Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of: Ben Rad, M.D., Petitioner, - v.- The Inspector General.	DATE: April 14, 1994 Docket No. C-93-076 Decision No. CR308

DECISION

On March 23, 1993, the Inspector General (I.G.) notified Petitioner that he was being excluded from participation in the Medicare program and from certain federally-assisted State health care programs for a period of three years.[1] The I.G. told Petitioner he was being excluded under section 1128(b)(3) of the Social Security Act (Act), based on Petitioner's conviction of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Petitioner requested a hearing and the case was assigned to me. I scheduled an in-person hearing in this case to begin on October 5, 1993. However, during a telephone conference on August 18, 1993, Petitioner waived his right to an in-person hearing and the parties requested that I decide the case on written briefs and exhibits. On August 19, 1993, I issued a prehearing order in which I established a briefing schedule.

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[1] The State health care programs from which Petitioner was excluded are defined in section 1128(h) of the Social Security Act and include the Medicaid program under Title XIX of the Act. Unless the context indicates otherwise, I use the term "Medicaid" here to refer to all State health care programs listed in section 1128(h).

Petitioner subsequently filed a brief accompanied by proposed findings of fact and conclusions of law, and four declarations.[2] The I.G. filed a responsive brief, proposed findings of fact and conclusions of law, and seven exhibits.[3] Petitioner filed a reply brief, to which the I.G. responded with an additional brief.[4]

I have carefully considered the evidence, the parties' arguments, and the applicable laws and regulations. I conclude that, pursuant to the criteria specified in 42 C.F.R. § 1001.401, the three-year exclusion is reasonable.

ADMISSION

Petitioner does not dispute that he was convicted of a criminal offense within the meaning of section 1128(b)(3) of the Act. June 29, 1993 Order and Notice of Hearing at p. 2.

ISSUE

The issue in this case is whether it is reasonable to exclude Petitioner for three years.

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[2] The four declarations were from Petitioner, Tyrone Arrington, Shelia Blake, and Mildred Goodwin. None of the declarations are marked as exhibits. I will refer to Petitioner's declaration as P. Ex. 1, that of Tyrone Arrington as P. Ex. 2, that of Shelia Blake as P. Ex. 3, and that of Mildred Goodwin as P. Ex. 4. In addition, none of the exhibits, with the exception of P. Ex. 1, were paginated. I have numbered each page of P. Ex. 2 - 4 in accordance with the instructions in my August 19, 1993 prehearing order.

[3] The I.G. marked and identified these exhibits as I.G. Ex. 1 - 7. The I.G. filed copies of the declaration of Christine Owens with the I.G.'s initial brief as I.G. Ex. 6. By letter dated January 7, 1994, the I.G. supplied my office with the original declaration signed by Ms. Owens. I then substituted the original declaration for the previously filed copy of Ms. Owens' declaration contained in the record.

[4] Neither party has contested the authenticity or otherwise objected to the exhibits submitted by the opposing party. I am admitting the exhibits into evidence as P. Ex. 1 - 4 and I.G. Ex. 1 - 7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW (FFCLs)

1. Petitioner is a physician licensed to practice medicine in the State of California. P. Ex. 1.

2. On March 6, 1992, the California Attorney General's Office filed an eight count complaint against Petitioner in the Fresno County Municipal Court. I.G. Ex. 2 at pp. 4 - 7.

3. The complaint charged Petitioner with one felony count of offering falsified documentary evidence, one felony count of preparing falsified documentary evidence, three felony counts of prescribing controlled substances without medical justification, two felony counts of furnishing controlled substances outside the regular practice of his profession, and one misdemeanor count of creating a false medical record. I.G. Ex. 2 at pp. 4 - 7.

4. On June 2, 1992, Petitioner pled guilty to two misdemeanor offenses: (1) creating a false medical record; and (2) prescribing a controlled substance without medical justification. I.G. Ex. 1, I.G. Ex 2 at p. 2.

5. The court accepted Petitioner's guilty plea and sentenced him to: (1) serve three years informal probation on the condition he serve one year in county jail, all but 15 days suspended; (2) perform 100 hours of community service; and (3) pay the $7,500 cost of the investigation to the Department of Justice, Bureau of Medi-Cal Fraud.[5] I.G. Ex. 1, I.G. Ex. 2 at p. 1.

6. Petitioner was convicted of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, within the meaning of section 1128(b)(3) of the Act. FFCLs 2 - 5; June 29, 1993 Order and Notice of Hearing at p. 2.

7. The Secretary of the Department of Health and Human Services (Secretary) delegated to the I.G. the authority to determine, impose, and direct exclusions pursuant to section 1128 of the Act. 48 Fed. Reg. 21,662 (1983).

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[5] In California, the Medicaid program is known as Medi-Cal. I.G. Ex. 7.

8. By letter dated March 23, 1993, the I.G. excluded Petitioner pursuant to section 1128(b)(3) of the Act for a period of three years.

9. The I.G. has authority to impose and direct an exclusion against Petitioner pursuant to section 1128(b)(3) of the Act. FFCLs 6 - 7.

10. Regulations published on January 29, 1992 establish criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to section 1128 of the Act. 42 C.F.R. Part 1001 (1992).

11. On January 22, 1993, the Secretary published a regulation which directs that the criteria to be employed by the I.G. in determining to impose and direct exclusions pursuant to sections 1128(a) and (b) of the Act are binding also upon administrative law judges, appellate panels of the Departmental Appeals Board (DAB), and federal courts in reviewing the imposition of exclusions by the I.G. 42 C.F.R. § 1001.1(b).

