

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Best Florida Homecare, Inc.
Docket No. A-18-17
Decision No. 2873
May 29, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Best Florida Homecare, Inc. (Petitioner) appeals the decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicare & Medicaid Services (CMS) to deny its application to enroll in the Medicare program as a new home health agency. *Best Florida Homecare, Inc.*, DAB CR4962 (2017) (ALJ Decision). CMS denied the enrollment application, citing CMS’s temporary moratorium on the enrollment of new home health agencies in Florida, where Petitioner is located.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

The Medicare program provides health insurance benefits to persons 65 years and older and to certain disabled persons. Social Security Act (Act) §1811.¹ Medicare is administered by CMS, which delegates certain program functions to private contractors that function as CMS’s agents in administering the program – in this case, Palmetto GBA (Palmetto). *See* Act §§ 1816, 1866, 1874A; 42 C.F.R. § 421.5(b).

The relevant regulations governing Medicare enrollment are found in 42 C.F.R. Part 424, subpart P (§§ 424.500 through 424.570). In order to receive Medicare payment for items or services furnished to program beneficiaries, a provider or supplier must be “enrolled” in Medicare. 42 C.F.R. § 424.505.

For purposes of Medicare enrollment, section 424.502 of the regulations defines “approve/approval” as “the enrolling provider or supplier has been determined to be

¹ The current version of the Social Security Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, cross-reference tables for the Act and the United States Code can be found at http://uscode.house.gov/table3/1935_531.htm and https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.”

The Medicare statute authorizes the Secretary of Health & Human Services (Secretary) to impose a “temporary moratorium on the [Medicare] enrollment of new providers of services and suppliers . . . if he determines such moratorium is necessary to prevent or combat fraud, waste, or abuse” in the Medicare program. 42 U.S.C. § 1395cc (j)(7)(A). CMS has issued regulations that implement the Secretary’s statutory authority in this area. Those regulations are found in 42 C.F.R. §§ 424.570, 424.530(a)(10), and 498.5(l)(4).

Section 424.570 specifies rules governing the imposition, extension, applicability, and enforcement of a temporary moratorium. Paragraph (a)(1) of that section states that CMS “may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type . . . in a particular geographic area.” 42 C.F.R. § 424.570(a)(1)(i). In addition, paragraph (a)(1) states that a temporary moratorium “does not apply to any enrollment application that has been approved by the enrollment contractor but not yet entered into PECOS [the internet-based Provider Enrollment, Chain, and Ownership System] at the time the moratorium is imposed.”² *Id.* § 424.570(a)(1)(iv).

Paragraph (b) of section 424.570 states that a moratorium may be imposed for a period of six months and, “if deemed necessary by CMS,” extended in six-month increments. *Id.* § 424.570(b). Notice of the imposition or extension of a temporary moratorium must be published in the Federal Register. *Id.* §§ 424.570(a)(1)(ii), 424.570(b).

Paragraph (c) of section 424.570 states that a “Medicare contractor denies” the enrollment application of a provider or supplier “if the provider or supplier is subject to a moratorium as specified in paragraph (a) of this section.” *Id.* § 424.570(c).

Consistent with section 424.570(c), section 424.530(a)(10) authorizes CMS to deny Medicare enrollment if the “provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium.” *Id.* § 424.530(a)(10).

A provider or supplier may appeal an enrollment denial “in accordance with” the regulations in 42 C.F.R. Part 498, subpart A. *Id.* § 424.545(a). Those regulations state that a prospective provider or supplier dissatisfied with an “initial determination” to deny

² PECOS, <https://pecos.cms.hhs.gov>, 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.” *UpturnCare Co., d/b/a Accessible Home Health Care*, DAB No. 2632, at 3 n.4 (2015).

its Medicare enrollment application may appeal that denial by first asking CMS for “reconsideration.” *Id.* § 498.5(l)(1). A party “dissatisfied with [the] reconsidered determination” is “entitled to a hearing before an ALJ.” *Id.* § 498.5(l)(2). A party entitled to hearing under section 498.5 may invoke its right to a hearing by filing a “request for hearing” that meets the timeliness and content requirements in section 498.40.

