Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Scott Meggison,	)	DATE: August 19, 1994
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-94-290
	)	Decision No. CR329
The Inspector General.	)	
	)	

DECISION

The above-captioned case has come before me pursuant to the hearing request filed by Scott Meggison (Petitioner) on February 4, 1994. Petitioner, a Physician's Assistant licensed in the State of Michigan, contests his three-year exclusion from participation in the Medicare, Medicaid, and other federally funded health care programs specified in section 1128(h) of the Social Security Act (Act).[1] Such an exclusion was imposed and directed by the Inspector General (I.G.) of the Department of Health and Human Services (HHS) for the reasons stated in the I.G.'s notice letter dated January 19, 1994.

The I.G. based her actions upon her determination that Petitioner's conviction (as defined by section 1128(i) of the Act) of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. Under section 1128(b)(3) of the Act, the I.G., by delegation from the Secretary of HHS, is authorized to impose and direct an exclusion for a conviction of this nature. HHS's implementing regulations specify an exclusion of three years under section 1128(b)(3) of the Act, unless the aggravating or mitigating factors specified in the regulation apply to alter the benchmark period. 42 C.F.R. § 1001.401.

---

[1] For the sake of convenience, I will refer to all the affected health care programs as "Medicare" and "Medicaid."

During the telephone prehearing conference of March 7, 1994, Petitioner stipulated that he was convicted of a criminal offense within the meaning of sections 1128(i) and 1128(b)(3) of the Act. Petitioner admitted that the only issue in controversy in this case is the reasonableness of the length of exclusion imposed and directed by the I.G. Petitioner argued that, under one of the agency's regulatory criteria, his three-year exclusion should be reduced because alternative sources of Physician's Assistant services are not available in the community where he practices. See 42 C.F.R. § 1001.401(c)(3)(ii). Petitioner admitted that the other portions of the regulation at 42 C.F.R. § 1001.401(c) could not be used to reduce the three-year exclusion. As also summarized in my March 18, 1994 Order and Schedule for Filing Briefs and Documentary Evidence, Petitioner requested that the case be decided on a paper record, and the I.G. had no objection to proceeding in this manner.

Having considered the parties' cross-motions for disposition on the documentary evidence and the exhibits

they have submitted in support,[2] I uphold the three-year exclusion imposed and directed by the I.G.

ISSUES

1. Whether the length of the three-year exclusion imposed and directed by the I.G. is unreasonable because "[a]lternative sources of the type of health care items or services furnished by the individual or entity are not available," within the meaning of 42 C.F.R. § 1001.401(c)(3)(ii).

---

[2] In accordance with the briefing schedule I had established, Petitioner submitted his Motion for Decision on the Documentary Evidence and Brief in Support (P. Br.) along with four proposed exhibits; and the I.G. submitted a Motion for Summary Disposition with a supporting brief (I.G. Br.) and seven proposed exhibits. Petitioner then submitted a Memorandum in Response to the I.G.'s Motion for Summary Disposition (P. Rep.), along with one additional proposed exhibit.

During a conference call held on June 14, 1994, the I.G. clarified that she was seeking summary disposition on what she considered to be controlling issues of law, but that if there existed any disputed issues of material facts, she had no objection to having the issues decided on the basis of her documentary submissions. Neither party wished to offer additional evidence at an in-person hearing. The I.G. waived the opportunity to cross-examine Petitioner's witnesses who submitted affidavits. June 21, 1994 letter sent by direction of the Administrative Law Judge (ALJ).

Also during the June 14, 1994 conference, I informed the parties that, absent any valid objections, I would look at the relative locations of the towns referenced by the parties on an area map. The parties had no objection to my so proceeding. Petitioner later forwarded certain officially published information to clarify the contents of his earlier submissions. The additional documents from Petitioner have been marked as Petitioner's Exhibits 5 through 11.

Having ascertained that all the documents submitted by the parties are relevant to the parties' arguments before me, and having received no objections as to the authenticity of the documents, I now admit Petitioner's Exhibits 1 to 11 (P. Ex. 1 to 11) and the I.G.'s Exhibits 1 to 7 (I.G. Ex. 1 to 7).

