanover asserts that it "complied with the requests of CMS and its contractors and has met the criteria in filing and submitting a timely POC . . . ." RR at 1. Hanover states that it "expressly referred to [its] request for reconsideration . . . as a

CAP" and filed evidence of its corrective action. Hanover asserts, "CMS has an ethical, legal and moral obligation" to construe Hanover's August 10, 2012 submission as a timely filed CAP." RR at 2. In support of this argument, Hanover cites a footnote in the

ALJ Decision, which states in part, "in the interest of justice, CMS should review Hanover's August 10, 2012 submission to determine whether Hanover's pro se reconsideration request should have been construed as a timely filed CAP." ALJ Decision at 4-5, n. 4.

Hanover's appeal rights in this case are set out in section 1866(j)(8) of the Social Security Act (Act) and the Medicare regulations.[*] Section 1866(j)(8) states that a provider whose application to enroll in Medicare is denied may have an administrative hearing and judicial review of such denial. Under sections 405.803(a), 424.545(a) and 498.3(b)(17) of the regulations, a prospective provider may appeal an initial determination to deny its Medicare enrollment application in accordance with the procedures at 42 C.F.R. Part 498, subpart A. Section 498.22(a) states that a prospective provider whose application for enrollment has been denied has a right to reconsideration by CMS or one of its contractors. If the prospective provider is dissatisfied with the reconsidered determination, it is entitled to a hearing before an ALJ pursuant to section 498.5(l) and subsequent review by the Board.

Here, Hanover has exercised its right to appeal the denial of its enrollment application and, for the reasons explained above, we conclude that the ALJ Decision on the appeal is supported by substantial evidence in the record and free from legal error.

The CMS Program Integrity Manual, section 15.25, describes a separate "CAP process" that gives an applicant an "opportunity to correct the deficiencies . . . that resulted in the denial of its application . . . ." The manual further states, however, that if a CAP is denied, the decision to deny the CAP is not appealable. *Id.* Furthermore, the Act and regulations do not provide a CAP process for a prospective provider after its enrollment application has been denied. The refusal by CMS or one of its contractors to enroll a provider or supplier after a correction attempt is not listed as an action that constitutes an initial determination subject to administrative appeal under section 498.3(b).

The ALJ noted in a footnote of his decision that the record here indicates that a CGS employee advised Hanover to submit a CAP by August 10, 2012, and that it appears Hanover submitted proof of corrective action by that date. ALJ Decision at 4, n. 4, *citing* P. Exs. 1-3; P. Supporting Documents at 9. The ALJ made clear, however, that his

[*] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP Home/ssact/ssact.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.

"jurisdiction in this case [was] limited to reviewing CMS's determination on reconsideration to deny Hanover's enrollment application." ALJ Decision at 5, n. 4, *citing* 42 C.F.R. §§ 405.809, 498.3(b)(17), 498.5(l). Although we agree with the ALJ's statement that that "in the interest of justice, CMS should review [Hanover's] August 10, 2012 submission to determine whether [it] should have been construed as a timely filed CAP," we also agree that the ALJ did not have the authority to require CMS to undertake this analysis, nor do we.

Conclusion

For the reasons explained above, we sustain the ALJ Decision.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member