Section 498.5(1)(4) of the regulations controls the scope of review on appeal of CMS’s determination to impose enrollment moratoria, which states:

For appeals of [enrollment] denials based on § 424.530(a)(10) . . . related to temporary moratoria, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. The agency’s basis for imposing a temporary moratorium is not subject to review.

Id. § 498.5(1)(4).

Case Background³

Petitioner is a home health agency in Orange County, Florida, a geographic area covered by a temporary moratorium, effective July 29, 2016, on the enrollment of new home health agencies. Petitioner’s Request for Review (RR), at 2; 81 Fed. Reg. 51,120, 51,123 (Aug. 3, 2016). On December 7, 2014, Petitioner submitted an initial application for Medicare enrollment and billing privileges as a home health agency provider. P. Ex. 7. By letter dated September 29, 2016, Palmetto notified Petitioner that Palmetto had denied its enrollment application due to the temporary moratorium. CMS Ex. 1. Petitioner requested reconsideration. CMS Ex. 2. A CMS Hearing Officer concluded that the moratorium applied to Petitioner’s enrollment application, and, on March 17, 2017, issued a reconsidered determination upholding the denial of the application. CMS Ex. 3, at 3.

Petitioner filed a request for ALJ hearing (RFH), arguing that Palmetto had misinterpreted the regulations when it applied the moratorium to Petitioner’s application. RFH at 6. Petitioner argued that the moratorium did not apply because Petitioner’s application was preliminarily approved, and the regulations exempt from the moratorium an application which has been approved but not yet entered into PECOS. *Id.* Further,

³ Our case summary is based upon facts found by the ALJ and upon undisputed information contained in the parties’ documentary evidence. Our summary should not be regarded as supplementing or modifying the ALJ’s findings of fact. *Breton Lee Morgan, M.D.*, DAB No. 2264, at 3 n.3 (2009), *aff’d*, *Morgan v. Sebelius*, 2010 WL 3702608 (D. W.Va. Sept. 15, 2010), *aff’d*, 694 F.3d 535 (4th Cir. 2012).

Petitioner argued that there is no statutory basis for the approval process Palmetto applied to its application, and, because its application had been submitted and approved, the moratorium did not apply. *Id.* at 7.

Petitioner also filed a cross motion for summary judgment and brief opposing CMS's motion for summary judgment (P. Br.), which essentially reiterates the contents of its request for hearing while also arguing that CMS applied the moratorium retroactively to Petitioner's enrollment application. In its brief, Petitioner framed the legal issue this way:

Whether the 6-month extension of temporary moratorium on HHA Medicare enrollments in six geographic areas effective July 29, 2016, and the subsequent August 3, 2016, state-wide application of the moratorium to include [Petitioner's] location of Winter Park, Orange County, Florida, is applicable to [Petitioner] whose application was, preliminary approval granted, survey of facility successfully completed, and favorable recommendation for certification and participation in Medicare provided prior to those dates? In other words, is [Petitioner] retroactively or prospectively subject to a moratorium which became effective after it submitted its application and received a favorable recommendation for certification?

P. Br. at 5.

The ALJ, applying the regulation at 42 C.F.R. § 498.5(l)(4), decided that the sole legal issue before her was whether the moratorium "applies to the provider or supplier appealing the denial." ALJ Decision at 4. In order to resolve the legal issue, the ALJ decided the factual issue whether Petitioner's enrollment application was already "approved by the enrollment contractor" on July 29, 2016, when CMS expanded the moratorium on new home health agency enrollment to include the entire state of Florida. *Id.* The ALJ applied the Board's reasoning in *UpturnCare Co., d/b/a/ Accessible Home Health Care*, DAB No. 2632 at 12 (2015), and concluded that Petitioner's application had not been approved when the expanded moratorium took effect and, therefore, the moratorium applied to its application, because, in the words of the Board:

[t]hat 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.