2. If the three-year exclusion imposed and directed by the I.G. is unreasonably long under the criterion specified in 42 C.F.R. § 1001.401(c)(3)(ii), then the extent to which the exclusion should be reduced.

FINDINGS OF FACT AND CONCLUSIONS OF LAW (FINDINGS)

1. Petitioner has been working as a licensed Physician's Assistant in the State of Michigan. P. Br. at 1.

2. Prior to June of 1993, Petitioner was employed at Dr. Kenneth Pelton's clinics (Pelton Clinics) in Pinconning and Prescott, Michigan.[3] P. Br. at 2 - 3; P. Ex. 1 at 1 - 2; I.G. Ex. 1 at 2.

3. In June of 1993, Petitioner pled guilty to two counts of attempting to prescribe controlled substances outside the scope and authority of a Physician's Assistant's license. I.G. Ex. 2, 3.

4. By order dated September 13, 1993, the court accepted Petitioner's guilty plea and entered a judgment of conviction. I.G. Ex. 3.

5. Petitioner was convicted of a criminal offense related to the unlawful manufacture, prescription, or dispensing of a controlled substance, within the meaning of the Act. Sections 1128(b)(3), 1128(i) of the Act; Findings 3, 4.

6. Petitioner was sentenced to serve 30 days in jail and 180 days of probation, and he was also ordered to pay $650 in fines and costs. His jail term was held in abeyance. I.G. Ex. 4.

7. By notice letter dated January 19, 1994, the I.G. imposed and directed a three-year exclusion against Petitioner pursuant to his conviction. I.G. Ex. 6.

8. The I.G. has been delegated the authority to impose and direct exclusions on behalf of the Secretary of HHS. 48 Fed. Reg. 21,662 (1983).

---

[3] Petitioner refers to his former employer as Kenneth Pelton. P. Br. at 2. The criminal complaint against Petitioner refers to Kevin Pelton. I.G. Ex. 1 at 2. This discrepancy is not material to any issue before me.

9. The exclusion imposed and directed against Petitioner is authorized under section 1128(b)(3) of the Act. Finding 5; P. Br. at 1.

10. The regulation requires the I.G. to impose a three-year exclusion, unless the enumerated factors apply to increase or decrease the benchmark exclusion period. 42 C.F.R. § 1001.401(c).

11. The regulation permits an increase of the three-year benchmark exclusion period imposed and directed by the I.G. where, as here, the sentence imposed by the court included incarceration. 42 C.F.R. § 1001.401(c)(2)(iii); I.G. Ex. 4.

12. The regulation permits a reduction of the three-year benchmark exclusion period imposed and directed by the I.G. if alternative sources of the type of health care item or service furnished by Petitioner are not available. 42 C.F.R. § 1001.401(c)(3)(ii).

13. "Alternative sources ... are not available" means that, due to the length of the exclusion at issue, either there will be no other health care provider in the geographical areas reasonably accessible to the Medicare beneficiaries and Medicaid recipients to care for them, or a significant portion of Medicare beneficiaries and Medicaid recipients will be deprived of reasonable access to health care services comparable to those provided by Petitioner. See 42 C.F.R. § 1001.401(c)(3)(ii); James H. Holmes, M.D., DAB CR270 at 13 - 14 (1993).

14. Petitioner has the burden of proving by a preponderance of the evidence that the three-year exclusion imposed and directed by the I.G. is unreasonable due to the unavailability of alternative sources of health care services furnished by Petitioner. 42 C.F.R. § 1001.2007(c); Holmes, DAB CR270 at 16.

15. During the course of the criminal proceedings against Petitioner, Dr. Pelton died, and the Pelton Clinics were closed. P. Br. at 3; P. Ex. 1 at 1.

16. In August of 1993, Petitioner accepted a job as a Physician's Assistant with the Pinconning Clinic and Prescott Clinic, which are located respectively in Pinconning and Prescott, Michigan, and are both managed by William Berner. P. Ex. 1.

