Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

SeniorBridge Family Companies (FL), Inc.,
(NPI: 1629462239),
SeniorBridge Family Companies (FL), Inc. – Clearwater,
(NPI: 1588939540),
SeniorBridge Family Companies (FL), Inc. – Winter Park,
(NPI: 1336445477),

Petitioners,

v.

Centers for Medicare & Medicaid Services

Docket No. C-17-472

Decision No. CR4938

Date: September 14, 2017

DECISION

The petitioners in these consolidated cases are Florida home health agencies, owned and operated by the same company, SeniorBridge Family Companies, Inc. Petitioners applied for enrollment in the Medicare program, and the Centers for Medicare and Medicaid Services (CMS) denied their applications because of its moratorium on enrolling new home health agencies in Florida. Petitioners appeal the denials, arguing that CMS is estopped from denying their enrollment because it impermissibly delayed the application process by adding additional hurdles not required by the regulation.

CMS has moved for summary judgment, which Petitioners oppose. I agree that no material facts are in dispute and this case turns on questions of law. In any event, neither party proposes any witnesses, so an in-person hearing would serve no purpose. *See* Acknowledgment and Prehearing Order at 3, 5-6 (¶¶ 4(c)(iv), 8-10) (March 29, 2017). This matter may therefore be decided on the written record, without considering whether the standards for summary judgment are satisfied.

For the reasons set forth below, I find that CMS properly denied Petitioners' enrollments. They were not enrolled in the Medicare program when the moratorium took effect, and the moratorium precludes their enrollments.

Background

Petitioners (SeniorBridge – Pensacola; SeniorBridge – Clearwater; and SeniorBridge – Winter Park) applied to enroll in the Medicare program as providers of services. CMS Exs. 1, 2, 3. In letters dated August 10, 2016, September 28, 2016, and September 30, 2016, the Medicare contractor, Palmetto GBA, denied their applications, explaining that CMS had imposed a temporary moratorium on home health agency enrollments for the state in which Petitioners have their practice locations (Florida). CMS Exs. 4, 5, 6. Petitioners sought reconsideration. CMS Exs. 7, 8, 9.

In reconsidered determinations, dated December 29, 2016 and January 26, 2017, a CMS hearing officer affirmed the denials. In each case, she found that the petitioner was not in "approved" status prior to July 29, 2016, when the state-wide moratorium took effect. She pointed out that that there are no exceptions for newly-enrolling home health agencies in moratorium areas, and that administrative review of any denial is limited to the question of whether the moratorium applies to the provider or supplier type or the geographic location. CMS Ex. 10 at 3; CMS Ex. 11 at 3; CMS Ex. 12 at 3.

Petitioners timely appealed and those consolidated appeals are now before me.

With its motion for summary judgment (CMS MSJ), CMS has submitted 19 exhibits (CMS Exs. 1-19). Petitioners have submitted their response (P. Resp.) with two exhibits (P. Exs. 1-2). In the absence of any objections, I admit into evidence CMS Exs. 1-19 and P. Exs. 1-2.

<u>Petitioners' subpoena request</u>. During these proceedings, Petitioners asked me to issue a subpoena directing CMS to produce a wide range of documents, including: 1) a complete copy of each home health agency's enrollment file; 2) copies of "any and all internal and external CMS communications relating to the processing of [their] enrollment applications"; and 3) copies of any other internal or external CMS communications "regarding the processing of outstanding home health agency enrollment applications generally" by CMS or its contractor within the twelve months preceding July 26, 2016.

The regulations do not allow me to issue subpoenas that are, in fact, broad requests for discovery. Specifically:

- The *requesting party* must *identify the documents* to be produced and describe their locations *with sufficient particularity* to permit them to be found. 42 C.F.R.

§ 498.58(c) (1) and (2). Here, Petitioners identify broad categories of records and ask that *CMS* be compelled to identify and locate particular documents that fit within those categories.

- The regulation requires that the requesting party "*specify* the pertinent facts the party expects to establish by the . . . documents and indicate why those facts could not be established without use of a subpoena." 42 C.F.R. § 498.58(c)(3). Petitioners allude generally to their expectation that some of these documents could support their chief argument, "namely equitable estoppel/affirmative misconduct." P. Motion at 2. But an ill-defined hope is not a specific fact and does not satisfy the regulation.

- Finally, the requesting party must establish that the documents sought are "reasonably necessary for the full presentation of a case." 42 C.F.R. § 498.58(a). This case turns on a narrow issue: whether Petitioners were subject to the moratorium on enrollment of home health agencies in Florida. Petitioner has not alleged, much less established, that they need the documents sought in order to show that they were not subject to the moratorium.

Thus, Petitioners' request does not satisfy the requirements of section 498.58, and they are not entitled to a subpoena.