12. My adjudication of the length of the exclusion in this case is governed by the criteria contained in 42 C.F.R. § 1001.401. FFCLs 10 - 11.

13. An exclusion imposed pursuant to section 1128(b)(3) of the Act must be for a minimum period of three years, unless aggravating or mitigating factors as specified in the regulations form a basis for lengthening or shortening that period. 42 C.F.R. § 1001.401(c)(1).

14. The I.G. has the burden of proving that aggravating factors exist which justify increasing an exclusion imposed pursuant to section 1128(b)(3) of the Act beyond the three-year benchmark established by regulation. 42 C.F.R. § 1001.401(c)(2)(i) - (iv); 42 C.F.R. § 1005.15(c).

15. The I.G. did not allege that aggravating factors are present in this case which justify increasing the exclusion imposed pursuant to section 1128(b)(3) of the Act beyond the three-year benchmark established by regulation.

16. Petitioner has the burden of proving that mitigating factors exist which justify reducing an exclusion below the three-year benchmark established by regulation. 42 C.F.R. § 1001.401(c)(3)(i) - (ii); 42 C.F.R. § 1005.15(c).

17. Petitioner alleged that, as a result of his exclusion, alternative sources of the type of health care items or services that he furnishes are not available within the meaning of 42 C.F.R. § 1001.401(c)(3)(ii).

18. In order to qualify as an alternative source within the meaning of the regulations, the alternative source must be able to substitute for the items or services furnished by the excluded provider without jeopardizing the health of the recipients of those items or services. James H. Holmes, M.D., DAB CR270 (1993); Sam Williams, Jr., M.D., DAB CR287 (1993).

19. An alternative source of health care is not available within the meaning of the regulations in circumstances where Medicare and Medicaid beneficiaries and recipients are not able to reasonably obtain the type of health care items or services furnished by the excluded provider in a practicable manner consistent with the Secretary's objective to protect beneficiaries and recipients from being deprived of needed health care as a result of the provider's exclusion. Holmes, DAB CR270; Williams, DAB CR287.

20. Petitioner completed a four-year residency in internal medicine in 1984. P. Ex. 1.

21. Petitioner has been engaged in the general practice of medicine in Fresno, California since approximately 1985. P. Ex. 1.

22. Prior to his exclusion, approximately 95% of the patients under Petitioner's care were Medicare and Medicaid patients. P. Ex. 1.

23. Approximately one third of Petitioner's patients were developmentally disabled or mentally retarded patients. Most of these patients resided in board and care facilities. P. Ex. 1.

24. Virtually all of the developmentally disabled or mentally retarded patients treated by Petitioner were either Medicare beneficiaries or Medicaid recipients. P. Ex. 1.

25. Prior to his exclusion, Petitioner provided medical services to residents of three board and care facilities in Fresno: Goodwin Family Home, Shady Grove Care Home, and Adler Care Home. P. Ex. 2, P. Ex. 3, P. Ex. 4, I.G. Ex. 4.

26. Prior to his exclusion, Petitioner treated residents of the three board and care facilities promptly when they needed medical care. P. Ex. 1, P. Ex. 2, P. Ex. 3, P. Ex. 4.

27. Since Petitioner was excluded, Dr. Rob Smith has been the attending physician for residents of Goodwin Family Home. P. Ex. 4 at p. 1.

28. Since Petitioner was excluded, Dr. Rob Smith, Dr. Warden Session, and Dr. Chia Chen have been the attending physicians for residents of Shady Grove Care Home. P. Ex. 4 at p. 1.

29. Since Petitioner was excluded, Dr. Avule and Dr. Baker have been the attending physicians for residents of Adler Care Home. P. Ex. 4 at p. 1.

30. The three board and care facilities use Fresno Community Hospital for emergency medical services. P. Ex. 4 at p. 1.

31. Many of the residents of the three board and care facilities have received medical treatment numerous times since Petitioner was excluded. The record is devoid of evidence establishing that the health of any of the residents has been jeopardized as a result of delays in obtaining medical treatment. P. Ex. 4.

32. The residents of the three board and care facilities have received adequate medical care in a timely fashion since Petitioner's exclusion. I.G. Ex. 3, I.G. Ex. 4; FFCLs 27 - 31.

33. The record is devoid of evidence establishing that Petitioner's former patients who are not residents of the three board and care facilities have been unable to obtain alternative medical care since Petitioner's exclusion.

34. Petitioner has not met his burden of proving that by virtue of his exclusion, alternative sources of the type of health care items or services that he provides are not available.

35. Petitioner has not proved the presence of any mitigating factors under 42 C.F.R. § 1001.401(c)(3).

36. There is no basis under the regulations for me to modify the three-year exclusion which the I.G. imposed against Petitioner.

37. The three-year exclusion which the I.G. imposed is reasonable pursuant to the criteria specified in 42 C.F.R. § 1001.401.

RATIONALE

Petitioner does not dispute that he was convicted of a criminal offense within the meaning of section 1128(b)(3) of the Act and that the I.G. has the authority to exclude him from participating in the Medicare and Medicaid programs. What is at issue here is whether it is reasonable to exclude Petitioner for a period of three years.

I. This case is governed by regulations published on January 29, 1992 and January 22, 1993.

During the June 17, 1993 prehearing conference, I expressed the view that my adjudication of the reasonableness of the length of the exclusion in this case is governed by the criteria contained in the Secretary's implementing regulations that were initially published on January 29, 1992 and subsequently clarified on January 22, 1993. June 29, 1993 Order and Notice of Hearing at p. 2. The parties have not argued that this interpretation is in error.