17. Pinconning and Prescott are located 25 miles apart in Bay County and Ogemaw County, respectively. See P. Ex. 5, 8, 11.

18. Pinconning currently has two clinics: the one employing Petitioner and another one operated by Dr. Smeltzer, who is nearing retirement. P. Ex. 1, 5 at 2.

19. Prescott has only the one clinic employing Petitioner. P. Ex. 1.

20. The clinics employing Petitioner also employ as health care providers John Russell (also a Physician's Assistant) and Carlton Capuson, D.O., who supervises the work of the Physician's Assistants employed by the clinics. P. Ex. 1, 5.

21. For nearly one year prior to Petitioner's hire in August of 1993, no other Physician's Assistant had accepted the job with the Pinconning and Prescott Clinics due to the low pay of the position and the locations of the clinics. P. Ex. 1 at 2.

22. Since Petitioner's exclusion, John Russell has been traveling 40 minutes each day between Pinconning Clinic and Prescott Clinic in order to see 30 to 40 patients at each site. P. Ex. 5 at 2 - 3.

23. The Medicare and Medicaid caseload at the Pinconning Clinic is approximately 70 percent, and it is approximately 60 percent at the Prescott Clinic. February 3, 1994 letter from William Berner to Petitioner's Counsel (attached to Request for Hearing)(Berner Letter).

24. Petitioner's evidence does not show that the Pinconning and Prescott Clinics' current Medicare and Medicaid caseload represents a significant increase from the time prior to Petitioner's hire, when John Russell worked as the only Physician's Assistant for the two clinics. See P. Ex. 1, 5.

25. Petitioner's evidence does not show that he had cared for Medicare or Medicaid patients prior to August of 1993.

26. The community hospital nearest to Prescott and Pinconning is the Standish Community Hospital, located in Standish. P. Ex. 1 at 2.

27. Standish Community Hospital also operates on its campus an emergency room and a walk-in urgent care center. P. Ex. 5 at 1.

28. Standish Hospital is located approximately 15 miles from Pinconning Clinic and approximately 25 to 30 miles from Prescott Clinic. P. Ex. 1 at 2.

29. The three towns of Prescott, Standish, and Pinconning are located more or less in a straight line, with Standish in the middle at approximately 15 miles south of Prescott and 9 miles north of Pinconning. P. Ex. 5 at 1 - 2.

30. Dr. Capuson works as the "acting physician on duty" at Standish Hospital's emergency room and ambulatory urgent care center. P. Ex. 5 at 1.

31. Dr. Capuson has little time to see patients at the Prescott and Pinconning Clinics. P. Ex. 5 at 2.

32. Petitioner's evidence does not establish that Dr. Capuson is the only doctor on the medical staff of Standish Hospital. See P. Ex. 1, 5.

33. Petitioner's evidence does not establish that no other doctor or health care professional capable of delivering services comparable to Petitioner's practices in the Standish area. See, e.g., P. Ex. 1, 5.

34. Pinconning and Prescott are located within HHS-designated "primary medical care health manpower shortage areas" or "Health Professional Shortage Areas." P. Ex. 2 - 4.

35. The "primary medical care health manpower shortage area" and "Professional Health Shortage Area" designations do not apply to all portions of Ogemaw County, Bay County, the Sterling/Standish health care service area, or the Hale/Whittemore/Prescott health care service area. P. Ex. 2 - 4, 6.

36. In the vicinity of Prescott, Standish, or Pinconning, there are other cities, towns, or communities, including Bay City, Midland, Sterling, Hale, and Whittemore. E.g., P. Ex. 7 - 11.

37. Petitioner's evidence does not establish the absence, unavailability, or inaccessibility of doctors, practitioners, or hospitals located in the towns, cities, or communities in the vicinity of Pinconning, Prescott, or Standish. See, e.g., P. Ex. 1, 5; see also Findings 35, 36.