Discussion

CMS properly denied Petitioners' Medicare enrollment applications because the home health agencies were not enrolled in the program when CMS's moratorium on enrolling new home health agencies in Florida went into effect, and the moratorium precludes their enrollment.[1]

Enrollment. To participate in the Medicare program, an entity must be enrolled. 42 C.F.R. § 424.505. Enrollment means the process Medicare uses to establish that a provider or supplier is eligible to submit claims for covered services and supplies. The process includes: 1) identifying the provider or supplier; 2) validating the provider/supplier's eligibility to provide items or services to Medicare beneficiaries; 3) identifying and confirming the provider/supplier's practice location(s) and owner(s); and 4) granting the provider/supplier Medicare billing privileges. 42 C.F.R. § 424.502.

Screening levels for home health agency applicants. Medicare contractors must screen all initial applications for Medicare enrollment based on CMS's assessment of the risk the applicant poses to program integrity. 42 C.F.R. § 424.518. Home health agencies fall

[1] I make this one finding of fact/conclusion of law.

into the "high-risk" category and are thus subject to more stringent enrollment procedures than limited or moderate risk applicants. 42 C.F.R. § 424.518(c); *see* CMS Program Integrity Manual (PIM) § 15.19.2.1C (May 7, 2012).

The moratorium. CMS, acting on behalf of the Secretary of Health and Human Services, may impose a temporary moratorium on the Medicare enrollment of new providers and suppliers if "necessary to prevent or combat fraud, waste, or abuse. . . ." Social Security Act (Act) § 1866(j)(7)(A); 42 C.F.R. § 424.570(a). CMS must deny a supplier's enrollment in the Medicare program if (among other reasons) its application is for a practice location in a geographic area where CMS has imposed a temporary moratorium. 42 C.F.R. §§ 424.530(a)(10); 424.570(c). The moratorium applies to all pending applications.

A home health agency may appeal the denial of its billing privileges based on CMS's imposing a moratorium on new enrollments, but the regulations limit my authority to review such appeals. My review is limited to "whether the temporary moratorium applies to the provider or supplier appealing the denial." CMS's basis for imposing the temporary moratorium is not reviewable. 42 C.F.R. § 498.5(*l*)(4); *see* 81 Fed. Reg. 51121 (August 3, 2016) (CMS Ex. 11 at 2); *see* Act § 1866(j)(7)(B) (precluding judicial review of CMS's determination to impose a moratorium).

In a Federal Register notice dated July 31, 2013, CMS imposed moratoria on the enrollment of new home health agencies in Miami-Dade County, Florida and Cook County, Illinois, in order "to prevent and combat fraud, waste, and abuse." The moratoria became effective July 30, 2013. 78 Fed. Reg. 46339-46340 (July 31, 2013); *see* CMS Ex. 11 at 2; CMS Ex. 15. CMS has extended and expanded the moratoria multiple times since originally imposed. 79 Fed. Reg. 6475 (February 4, 2014); 79 Fed. Reg. 44702 (August 1, 2014); 80 Fed. Reg. 5551 (February 2, 2015); 80 Fed. Reg. 44967 (July 28, 2015); 81 Fed. Reg. 5444 (February 2, 2016).

The home health agencies in this case are not located in Miami-Dade so that moratorium did not apply to them. However, in a Federal Register notice published August 3, 2016, CMS expanded the moratoria to include all newly enrolling home health agencies in the State of Florida (as well as the entire states of Texas, Illinois, and Michigan). CMS explained that a "high risk of fraud, waste, and abuse" exists in these areas. Effective **July 29, 2016**, no new Florida home health agencies would be enrolled "unless their enrollment application has already been approved but not yet entered into PECOS. . . ."[2] 81 Fed. Reg. 51123 (August 3, 2016); *see* 42 C.F.R. § 424.570(a)(1)(iv); CMS Ex. 11 at

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[2] PECOS – Provider Enrollment, Chain and Ownership System – is the electronic system through which providers and suppliers may enroll in the Medicare program.

4. By notice dated January 9, 2017, CMS extended the moratorium. 82 Fed. Reg. 2363-2366 (January 9, 2017).

The Medicare enrollment process for home health agencies. The Medicare enrollment process can obviously be described in any number of ways. In an effort to keep this explanation relatively simple and understandable, I break the complicated process down into steps, each step representing – in my view – a major component of the process.

Step 1: Apply. To enroll in Medicare, a prospective provider must complete and submit an enrollment application. 42 C.F.R. § 424.510(d)(1); *see* CMS Ex. 13 (CMS S&C: 12-15-HHA).

Here, although the parties quibble about the exact dates, they agree that Petitioners submitted enrollment applications in April 2015 (Pensacola), May 2013 (Clearwater), and July 2013 (Winter Park). CMS Exs. 1, 2, 3. The Medicare contractor assessed their applications and forwarded them to the appropriate entity for review. By letters dated May 22, 2015 (Pensacola), August 6, 2013 (Clearwater), and August 13, 2013 (Winter Park), the contractor advised the home health agencies that the next step required a survey by the state survey agency or a CMS-approved accrediting organization to ensure compliance with Medicare requirements. CMS Exs. 17, 18, and 19.