The I.G. contends that a three-year exclusion is reasonable pursuant to the criteria for determining the length of exclusions contained in the regulations adopted by the Secretary on January 29, 1992 and clarified on January 22, 1993. Petitioner contends that the three-year exclusion imposed by the I.G. is excessive under the applicable regulations. In resolving this issue, it is instructive to discuss the criteria for adjudicating the reasonableness of the length of exclusions contained in the regulations.

The controlling regulations at 42 C.F.R. § 1001.401 establish a benchmark of three years for all exclusions imposed pursuant to section 1128(b)(3) of the Act. The regulations mandate that, in cases of exclusions imposed pursuant to section 1128(b)(3) of the Act, the exclusion will be for three years unless specified aggravating or mitigating factors form a basis for lengthening or shortening the exclusion. 42 C.F.R. § 1001.401(c)(1). The standard for adjudication contained in the regulations provides that, in appropriate cases, exclusions imposed pursuant to section 1128(b)(3) may be for more than three years where there exist aggravating factors (identified by 42 C.F.R. § 1001.401(c)(2)) that

support a lengthening of the exclusion while taking into consideration any mitigating factors which might be present (identified by 42 C.F.R. § 1001.401(c)(3)). Similarly, an exclusion imposed pursuant to section 1128(b)(3) may be for a period that is less than three years where there exist mitigating factors which warrant a reduction in the length of the exclusion even with consideration of any of the aggravating factors which might be present.

The regulations specifically state those factors which may be classified as aggravating and those factors which may be classified as mitigating. Under the regulatory scheme, evidence which relates to factors which are not among those specified as aggravating or mitigating is not relevant to adjudicating the length of an exclusion and cannot be considered.

In this case, the I.G. imposed the three-year benchmark exclusion. The I.G. does not contend that there are aggravating factors present in this case which are sufficiently serious to justify lengthening the exclusion beyond the three-year benchmark period. I.G. brief at p. 5. Thus, the only disputed issue before me is whether the length of Petitioner's exclusion should be shortened below the three-year benchmark period. The possible mitigating factors which can be considered as a basis for shortening the three-year benchmark period of exclusion are very limited. The applicable regulation provides that only the following factors may be considered:

> (i) The individual's or entity's cooperation with Federal or State officials resulted in -
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> (A) Others being convicted or excluded from Medicare or any of the State health care programs, or
>
> (B) The imposition of a civil money penalty against others; or
>
> (ii) Alternative sources of the type of health care items or services furnished by the individual or entity are not available.

42 C.F.R. § 1001.401(c)(3)(i) - (ii).

Citing the mitigating circumstance identified at 42 C.F.R. § 1001.401(c)(3)(ii), Petitioner asserts that his exclusion is unreasonable because alternative sources of the type of health care items or services he furnishes are not available. Petitioner contends that the presence of this factor in this case justifies a reduction in the length of his exclusion from three years to one year. Petitioner brief at p. 1. The I.G. contends that the

evidence fails to establish that this mitigating factor is present in this case. I.G. brief at p. 5.

In addition, the I.G. contends that the aggravating factor specified at 42 C.F.R. § 1001.401(c)(2)(iii), the sentence imposed by the court included incarceration, is present in this case. While the I.G. chose not to impose an exclusion greater than three years based on this factor, the I.G. asserts that this factor has sufficient weight to offset any weight I accord to the mitigating factor specified at 42 C.F.R. § 1001.401(c)(3)(ii). I.G. brief at p. 19. The I.G. reasons that even if I were to find that the mitigating factor at 42 C.F.R. § 1001.401(c)(3)(ii) is present, the three-year exclusion should still be upheld based on the presence of the aggravating factor at 42 C.F.R. § 1001.401(c)(2)(iii).

In analyzing the evidence in this case, my task is to first determine whether the mitigating factor cited by Petitioner is present. If I determine that this factor is not present, my inquiry ends. Under these circumstances, there would not be any basis to shorten the three-year exclusion pursuant to the criteria established by the regulations. If I determine that this factor is present, my task is to evaluate the reasonableness of the three-year exclusion by determining the relative weight of this mitigating factor in the context of any aggravating factors which are present. Accordingly, I will now consider the threshold question of whether the mitigating factor cited by Petitioner, that alternative sources of the type of health care items or services he furnishes are not available, is present in this case.

II. Petitioner has the burden of proving mitigating circumstances, including the burden of proving that alternative sources of health care items or services of the type he furnishes are not available.

There is no specific regulation allocating the burden of proof regarding aggravating and mitigating factors in exclusion cases under 42 C.F.R. § 1001.401. However, 42 C.F.R. § 1005.15(c) expressly reserves the duty of allocating such burdens to administrative law judges.

A fair reading of the regulations supports the conclusion that the Secretary intended the mitigating factors be in the nature of affirmative defenses to the imposition of the mandated three-year exclusion. See, 42 C.F.R. § 1005.15(b). It does not make practical sense to require the I.G. to prove a negative -- the absence of mitigating circumstances -- in cases where the I.G. has imposed the

regulation-mandated minimum exclusion. Furthermore, allocation of the burden of proof on Petitioner to prove any mitigating factor is consistent with decisions in exclusion cases issued prior to promulgation of the current regulations and with decisions issued subsequent to such regulations. Bernardo G. Bilang, M.D., DAB 1295 (1992); Jose Ramon Castro, M.D., DAB CR259 (1993); James H. Holmes, M.D., DAB CR270 (1993); Sam Williams, Jr., M.D., DAB CR287 (1993); Joseph Weintraub, M.D., DAB CR303 (1994).