38. At no time was the patient-to-physician ratio for Pinconning 4,246 to 1; nor was the ratio for Prescott ever 7,708 to 1. See P. Ex. 2 - 4; P. Br. at 2.

39. Since Petitioner's exclusion became effective, Mr. Russell has been overworked and sees each patient at the Prescott and Pinconning Clinics for only a few minutes. P. Ex. 5 at 2 - 3.

40. Mr. Berner, the Clinics' manager, may reduce the hours of both clinics by half or close one of the clinics. P. Ex. 5 at 3.

41. Since his exclusion, Petitioner has been assigned to work as a manager at the Prescott Clinic, which has a non-Medicare and non-Medicaid patient caseload of 40 percent that can be cared for (but is not being cared for) by Petitioner as a Physician's Assistant. P. Br. at 2; I.G. Ex. 6; Finding 23.

42. Petitioner has failed to establish by a preponderance of the evidence that his exclusion caused any of the following:

(a) Mr. Russell is overworked;
(b) Mr. Russell spends less time with patients;
(c) The Prescott Clinic or the Pinconning Clinic may be closed; or
(d) The hours of both clinics may be reduced by 50 percent.

43. Dr. Capuson believes that closing one of the two clinics, or having Mr. Russell alternate his days at the clinics, may jeopardize the patients' health by forcing those with potentially serious conditions to wait one or two days to see a Physician's Assistant at the Prescott and Pinconning Clinics. P. Ex. 5 at 3.

44. It is not medically advisable for patients to use the Standish Hospital's emergency room or ambulatory urgent care center when they should be seeking services from their regular caregiver on a non-emergency basis. P. Ex. 5 at 3 - 4.

45. Petitioner's evidence does not establish that the Clinics will be unable to make medically appropriate referrals for their excess patients. See, e.g., P. Ex. 1, 5.

46. Petitioner's evidence does not establish that patients with potentially serious conditions will need to wait for days to be seen by doctors or Physician's

Assistants if Prescott and Pinconning Clinics referred them to a hospital emergency room or to other practitioners. See, e.g., P. Ex. 1, 5.

47. Petitioner's evidence does not establish that no other practitioner capable of providing services comparable to Petitioner's in the geographical areas of Pinconning and Prescott will accept referrals of the excess patients from Pinconning and Prescott Clinics.

48. Petitioner's evidence does not establish that a significant number of Medicare beneficiaries and Medicaid recipients will be deprived of reasonable access to comparable health care services if Petitioner is excluded for three years. Findings 15 - 47.

49. Petitioner has failed to prove by a preponderance of the evidence that the three-year exclusion imposed and directed by the I.G. is unreasonably long. Findings 1 - 48.

THE PARTIES' POSITIONS

Petitioner's Arguments and Evidence

Petitioner has been employed as a Physician's Assistant at the Pinconning Medical Care, P.C. (Pinconning Clinic) in Pinconning, Michigan, and at the Prescott Clinic, P.C. (Prescott Clinic) in Prescott, Michigan, since August of 1993. P. Br. at 2. Before August of 1993, Petitioner was employed by the Pelton Clinics, two different clinics also located in the same area.[4] P. Br. at 2 - 3; P. Ex. 1 at 1 - 2. After the death of Dr. Pelton, the physician who owned and operated the Pelton Clinics, these two clinics closed. P. Ex. 1 at 1. Petitioner then joined the Prescott Clinic and Pinconning Clinic, both of which are managed by William Berner of the Prescott Management Company. Id.

Mr. Berner stated that he had been recruiting Physician's Assistants for nearly a year before he hired Petitioner in August of 1993. P. Ex. 1 at 2. Mr. Berner attributed the difficulties to the low pay caused by an "overabundance" of Medicare and Medicaid patients (as

---

[4] The documents relating to Petitioner's criminal proceedings indicate that the Pelton Clinics were located in Prescott and Pinconning. I.G. Ex. 1 at 2. Petitioner states that the Pelton Clinics were located in Pinconning and Skidway Lake. P. Br. at 5, n.2.

opposed to patients whose care is reimbursed by private insurers), together with the general reluctance of health care providers to relocate to remote areas. Id.