Id. at 5 (quoting *UpturnCare* at 12) (italics in original). The ALJ also rejected Petitioner’s statutory construction arguments, reasoning that it is clear that the moratorium was not retroactively applied to Petitioner’s application, thus obviating the need for statutory construction analysis, and because the presumption against retroactive applicability is based on protecting citizens from surprise. *Id.* at 6. The ALJ also noted the statute was enacted in 2010 and the regulations became effective in 2011, so Petitioner should have been aware of the potential for moratoria to be imposed at any point prior to actual approval of an application. *Id.* Likewise, the ALJ rejected Petitioner’s arguments that the moratorium was effective only against applications submitted after its effective date and that the statute does not distinguish between preliminary and final approval. *Id.* at 7. The ALJ reasoned that, where the statute was silent, the Secretary “was free to issue regulations on this point” and had done so, expressing the intention for a moratorium to apply to applications pending on the effective date of the moratorium. See *id.*, at n.7. Finally, the ALJ ruled that she had no authority to grant Petitioner relief based on equitable grounds,⁴ or invalidate a law or regulation, citing the Board’s decisions in *US Ultrasound*, DAB No. 2302, at 8 (2010) and *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009). This appeal followed.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider’s or Supplier’s Enrollment in the Medicare Program*, accessible at <http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en>.

Analysis

In its Request for Review, Petitioner disagrees with the ALJ Decision on two grounds. First, Petitioner contends the ALJ erred when she concluded that the temporary moratorium applied to Petitioner’s enrollment application because the application was pending but was not approved when the statewide moratorium became effective. RR at 3. Second, Petitioner contends the ALJ incorrectly rejected Petitioner’s statutory construction arguments because the statute and regulations authorizing the temporary moratorium were in effect before Petitioner submitted its enrollment application in 2014. *Id.* We conclude that Petitioner’s arguments are meritless. Substantial evidence in the record supports the ALJ’s finding that Petitioner’s Medicare enrollment application had

⁴ Petitioner argued “[i]t would be unjust, harsh and inequitable to deny enrollment to [Petitioner] who has done everything within its powers to comply with the application process, and has incurred over \$250,000.00 in expenses in the application process.” P. Br. at 12.

not been approved by the effective date of the expanded Florida home health agency enrollment moratorium, and CMS did not apply the moratorium retroactively in denying Petitioner's application. The ALJ did not err when she concluded that the moratorium therefore applied to Petitioner's Medicare enrollment application. Below, we explain our reasoning.

1. *Substantial evidence in the record supports the ALJ's finding that Petitioner's enrollment application had not been approved by July 29, 2016.*

As a threshold matter, we first address the posture of Petitioner's enrollment application at the time the moratorium was extended to apply to the entire state of Florida. There is no question Petitioner is the type of supplier covered by the moratorium. Therefore, the "basic factual issues determinative of whether" the moratorium applies to Petitioner are:

- whether [the] application is an initial application for enrollment in the Medicare program rather than an application reporting a change in practice location or a change to other information on file with CMS concerning an enrolled provider or supplier (such as provider's or supplier's phone number, address, or owners);
- whether the applicant is "seeking to practice in a geographic area for which the moratorium on enrollments [is] in effect"; and
- whether the enrollment application "had been 'approved' [within the meaning of section 424.570(a)(1)(iv)] when the moratorium went into effect[.]"

UpturnCare, at 10 (2015). There is no dispute that Petitioner's enrollment application was an initial application to participate in Medicare, and sought permission to operate in a geographic area targeted by the moratorium.⁵ Therefore, the moratorium applies to Petitioner unless its application was "approved . . . at the time the moratorium [was] imposed." *City of Sugar Land*, DAB No. 2719 at 6 (2016) (citing 42 C.F.R. § 424.570(a)(1)(iv)).