III. For the mitigating factor at 42 C.F.R. § 1001.401(c)(3)(ii) to apply, Petitioner must prove that his exclusion will result in a reduction in health care services to the point that obtaining comparable sources of health care imposes an unreasonable hardship on Medicare and Medicaid beneficiaries and recipients.

A purpose of the exclusion law is to protect the beneficiaries and recipients of federally-funded health care programs from incompetent practitioners and from inappropriate or inadequate care. S. Rep. No. 109, 100th Cong., 1st Sess. 1, reprinted in 1987 U.S.C.C.A.N. 682. The regulation at 42 C.F.R. § 1001.401(c)(3)(ii) contemplates that, in determining the appropriate duration of an exclusion, the factfinder will consider Congress' interest in ensuring the protection of Medicare and Medicaid beneficiaries and recipients and will balance that interest against the competing interest of ensuring that beneficiaries and recipients will not be deprived of needed health care as a result of a provider's exclusion. Holmes, DAB CR270, at 15 - 16.[6]

As I observed in Holmes, the mitigating factor specified in 42 C.F.R. § 1001.401(c)(3)(ii) (that alternative sources of the type of health care items or services furnished by the individual or entity are not available) is not defined by statute. I found, however, that to qualify as an "alternative source" within the meaning of the regulations, the alternative source must provide health care items or services that are comparable or equivalent in quality to the type of items or services provided by the excluded provider. The alternative

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[6] In Holmes, I set forth the legal standard which I am following in this case. Both Dr. Holmes and the Petitioner here were excluded for three years pursuant to section 1128(b)(3) of the Act. Both Dr. Holmes and the Petitioner here argued that the mitigating factor at 42 C.F.R. § 1001.401(c)(3)(ii) is a basis for reducing their three-year exclusions.

source must be able to substitute for the items or services furnished by the excluded provider without jeopardizing the health of the recipients of those items or services. Holmes, DAB CR270, at 13.

The alternative source must also be "available." In Holmes, I found that alternative sources are not available within the meaning of the regulations if such sources are not reasonably available. This standard contemplates that an alternative source is not available in circumstances where Medicare and Medicaid patients are not able to reasonably obtain the type of medical services provided by the excluded provider in a practicable manner consistent with the Secretary's objective to protect program beneficiaries and recipients from being deprived of needed health care as a result of the provider's exclusion. For example, an alternative source of health care might be identified as being present to provide the type of health care provided by the excluded provider. However, that alternative source would not be "available" within the meaning of the regulations if it is located at such a great distance in miles from the excluded provider's former Medicare and Medicaid patients that obtaining the alternative health care would result in an unreasonable hardship to those patients.

On the other hand, merely showing that the consequence of an exclusion is a reduction in the availability of health care services is not tantamount to showing that those services are not available. Certainly, any provider could show that health care services are less available because the provider is excluded. However, in order for the mitigating factor at 42 C.F.R. § 1001.401(c)(3)(ii) to apply, there must be a showing that a consequence of an exclusion is a reduction in health care services to the point that obtaining alternative sources of health care is so impractical that it imposes an unreasonable hardship on Medicare and Medicaid beneficiaries and recipients. This is a far more stringent test to meet than showing merely a reduction in the availability of health care. Holmes, DAB CR270, at 14.

In addition, language in the preamble to the January 29, 1992 regulation indicates that reasonable availability of alternative sources of health care must be viewed in the context of the Medicare and Medicaid programs. The preamble to the regulations states that, in evaluating the availability of alternative sources of health care pursuant to 42 C.F.R. § 1001.401(c)(3)(ii), the Secretary contemplates that the factfinder "will look to whether there are service providers who accept Medicare and

Medicaid patients, rather than merely whether services are available generally." 57. Fed. Reg. 3316 (1992). Under this standard, alternative sources of health care of the type furnished by an excluded provider are not reasonably available within the meaning of the regulations if program beneficiaries and recipients cannot use that source, such as in the situation where the alternative health care provider does not participate in the Medicare or Medicaid programs.

IV. Petitioner has not met his burden of proving that by virtue of his exclusion, alternative sources of the type of health care items or services he provides are not available.

Based on my review of the evidence of record, I conclude that Petitioner has failed to sustain his burden of proving that alternative sources of the type of health care he provides are not available.

Petitioner is a physician licensed to practice medicine in the State of California. FFCL 1. Petitioner completed a four-year residency in internal medicine in 1984. FFCL 20. Petitioner has been engaged in the general practice of medicine in Fresno, California since approximately 1985. FFCL 21. Prior to his exclusion, approximately 95% of the patients under Petitioner's care were Medicare and Medicaid patients. FFCL 22. Approximately one third of Petitioner's patients were developmentally disabled or mentally retarded patients. Most of these patients resided in board and care facilities. FFCL 23. Virtually all of the developmentally disabled or mentally retarded patients treated by Petitioner were either Medicare beneficiaries or Medicaid recipients. FFCL 24.

Petitioner contends that as a consequence of his exclusion, the developmentally disabled and mentally retarded patients treated by him prior to his exclusion have been unable to obtain needed medical services. Based on this, Petitioner argues that, by virtue of his exclusion, alternative sources of the type of health care services that he provides are not available to this segment of the patient population in the Fresno area of California. Petitioner brief at pp. 1 - 2.