Pinconning and Prescott are located in two different counties in the northern part of Michigan, around Saginaw Bay. Pinconning is in Bay County. P. Ex. 4 at 1; P. Ex. 8. Prescott is in adjoining Ogemaw County. P. Ex. 3, 11. Prescott is approximately 25 miles from Pinconning. P. Ex. 5 at 2. It takes approximately 40 minutes to drive from the Prescott Clinic to the Pinconning Clinic. P. Ex. 5 at 2 - 3.

According to Petitioner, both the Pinconning Clinic and Prescott Clinic are located within what HHS has designated as primary care "Health Professional Shortage Areas" (HPSAs) or "primary medical care health manpower shortage areas" (HMSAs). P. Br. at 2; P. Ex. 2 - 4. The classifications are based on the ratio of "full-time equivalent primary care physicians" to the "adjusted population" of areas that include, but are not limited to, Pinconning and Prescott. P. Ex. 2, 3, 6 - 11. In 1990, HHS granted Mr. Berner's request on behalf of Prescott Clinic to reinstate Richland Township, which includes Prescott, as a HMSA in the Hale/Whittemore/Prescott Service Area of Ogemaw County. P. Ex. 3 at 1. In 1991, HHS granted Mr. Berner's request to have Pinconning township designated a HPSA within the Sterling/Standish Service Areas of Arenac, Bay and Gladwin Counties. P. Ex. 2. Pinconning and Prescott continued to have the HPSA designation until at least January of 1993.[5] P. Ex. 4.

At present, Pinconning has two medical clinics: the Pinconning Clinic and another clinic staffed by a physician, Dr. Smeltzer; Prescott has only the Prescott Clinic. P. Ex. 1, 5. The two clinics employing Petitioner are staffed by Petitioner, another Physician's Assistant named John Russell, and Carlton Capuson, D.O. P. Ex. 1, 5. Dr. Capuson stated that he is the only doctor serving Prescott and he spends only 10 percent of his workday in Prescott due to his work commitments

---

[5] Petitioner has not explained the difference, if any, between the HPSA and the HMSA designation. If there were a difference, it would not be material to my decision, in any event. Both Prescott and Pinconning are identified as HPSAs in P. Ex. 4, which is the most recent in time. That Exhibit makes no mention of the HMSA designation. For simplicity, I refer in my analysis to Prescott and Pinconning as HPSAs.

elsewhere. P. Ex. 5 at 2. Also due to his other work commitments, he does not personally see many patients in the Prescott Clinic or the Pinconning Clinic. Id. He believes that Dr. Smeltzer in Pinconning is nearing retirement and is not accepting new patients. Id.

The community hospital nearest to both Pinconning and Prescott is located in Standish. P. Br. at 2; P. Ex. 1 at 2. Standish Hospital operates on its campus an emergency room as well as a walk-in urgent care clinic. P. Ex. 5 at 1. Pinconning and Prescott are located in a line with Standish. Id. Prescott is approximately 15 miles north of Standish, and Pinconning is approximately 9 miles south of Standish. P. Ex. 5 at 1 - 2. Pinconning Clinic is located 25 to 30 miles from Standish Hospital, and Prescott Clinic is located 15 miles from Standish Hospital. P. Ex. 1 at 2.

Dr. Capuson, who supervises the work performed by Petitioner and John Russell at the Prescott Clinic and Pinconning Clinic, also works as "the acting physician on duty" at Standish Hospital's emergency room and walk-in urgent care clinic (Urgent Care). P. Ex. 5. He notes that hospital treatment is not an adequate or sensible alternative to treatment by a family doctor or Physician's Assistant. P. Ex. 5 at 3.