The regulations exempt from a temporary moratorium "any enrollment application that has been approved by the enrollment contractor but not yet entered into PECOS at the time the moratorium is imposed." 42 C.F.R. § 424.570 (a)(1)(iv). Petitioner argues that, CMS acted retroactively by applying the moratorium to Petitioner's enrollment application even though the application had received preliminary approval from Palmetto

⁵ Petitioner contends that the moratorium did not apply to its intended Orange County, Florida location at the time Petitioner submitted its enrollment application. While this is true, we explain later in the analysis why this fact is immaterial to the disposition of Petitioner's appeal.

prior to extension of the previously imposed moratorium on July 26, 2016.⁶ RR at 2, 4. For Petitioner to show that CMS applied the moratorium retroactively to Petitioner's application, Petitioner must show that its application had been approved prior to state-wide expansion of the moratorium on July 26, 2016. For Petitioner to prove that its enrollment application had been approved, Petitioner must show that it had "been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number *and* be granted Medicare billing privileges." 42 C.F.R. § 424.502 (italics added). The process by which CMS's contractors conduct initial screening is set forth in the Medicare Program Integrity Manual (MPIM), Chapter 15.

Substantial evidence in the record as a whole does not show that Petitioner had received a billing number and had been granted Medicare billing privileges prior to July 26, 2016. In general, the contractor was required to validate and process the enrollment application. MPIM Ch. 15 § 15.1.3(C).⁷ Under the Subpart P regulations, CMS deems prospective or "newly-enrolling" home health agencies "high categorical risk" providers. 42 C.F.R. § 424.518(c)(1)(i); *see also*, *UpturnCare* at 2. High-risk providers are subjected to high-

⁶ Petitioner wrote: "[u]nder the ordinary and plain meaning of the word "submits" as used in 42 C.F.R. § 424.530(a)(10), because [Petitioner's] application submission and preliminary approval occurred prior to the moratorium effective date, a bar is not applicable to [Petitioner]."

⁷ As of July 2014, "validation and processing" of enrollment applications required contractors to:

Review the application to determine whether it is complete and that all information and supporting documentation required for the applicant's provider/supplier type has been submitted on and with the appropriate enrollment application. Unless stated otherwise in this chapter or in another CMS directive, the provider must complete all required data elements on the Form CMS-855 via the application itself.

- Unless stated otherwise in this chapter or in another CMS directive, verify and validate all information collected on the enrollment application
- Coordinate with State survey/certification agencies and regional offices (ROs), as needed
- Collect and maintain the application's certification statement (in house) to verify and validate Electronic Funds Transfer (EFT) changes in accordance with the instructions in this chapter and all other CMS directives.
- Confirm that the applicant, all individuals and entities listed on the application, and any names or entities ascertained through other sources, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG) or through the System for Award Management.

level screening.⁸ *Id.* § 424.518(c)(2). Palmetto notified Petitioner by letter dated March 20, 2015 that Petitioner was subject to such high risk screening. P. Ex. 1. Prospective home health agencies also need to have complied with CMS policies set forth in the CMS State Operations Manual (CMS Pub. 100-07), the Claims Processing Manual (CMS Pub. 100-04), and the Benefit Policy Manual (CMS Pub. 100-02). MPIM Ch. 15 § 15.4.1.6(A), (E).

The evidence shows that Palmetto assessed Petitioner's Medicare enrollment application in the first instance, notified Petitioner by letter dated September 24, 2015 that it had assessed Petitioner's enrollment application, and stated:

[t]he next step will be a survey visit conducted by a State Survey Agency or a CMS approved deemed accrediting organization to ensure compliance with required Conditions of Participation. Once the CMS Regional Office confirms that these conditions are met, we will send you our decision.