In support of this contention, Petitioner submits his own declaration. Petitioner asserts in his declaration that it "is very difficult to find physicians who will take [Medicaid] or Medicare patients in the Fresno [area], and particularly difficult to find physicians who will take such patients who also are either developmentally

disabled or mentally disabled." According to Petitioner, his former Medicare and Medicaid patients who are developmentally disabled or mentally retarded "have been unable to find adequate medical services" since his exclusion went into effect. P. Ex. 1.

Petitioner states in his declaration also that he has "always made it a practice to find room on my schedule to see such patients immediately, if necessary and within a day if they can wait a day, regardless of their disabilities and regardless of their ability to pay my fees." Petitioner then expresses the view that "there are not reasonably available to developmentally disabled and mentally retarded patients on [Medicaid] or Medicare, comparable services from other physicians in the Fresno area."

The burden of proving that alternative sources of health care are unavailable is on Petitioner. Absent additional evidence to support his declaration, Petitioner's self-serving assertion that alternative sources of health care are unavailable is not sufficient to sustain Petitioner's burden of proof. Petitioner's assertions are vague and are not specific as to the number and identity of patients, the frequency that physician services were sought and not rendered timely and whether the failure to obtain "prompt" medical services resulted in any harm to the patients.

Petitioner states in his declaration that he bases his assertions on his "knowledge of the services available in the Fresno area and of the services provided by me." While Petitioner may have personal knowledge of the services he provides, he has not established that he is sufficiently knowledgeable regarding the availability of the medical resources in Fresno to render a competent opinion on the availability of alternative sources of health care.

The only references Petitioner makes to independent sources of information to support his assertions are "conversations" with unnamed individuals. Specifically, Petitioner states that his assertions are based on conversations with various patients, parents or guardians of mentally retarded patients, and proprietors of board and care facilities in the Fresno area. Petitioner has not offered declarations from any of his patients or the parents or guardians of mentally retarded patients to corroborate his "conversations" with them. While Petitioner has produced declarations from the

administrators of three board and care facilities[7] located in Fresno, he has offered no evidence to corroborate his statements with respect to the experience of other board and care facilities in the Fresno area. In addition, the three declarations from administrators of board and care facilities which Petitioner did provide are not sufficient to establish that alternative sources of health care are unavailable to developmentally disabled and mentally retarded patients in Fresno.

The administrators' declarations contain sweeping statements to the effect that since Petitioner was excluded, they have been unable to obtain adequate medical care for the residents of their facilities. Although all three administrators make strong statements that adequate medical care for the residents of their facilities has been unavailable since Petitioner's exclusion, none of them provide any convincing support for these statements. The only specific reason given for these statements is that there are delays in getting residents of their facilities seen by physicians.

Each of the three administrators state that, prior to his exclusion, Petitioner was willing to treat the residents of their facilities promptly when they needed medical attention. Each of the three administrators complain that they have been unable to find another physician who is willing to provide the same prompt service. In describing this problem, Tyrone Arrington states:

> First, it is extremely difficult to find doctors who will take [Medicaid] patients at all. Secondly, when we can find a physician who will see our clients, that physician will generally require an appointment at least three weeks in advance. Our patients are generally patients with behavior problems who are in wheel chairs and who simply cannot wait 3 weeks to receive medical care. We do

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[7] These three declarations are from individuals who describe themselves, respectively, as: the administrator of a "residential care home for [five] developmentally disabled adults" (P. Ex. 2); the administrator of a "board and care facility for [five] developmentally disabled adults" (P. Ex. 3); and the administrator of a "boarding care facility with six developmentally disabled residents" (P. Ex. 4). In his own declaration, Petitioner refers to these facilities collectively as "board and care facilities," and that term will be used here. These facilities have a total of sixteen residents.

> have available to us emergency rooms for various emergencies but many times our clients have problems which require that a physician see them on that day or the following day and which do not warrant use of the emergency room. For those instances, we simply have been unable to find medical care since [Petitioner's] exclusion. [Petitioner] always made himself available for our patients and would move his schedule around so that he would see and treat our patients on the day that they had a problem.
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> I have searched for a physician to care for our patients all over Fresno and have been unable to find anyone willing to tend to our patients on a timely basis.

P. Ex. 2 at pp. 1 - 2.

Ms. Blake makes a similar complaint in her declaration:

> Often our clients will have a problem like a small infection or an unexplained swelling or some fever which will require medical care. In those instances, the matter is not serious enough for the use of an emergency room but requires that our clients be able to see a doctor within a day or two. I have been unable to find doctors who are willing to see our clients unless an appointment is made weeks in advance.

P. Ex. 3 at p. 1.

Ms. Goodwin, the third administrator, states that since Petitioner's exclusion:

> we have no medical services available to us other than emergency services at the hospital unless we are willing to wait months. I have looked for physicians who will see our patients throughout Fresno and have been unable to find anyone other than physicians who are willing to see our patients if arrangements are made three months in advance.
>
> When [Petitioner] was seeing our patients and they would become ill with the flu or have some other problem which required medical attention, we could bring our residents over to his office right away and he would tend to their medical needs. One example of the problems we have had is the recent case where the patient . . . had pneumonia. We were unable to find a physician to see that patient and finally the caseworker was able to find a physician

> who saw the patient some three weeks later. When [Petitioner] was tending to the needs of our patients we could have brought that patient into his office on the day that the problem arose or the following day.