Step 2: Survey. To participate in the Medicare program, a home health agency must demonstrate that 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. To determine its compliance, a state survey agency or an approved accrediting organization must survey the applicant. Act §§ 1864(a); 1865(a); 42 C.F.R. §488.10; *see* Act § 1891; 42 C.F.R. Part 488, Subpart I.

Here, following surveys completed May 18, 2016 (Pensacola) and January 28, 2016 (Winter Park), an accrediting organization determined that the two home health agencies met program participation requirements. In letters dated June 21, 2016 and February 19, 2016, it recommended that they be certified. CMS Exs. 14 and 16. The accrediting organization also completed a survey of the third home health agency (Clearwater) on November 3, 2015, but apparently found deficiencies. After the home health agency submitted an acceptable plan of correction, the accrediting organization, by letter dated January 14, 2016, recommended that it too be certified. CMS Ex. 15. The letters all warned that CMS made the final determination regarding Medicare certification.

Step 3: Contractor review and site visit. Prior to December 2011, this would have completed the enrollment process. *See* CMS Ex. 13 at 1 (S&C: 12-15-HHA). However, "in order to reduce the Medicare program's vulnerability to fraud," on **December 23, 2011**, CMS added additional safeguards to the process: following the certification survey, the Medicare contractor must verify the applicant's financial situation (to assure

that it remains solvent); verify its enrollment eligibility (i.e., assure that neither the home health agency nor its principals have been excluded); and conduct a site visit (to assure that it remains operational). *See UpturnCare Co., d/b/a/ Accessible Home Health Care*, DAB No. 2632 at 12 (2015) (holding that "a successful accreditation outcome . . . does not mean that CMS (through its contractor) has in fact determined that [the home health agency] has met all requirements for enrollment. . . .").

To this end, after CMS has reviewed the survey findings and determined that the home health agency is in substantial compliance with Medicare conditions of participation, it sends a "tie-in notice" or approval letter to the Medicare contractor. The contractor must then verify that the home health agency meets capitalization requirements; it must check the Medicare exclusion database to insure that neither the home health agency nor its owners nor principals have been excluded from program participation; it must order a site visit – which is not the same as the certification survey. CMS PIM §§ 15.19.2.1C (eff. 12-29-14); 15.26.3 (eff. 01-07-14) (P. Ex. 2); P. Ex. 1 (S & C: 13-53-HHA (August 9, 2013)); *UpturnCare Co., d/b/a/ Accessible Home Health Care*, DAB No. 2632 (2015) at 2; *see* 42 C.F.R. § 424.517(a) (authorizing CMS to perform onsite review whenever it deems necessary and to deny or revoke Medicare billing privileges based on the results of the onsite review).

Petitioners complain that CMS had no authority to add these additional steps to the process. To the contrary, CMS has broad authority to add additional requirements. 42 C.F.R. §§ 424.510(d)(8); 424.517(a); *UpturnCare Co*. at 12.

In these cases, Petitioners question whether CMS ever issued their tie-in notices so that the contractor could complete the verifications. P. Response at 3-4. The reconsideration determinations indicate that the contractor received the tie-in notices on July 22, 2016 (Pensacola) and September 15, 2016 (Clear Water and Winter Park), but, aside from those findings, CMS has not produced any evidence that the notices were, in fact, issued. CMS Ex. 10 at 3; CMS Ex. 11 at 3; CMS Ex. 12 at 3. But the question is irrelevant; whether or not CMS sent the notices, the required verifications and site visits had not been completed, and the home health agencies could not have been enrolled.

Petitioners also complain that, assuming the tie-in notices were issued, the "timelines for the Clearwater and Winter Park enrollment applications "show unusual, significant, unexplained, and prejudicial delays in CMS's issuing the tie-in notices necessary. . . ." P. Response at 4. In fact, the record does not support this accusation. The surveys for these entities were completed in November 2015 (Clearwater) and January 2016 (Winter Park). Following its survey, Clearwater had to submit an acceptable plan of corrections. The accrediting organization forwarded its recommendations to CMS in January and February 2016, so any delays in CMS's issuing tie-in notices would be measured in months, not years. The *real* delays in these cases seem to have been in scheduling and conducting the

surveys, which would have been coordinated by the home health agencies and the accrediting organization.[3] CMS can hardly be held responsible for their arrangements. In any event, the question of blame for any purported delays – which amounts to a request for equitable relief – is not reviewable in this forum. *UpturnCare Co*. at 19; *see* 42 C.F.R. § 498.5(*l*)(4) (limiting the scope of my review to whether the moratorium applies to the provider appealing the denial).

Conclusion

Petitioners were not enrolled in the Medicare program before CMS imposed its moratorium on enrolling home health agencies in the State of Florida. CMS therefore properly denied their enrollment applications. Thus, I affirm CMS's reconsidered determination.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[3] Clearwater applied in May 2013, was not surveyed until November 2015, and the accrediting organization did not approve its plan of correction until January 2016. Similarly Winter Park applied in July 2013 but was not surveyed until January 2016. As a general rule, an accrediting organization will not survey an applicant unless it indicates that it is ready. Of course Petitioners would be in the best position to explain the delays, they have not done so.