CMS Ex. 5. The language in the September 24, 2014 letter was the standard language CMS intended its contractors to use when notifying an applicant of the status of initial enrollments requiring referral to the state agency. *See* MPIM Ch. 15 § 15.24.6.1. Notably, this letter established that there were at least two additional steps outstanding in the approval process: (1) a state survey visit and (2) verification of Petitioner's compliance with Conditions of Participation (required under the regulation at 42 C.F.R. Part 484). Further, a third step not mentioned in that letter also remained outstanding: verification of adequate capitalization, as required under the regulation at 42 C.F.R. § 489.28.⁹ Moreover, the referral Palmetto sent to the state agency on September 24, 2015 includes Palmetto's recommendation for approval but does not include a provider number for Petitioner. CMS Ex. 6. Petitioner has provided no evidence to establish that the state agency had completed its survey of Petitioner, that Petitioner had satisfied the Conditions of Participations set forth in section 424.484 of the regulations, or that

⁸ High level screening includes: verification of the provider's compliance with all Federal, state, and local regulations; verification of the provider's licenses; database checks to confirm pre- and post-enrollment compliance with enrollment criteria; an on-site visit; fingerprint background check for any owner with 5% or more ownership interest in the provider; and completion of a finger-print based criminal history and FBI background check for any owner of more than 5% ownership interest in the provider. *See* § 424.518(a)(2), (b)(2), and (c)(2).

⁹ “[A]n HHA entering the Medicare program . . . must have available sufficient funds, which we term initial reserve operating funds at (1) the time of application submission, and (2) all times during the enrollment process, to operate the HHA for the three-month period after Medicare billing privileges are conveyed by the Medicare contractor[.]” MPIM Ch. 15 § 15.26.2(A).

Petitioner was adequately capitalized under section 424.489 of the regulations.¹⁰ Nor has Petitioner submitted evidence that Palmetto or CMS issued Petitioner a billing number and granted it access to the Medicare trust. Therefore, we find that substantial evidence in the record as a whole supports the ALJ Decision.

2. *The ALJ did not err when she concluded that CMS did not apply the temporary moratorium retroactively to Petitioner's enrollment application because Petitioner's application had not been approved as of the date of the imposition of the state-wide moratorium on July 29, 2016.*

As discussed above, evidence in the record does not show that Petitioner's application was ever approved. Therefore, we cannot conclude that CMS applied the moratorium retroactively to deny Petitioner's enrollment application. The temporary moratorium initially took effect on January 31, 2014. CMS Ex. 1. The moratorium, subject to extension in six-month increments at CMS's discretion, was extended through July 26, 2016, when CMS expanded its scope to encompass the entire state of Florida, effective July 29, 2016. *Id.*; 81 Fed. Reg. 51,123 (Aug. 3, 2016). Petitioner had submitted its enrollment application on December 7, 2014, but it is irrelevant that Petitioner submitted its application prior to state-wide expansion of the home health agency enrollment moratorium. CMS Ex. 3 at 3. Under the regulations, only pending enrollment applications that had "been *approved* by the enrollment contractor but not yet entered into PECOS at the time the moratorium [was] imposed" were exempt. 42 C.F.R. § 424.570(a)(1)(iv) (*italics added*). Moreover, although the regulation indicates that it is the contractor which would approve the application, CMS has the ultimate authority to grant applicants access to Medicare trust funds. As the Board has stated:

[T]he enrollment contractor (like Palmetto) acts with authority delegated by CMS. 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. *See* 42 C.F.R. § 424.516(a); *see also id.* § 424.510(a) ("CMS enrolls the provider or supplier into the Medicare program.").

¹⁰ The ALJ found that "an accrediting organization had performed a survey and made its recommendation." ALJ Decision at 5. However, we do not see where the ALJ cited to evidence in the record to support this conclusion. As neither party has raised a dispute over this specific finding, and because it does not affect our analysis of this appeal, we offer no further comment on it.

UpturnCare at 12. No evidence in the record reflects that CMS approved Petitioner's application. Petitioner effectively concedes this point in its Request for Review, stating:

The Secretary of Health and Human Services and CMS incorrectly applied a temporary moratorium that was effective as of July 29, 2016 to retroactively affect Petitioner/Appellant's enrollment application that was already *submitted* and *in the process* as of December 7, 2014.