P. Ex. 4 at pp. 1 - 2.

The only problem with medical care identified by the three administrators is one of delay, which, according to the declarations, varies from three weeks to three months. In Holmes, as in this case, there was evidence that some of Dr. Holmes' former patients experienced delays in making an appointment with another physician after Dr. Holmes was excluded. I concluded that the fact that some of Dr. Holmes' former patients had to wait to see a physician is not a basis for finding that alternative sources of medical care are not available. Holmes, DAB CR270, at 22. There must be an affirmative showing that the delays in obtaining medical care jeopardized the health and safety of Petitioner's patients.

Apparently, the administrators recognized the availability of medical facilities to respond to the emergency care needs of their residents. They imply that there is a need for an additional level of care for their residents -- one of urgent care for medical problems requiring prompt attention but not arising to the level of an emergency. While the administrators have indicated that it is difficult to make appointments with local physicians to provide such care, Petitioner has offered no evidence to demonstrate that "urgent care" medical facilities[8] are unavailable in such circumstances.

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[8] This term is used to describe clinics or other medical facilities that see patients without the need for advance appointments and on a first-come, first-served basis. As I mention at footnote 12 of this Decision, the I.G. has produced evidence identifying two hospitals in Fresno which have urgent care clinics that will treat residents of board and care facilities on a walk-in, same-day basis. Conceivably, obtaining care at such urgent care clinics might result in time consuming queuing while waiting to obtain medical services. However, while this might inconvenience the personnel accompanying the residents and the residents themselves, Petitioner has offered no evidence that this would jeopardize the health or safety of such residents. Moreover, rather than relying on "urgent care" medical

(continued...)

Petitioner has not shown that any delay in obtaining medical services jeopardized the health or safety of any resident. In fact, all three declarations indicate that emergency medical care is available to developmentally disabled residents of board and care facilities in Fresno. It can be inferred from this that medical care is available in situations where a board and care resident has a medical problem requiring immediate medical attention. The administrators complain that residents of their facilities have experienced delays in receiving medical care for non-emergency medical conditions which nonetheless require prompt medical attention. However, they have not provided one specific instance showing that the health of a board and care resident has been jeopardized by the delays of which they complain. At most, the administrators' declarations show that the board and care residents have been inconvenienced by these delays.[9] As I stated in Holmes, inconvenience is not the standard to be used in applying the mitigating factor under 42 C.F.R. § 1001.401(c)(3)(ii). Holmes, DAB CR270, at 23. In view of the foregoing, Petitioner has failed to meet his burden of proving that the mitigating circumstance specified at 42 C.F.R. § 1001.401(c)(3)(ii) is present in this case.

V. An investigation conducted by the California Department of Social Services establishes that the residents of the three board and care facilities relied upon by Petitioner to demonstrate the lack of alternative medical sources instead have received needed medical services in a timely fashion since Petitioner was excluded from the Medicare and Medicaid programs.

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[8](...continued)
facilities, the administrators appear to prefer to wait for an appointment with a local physician, either for an office visit or care rendered at the board and care facility itself. Any delay associated with the latter circumstance would be generated by the decisions of the administrators rather than the lack of adequate alternative medical sources.

[9] The results of a detailed examination of the records of medical care rendered to the residents at these facilities shows that such persons were able to obtain timely care from physicians in the Fresno area subsequent to the exclusion of Petitioner. See, Section V., pages 17 - 24 of this Decision.

The I.G. has produced persuasive evidence which rebuts Petitioner's contention that alternative sources of health care are not available in Fresno.

Randall K. Brooks, counsel for the I.G., provided copies of the four declarations submitted by Petitioner to David Guinan, the Manager of the Fresno District Office of the California Department of Social Services Community Care Licensing Branch (Department of Social Services). This office is responsible for licensing board and care facilities for developmentally disabled and mentally retarded individuals in Fresno. I.G. Ex. 3.

In discharging this function, the Department of Social Services is responsible for conducting investigations and inspections of board and care facilities in Fresno to determine whether such facilities are in compliance with applicable State statutory and regulatory criteria for lawful operation. The operators of board and care facilities are responsible under State law for arranging appropriate medical care for facility residents and for providing transportation for the residents in connection with that medical care. I.G. Ex. 3.

Upon reviewing the declarations provided to him by Mr. Brooks, Mr. Guinan initiated an investigation of the three board and care facilities whose administrators signed the declarations. The three board and care facilities investigated by Mr. Guinan's office are the Goodwin Family Home, Shady Grove Care Home, and Adler Care Home.[10] The purpose of the investigation was to delve further into the statements made by the three administrators in their declarations to determine whether residents of their board and care facilities have received adequate medical care since March 23, 1993, the date Petitioner was excluded. I.G. Ex. 3, I.G. Ex. 4.

On December 13, 1993, two investigators under Mr. Guinan's supervision visited each of the three facilities. One of the investigators personally interviewed the administrators who signed the declarations, and completed written reports of these interviews. The other investigator reviewed the medical records of each resident maintained at these facilities. That investigator recorded information concerning medical

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[10] Declarant Sheila Blake is the administrator of Goodwin Family Home; Declarant Mildred Goodwin is the administrator of Shady Grove Care Home; Declarant Tyrone Arrington is the administrator of Adler Care Home. I.G. Ex. 4.

treatments received by the facilities' residents, including each appointment with a physician since March 1993. The two investigators then discussed the results of their investigation with Mr. Guinan. I.G. Ex. 3, I.G. Ex. 4.