RR at 8 (*italics added*). In addition, the plain language of the regulation explicitly exempts from the moratorium *approved* applications which await only entry into PECOS, and does *not* exempt applications in process but not yet approved. Petitioner fails to explain why expansion of the moratorium would constitute a retroactive bar to enrollment under the regulations where its application was still in process when the expansion took effect and where, as the ALJ points out, CMS has interpreted the Affordable Care Act's temporary moratorium provision as applying to pending enrollment applications. ALJ at 6-7, n.7 (citing 76 Fed. Reg. at 5919, 5965 (Feb. 2, 2011)).¹¹

Petitioner contends that, in sum, the ALJ overlooked or misunderstood its argument that the CMS had applied the 2016 moratorium expansion retroactively to its 2014 enrollment application. RR at 8-9. We disagree that the ALJ "missed" Petitioner's argument and conclude that the ALJ rejected it, stating:

Petitioner argues that application of the moratorium to [Petitioner's pending application] 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.

¹¹ The citation shows that, in response to comments to the Final Rule, CMS wrote:

In the NPRM, we indicated both in the preamble and the proposed regulations that an application to enroll in Medicare from a provider or supplier that is subject to a temporary enrollment moratorium would be denied. With regard to pending applications, we interpret the ACA as applying to pending applications. If a temporary enrollment moratorium is deemed necessary for any provider or supplier type, or for any geographic area, then all enrollment applications from unenrolled providers and suppliers of the type subject to the temporary enrollment moratorium or in the geographic area subject to the moratorium would be denied. However, we will not deny any enrollment for which the Medicare enrollment contractor has completed review of the application and has determined that the provider or supplier meets all the requirements for enrollment and all that remains is to assign appropriate billing number(s) and enter the provider or supplier into PECOS.

Id. at 76 Fed. Reg. at 5919.

ALJ Decision at 6. In reaching her conclusion, the ALJ reasoned that the statute and regulations authorizing the temporary moratorium were in effect prior to Petitioner submitting its enrollment application in 2014. ALJ Decision at 7. Further, the ALJ explained that CMS had published in the Federal Register and the Code of Federal Regulations the rules that would apply to Petitioner's Medicare enrollment, and, had Petitioner done so, Petitioner would have known that the Secretary would treat in-process applications as subject to the temporary moratorium. *Id.* We, too, reject Petitioner's retroactive application argument for the reasons we already discussed. Petitioner reiterates on appeal the argument that it had submitted, for purposes of section 424.530(a)(10), its enrollment application prior to the date on which CMS "has imposed," for purposes of section 424.570(a)(1)(iv), a temporary moratorium covering Orange County. RR at 10. Petitioner contends that the ALJ erroneously adopted CMS's interpretation of the Affordable Health Care Act's temporary moratorium provision because, in sum, the word "submits" indicates a current act in the present tense, and the phrase "has imposed" indicates a past act. *See id.* at 11-12. Thus, as a matter of chronology, Petitioner's argument suggests, CMS had not imposed its moratorium on Winter Park, Orange County in December 2014, when Petitioner submitted its Medicare enrollment application, thereby making application of the recently expanded moratorium retroactive on the previously submitted enrollment application.

Petitioner offers no persuasive support for this argument. Petitioner relies on the fallacious premise that submission of its enrollment application along with the contractor's recommendation of approval constituted approval by CMS of the application for purposes of the moratorium. Petitioner contended that the regulation makes no distinction between preliminary and final approval. RR at 12. This argument is specious in the face of the myriad requirements (which CMS policy expanded in 2011) that an enrollment application must meet for approval beyond the preliminary stage, as discussed in the first section of this analysis. *See CMS Ex. 4.* The preliminary approval on which Petitioner's argument relies occurs prior to, for example, the site survey visit and before capitalization evaluation, each of which is provided for in the regulations. For there to be no distinction between a preliminary or recommended approval and final approval would make a mockery of the entire regulatory scheme CMS has established for evaluating the enrollment applications of high-risk applicants such as home health agencies. Winter Park, Orange County became subject to the moratorium along with the rest of Florida before Petitioner's application would have reached actual approval, had it done so. Under the regulations, CMS may deny a provider's or supplier's enrollment in the Medicare program where "a provider or supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium." 42 C.F.R. § 424.530(a)(10). As of July 29, 2016, Petitioner's Medicare enrollment application was still under review and not approved by CMS and thus Petitioner's application was not exempt from the moratorium.

Finally, Petitioner argues that our decision in *UpturnCare* is not on point with this appeal because *UpturnCare* did not address the issue of retroactivity. RR. at 13. However, here, as we discussed above, the notion that the temporary moratorium was applied retroactively to Petitioner’s enrollment application rests upon on the presumption that Petitioner’s application had been approved on the effective date of the expanded moratorium, which, in turn, is based on the mistaken notion that there is no difference between preliminary (or recommended) approval and final approval, as it applies to an enrollment application. The moratorium can be said to have been applied retroactively here only if we were to adopt Petitioner’s expansive definition of “approved” to trigger an exemption for applications submitted for enrollment in geographic areas not yet covered by the moratorium. Consistent with our decision in *UpturnCare*, we reject Petitioner’s argument that there is no difference between a preliminary and final approval for purposes of applying a temporary moratorium to an enrollment application.

In promulgating the enrollment regulations, CMS specified that recommended approval and approval have different meanings. As we said in *UpturnCare*:

[A] “recommendation for approval” means only that the application has cleared the initial step. It precedes the next step, the survey and certification process, which also must be cleared.

* * * *

The term “approved,” in contrast, contemplates a determination to allow enrollment following successful completion of the entire review process. Section 424.502 defines the term “Approve/Approval” to mean that “the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges,” which, [. . .], is a determination that CMS makes.

UpturnCare at 13-14 (citing 75 Fed. Reg. 50,042, 50,402 (Aug. 16, 2010)). Also in *UpturnCare*, we explained that CMS had issued a letter (the “S&C Letter”) regarding a 2013 moratorium covering Miami, Florida and Chicago, Illinois (later expanded to encompass Dallas, Texas), in which it explained the meaning of the word “approved” as it relates to the applicability of the moratorium.¹² *Id.* at 14. The S&C Letter states

¹² On August 9, 2013, CMS’s Center for Clinical Standards and Quality/Survey & Certification Group issued a S&C Letter, S&C: 13-53-HHA, addressed to all State Survey Agency Directors, explaining how CMS would apply a temporary moratorium that became effective on July 30, 2013 in the Miami, Florida and Chicago, Illinois areas. Although this S&C Letter was issued before the January 30, 2014 moratorium at issue in *UpturnCare* (as well as prior to the moratorium at issue in this appeal), we nevertheless found it instructive there, as we do here, on the meaning of the word “approved” as it relates to the applicability of the moratorium. *See id.*

(Italics added):

Prospective HHA applications within the affected areas which were **not approved** prior to [the effective date] will be denied by the [MAC]. *Approved means that by 12:00 AM [the effective date] the initial certification survey was completed; the second MAC review was completed; the CMS Regional Office (RO) sent the tie-in notice to the MAC; the MAC performed a site visit and the MAC decided to switch the HHA's [PECOS] record to an "approved" status. (Citation omitted.)*

Id. Accordingly, Palmetto's approval recommendation does not equate to CMS's approval for purposes of an exemption to the temporary moratorium under section 424.570(a)(1)(iv) of the regulations. Therefore, the ALJ did not err when she rejected Petitioner's retroactive application argument.

Conclusion

For the foregoing reasons, we affirm the ALJ's decision.

/s/

Leslie A. Sussan

/s/

Constance B. Tobias

/s/

Christopher S. Randolph
Presiding Board Member