Mr. Guinan reported on the results of the investigation in a December 14, 1993 letter to Mr. Brooks, stating:

> 1. Each client had an attending physician[.] [A]t the Goodwin [Family] Home, Dr. Rob Smith was in attendance. Shady Grove Care Home used Dr. Rob Smith, Dr. Warden Session, and Dr. Chia Chen. Adler Care Home used Dr. Avule and Dr. Baker.[11]
>
> 2. In reviewing the records, Analysts determined that many of the clients saw physicians numerous times during the last year. At no time was it determined clients failed to receive needed medical care in anything other than a timely fashion.
>
> 3. In discussing medical resources available to the clients, Licensees/Administrators stated all clients had an attending physician. Arrangements had also been made for emergency services at Fresno Community Hospital. They also stated that at no time did clients go without timely medical treatment. Their impression of medical care available to their clients was rated as good.

I.G. Ex. 4 at p. 1. Based on these results, the Department of Social Services concluded that "at no time since March 1993 has any facility resident failed to receive needed medical attention in anything other than a timely fashion." I.G. Ex. 3 at p. 4.

Petitioner attacks the conclusions of the Department of Social Services by questioning the credibility of statements made by the three administrators during the investigation. Petitioner argues that administrators of board and care facilities "are understandably unwilling to state directly that they are not providing necessary

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[11] A review of the investigator's notes concerning medical treatments received by facility residents shows that these attending physicians identified by Mr. Guinan were not the only physicians who treated the board and care residents during the relevant period. In addition to receiving treatment from these attending physicians, there are several instances where other physicians were consulted when necessary.

medical services to the patients of their facilities when asked that question by the licensing authority in the state." Petitioner reply brief at pp. 1 - 2.

I agree with Petitioner that there are strong pressures on administrators of board and care facilities to portray the medical care provided to residents in their facilities in a favorable light in responding to inquiries from the State agency responsible for their licenses. However, even taking these pressures into account, I find the conclusion of the Department of Social Services' investigation to be reliable and credible.

The Department of Social Services based its conclusion not only on interviews with the three administrators, but also on an independent review of medical documentation. A thorough review of the medical records of each facility resident was conducted, including an examination of every medical appointment made since Petitioner was excluded. The Department of Social Services did not find anything in these medical records which would lead to the conclusion that any of the facility residents had received inadequate medical care. Instead, the Department of Social Services found that the medical records were consistent with the statements made by the administrators in their interviews, and that both the interviews and the medical documentation supported the conclusion that facility residents had received needed medical care in a timely fashion since Petitioner was excluded.

Petitioner argues also that, while the administrators of the facilities may have been unwilling to state directly that their residents were not receiving necessary medical care, they nonetheless made various statements in the course of their interviews with the investigator that suggested this. Petitioner goes on to argue this point by quoting fragments of the interview reports.

For example, Ms. Blake reportedly told the investigator that a physician named Rob Smith has been treating the residents of her facility and that she "would like it if (Dr. Smith) made house calls." Petitioner argues that this statement "strongly suggests that Dr. Smith is really not meeting the needs of the client population formerly served by [Petitioner]." Petitioner reply brief at p. 2.

In making this argument, Petitioner fails to mention other statements made by Ms. Blake in her interview. When Ms. Blake's statement to the investigator is read in

context, it contradicts Petitioner's interpretation of her words. The investigator's interview report states the following:

> . . . Dr. Rob Smith has been the medical doctor providing services. Dr. Smith[']s services have met all her clients needs and he has provided them on [a] timely basis. An example of this was when one of her clients developed a case of cellulitis. Mrs. Blake contacted Dr. Smith's office on a Thursday [and] the client was seen on Friday.
>
> Mrs. Blake stated that her client[s] have never had a medical emergency when medical services were not available. At the facility if [a] medical emergency [arises] the client is taken to the Community Hospital at which time Dr. Smith is contacted . . .
>
> Mrs. Blake state[s] that she has the utmost respect for Dr. Smith and that his services have never been lacking. She would like it if he made house calls.
>
> In response to the question of her overall assessment of medical services to her clients in the Fresno area, she stated that it has been very good.

I.G. Ex. 4 at p. 5.

Thus, a more complete reading of the investigator's interview report of Ms. Blake reveals that Ms. Blake is of the opinion that residents in her facility are receiving adequate care. In addition, while Ms. Blake might prefer Dr. Smith to make house calls, there is no evidence in the record to suggest that Petitioner ever made house calls either. On the contrary, the declaration of another administrator, Ms. Goodwin, states that "[w]hen [Petitioner] was seeing our patients and they would become ill with the flu or have some other problem which required medical attention, <u>we could bring our residents over to his office</u> . . . " (emphasis added.) P. Ex. 4. This suggests that board and care facility residents were brought to Petitioner at his office.

Furthermore, even if the record showed that Petitioner made house calls and that other physicians did not, this alone would not be sufficient to establish that alternative sources of medical care are not available. Absent a showing that making house calls was an integral component of the health care provided by Petitioner, there would be no basis for concluding that other physicians who do not make house calls do not provide

medical services that are comparable in quality to those provided by Petitioner.

Ms. Goodwin reported to the investigator that her facility also uses the medical services of Dr. Rob Smith. As additional support for his contention that Dr. Smith is not meeting the needs of board and care residents, Petitioner cites Ms. Goodwin's statement to the investigator that Dr. Smith is not always pleasant and he "always seems to have a great number of patients." Petitioner reply brief at p. 2.

Again, when this comment is read in context with Ms. Goodwin's other comments made in the course of her interview, there is no support for Petitioner's contention that alternative sources of medical care are not available. According to the interview report of the investigator, Ms. Goodwin related the following:

> The facility utilizes Dr. Rob Smith for necessary medical services to the client, additionally also used are Dr. Warden Session and Dr. Chia Chen. All [of] these doctors accept medical payments.
>
> In cases when the regular doctor is not available and the client needs emergency services, they are taken to Community Hospital for services . . .
>
> The only problem that Dr. Smith presents is that h[is] manner is at times not pleasant and he always seems to have a great number of patients.
>
> The facility clients have never had to go without medical services because of a lack of medical doctors. Overall the medical services available to the facility in the Fresno area have been good.

I.G. Ex. 4 at p. 7.

The fact that Dr. Smith "always seems to have a great number of patients" is not relevant to this inquiry unless it can be shown that the size of his practice prevents him from being available to provide alternative care. Petitioner has made no such showing. Furthermore, even if Dr. Smith is unavailable to provide alternative care, there is evidence that satisfactory medical care is available from other sources. Ms. Goodwin mentions several other sources of medical care for residents in addition to Dr. Smith. Further, the fact that Ms. Goodwin perceives Dr. Smith to be unpleasant at times is not a basis for finding that alternative sources of medical care are not available. There must be an

affirmative showing that the services rendered by Dr. Smith cannot be substituted for Petitioner's services without jeopardizing the health of Petitioner's former patients.

Petitioner points also to several negative comments made by Mr. Arrington in his interview. Specifically, Mr. Arrington told the investigator that Petitioner always saw residents on short notice, and that this was not always the case with other doctors. Mr. Arrington told the investigator that he has heard that some doctors have told administrators of other board and care facilities not to bring residents of their facilities back for treatment. In addition, Mr. Arrington indicated to the investigator that he believes medical services in the Fresno area were in need of improvement. Petitioner argues that Mr. Arrington's comments establish that the residents of the board and care facilities have been unable to obtain adequate care since Petitioner's exclusion. Petitioner reply brief at pp. 2 - 3.

While a reading of the investigator's interview report with Mr. Arrington shows that Mr. Arrington made these comments, Petitioner does not mention Mr. Arrington's overall assessment of the medical services in Fresno. According to the interview report, "[Mr. Arrington] would rate the overall medical services in the Fresno area as good; but in need of some improvement." Although Mr. Arrington told the interviewer that "As a licensee he has found it very difficult to have to shop for a doctor to provide services to the clients," he did not state that he had been unable to obtain adequate care for residents of his facilities since Petitioner was excluded. I.G. Ex. 4 at p. 9.

Petitioner argues at page three of his posthearing reply brief that:

> The evidence submitted by the Petitioner establishes that the board and care facilities in question have been unable to obtain adequate medical care for their residents since [Petitioner's] exclusion. The evidence submitted by the Inspector General does little to detract from that evidence.

I disagree. The Department of Social Services' investigation speaks directly to the experience of the three facilities from whose administrators Petitioner obtained declarations. The results of this investigation provide persuasive evidence that all three of these facilities have been able, since Petitioner's exclusion, to obtain adequate medical care for the residents of the

facilities. Even if it is true that Petitioner was willing to see residents more promptly than some other doctors for non-emergency conditions, the Department of Social Services' investigation did not uncover a single instance where a resident's health was compromised due to delays in obtaining treatment. The results of the investigation clearly rebut Petitioner's claim that he provided a medical service for which there are not alternative sources.[12]

Throughout this proceeding, Petitioner has argued that his former Medicare and Medicaid patients who reside in board and care facilities are not able to obtain adequate medical care. The burden of proving the unavailability of alternative sources of health care falls on Petitioner. Petitioner has not met this burden of proof. Moreover, the evidence gathered by the Department of Social Services affirmatively demonstrates that subsequent to Petitioner's exclusion the residents of the facilities serviced by Petitioner and relied on by him to prove the existence of the lack of alternative medical sources did, in fact, receive adequate alternative medical services.

Petitioner has not shown that there exist mitigating circumstances as defined by 42 C.F.R. § 1001.401(c)(3). Accordingly, there is no basis to modify the three-year exclusion which the I.G. imposed and directed against Petitioner.

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[12] In addition to the alternative medical sources identified in the Department of Social Services' investigation, the I.G. submitted proof of other providers in the Fresno area who will treat Medicare or Medicaid patients who reside in board and care facilities in a timely manner. The providers include two hospitals located within three miles of Petitioner's office which participate in the Medicare and Medicaid programs. Both of these hospitals have urgent care clinics which are available to treat residents of board and care facilities on a walk-in, same-day basis. I.G. Ex. 5 - 7. While I recognize that such evidence is commonly offered by the I.G. in section 1128(b)(3) cases where the mitigating factor of a lack of alternative medical services is at issue, a careful review of the evidence of care rendered to the residents of the facilities relied on by Petitioner demonstrates that such persons received adequate alternative medical services subsequent to Petitioner's exclusion. Thus, proof of additional sources of medical care to these persons is cumulative.

CONCLUSION

I conclude that the three-year exclusion which the I.G. imposed and directed against Petitioner is reasonable, pursuant to the criteria specified in 42 C.F.R. § 1001.401.

/s/

Edward D. Steinman
Administrative Law Judge