Dr. Capuson believes that the Standish Hospital's emergency room and Urgent Care center are not "geared" to deal with the same family practice caseload as the Prescott Clinic and the Pinconning Clinic. P. Ex. 5 at 3 - 4. If Urgent Care or the emergency room are forced to take up the patient caseload of those two clinics, he thinks patients will receive health care which is less well suited to their needs, and they will have to wait longer for it. P. Ex. 5 at 4. As examples, he states that, at Urgent Care, he and the staff either tell patients to seek follow-up care with their regular caregiver or refer them to specialists; if the patients return to Urgent Care, they would not see the same caregiver, and the loss of continuity may jeopardize their health. Id.

Since the effective date of Petitioner's exclusion, Petitioner has been working as a Physician's Assistant on a rotational basis at the Pinconning Clinic and as a manager at the Prescott Clinic. P. Br. at 2. In order to see the Medicare and Medicaid patients of both clinics, John Russell, the other Physician's Assistant employed by the two clinics, has been travelling the 40 minutes between the two clinics each day since Petitioner's exclusion to see 30 to 40 patients at one

clinic in the morning, and an equal number of patients at the other clinic in the afternoon. P. Ex. 5 at 2 - 3.

According to Mr. Berner's letter to Petitioner's counsel,

> Our Pinconning Clinic has approximately 42% Medicaid and 28% Medicare. Our Prescott Clinic has approximately 32% Medicaid and 28% Medicare.

Berner Letter. Prior to his exclusion, Petitioner had a total caseload of approximately 160 patients per week. Id. According to Petitioner, if he is excluded from practicing for any substantial period of time, one of the clinics employing him would be forced to close, or, alternatively, both clinics would have to reduce their office hours by nearly one half. Petitioner contends that either of these alternatives would be detrimental to providing effective and timely patient care in both communities. P. Br. at 3 - 4.

Petitioner argues that the evidence compels the conclusion that the mitigating factor identified at 42 C.F.R. § 1001.401(c)(3)(ii) applies. Petitioner contends that his exclusion should be reduced to the period already served because he "provides a unique and irreplaceable service to the patients of this underserved area of Northern Michigan" and his removal "would in fact endanger the health and safety of the patient population in these communities contrary to the policies expressed in the regulations themselves." P. Rep. at 2.

The I.G.'s Arguments and Evidence

The I.G.'s evidence shows that Petitioner was convicted within the meaning of the Act on June 21, 1993 in Michigan State Court on two counts of attempting to prescribe controlled substances. I.G. Ex. 2 - 4. Prior to or during August of 1993, Petitioner was sentenced to serve 30 days in jail, which was held in abeyance, and he was placed on 180 days of informal probation. I.G. Ex. 4.[6] Petitioner was also ordered to pay $605.00 in fines

---

[6] Where, as here, the evidence introduced for my de novo review establishes that the sentence imposed by the court included incarceration, I have the authority to increase the three-year benchmark exclusion period. 42

(continued...)

and costs. Id. On September 14, 1993, the I.G. notified Petitioner of his possible exclusion and solicited comments for her deliberation. I.G. Ex. 5. On January 19, 1994, the I.G. notified Petitioner of his exclusion, which would become effective 20 days thereafter. I.G. Ex. 6.

The I.G. argues that Petitioner has made no showing that alternative sources of the type of health care services he furnishes are unavailable in his local area. According to the I.G., the phrase "alternative sources . . . are not available" in 42 C.F.R. § 1001.401(c)(3)(ii) is not defined by statute or regulation. I.G. Br. at 5. The I.G. urges me to adopt a plain-meaning construction of the term applied by other administrative law judges. Id. at 5 - 6. The I.G. notes that, according to Petitioner's evidence, there is another Physician's Assistant working with him and there is a physician supervising their activities. Id. at 9. The I.G. also argues that Petitioner has made no showing that the area hospital is unwilling to absorb Petitioner's Medicare and Medicaid caseload. Id. at 8. According to the I.G., Petitioner has failed to prove that patients traveling from Prescott or Pinconning to the community hospital would be exposed to undue hardships and barriers of such a magnitude that, as a practical matter, the patients would be precluded from obtaining access to alternative sources of health care at the hospital. Id. at 8 - 9.

With respect to Petitioner's use of the evidence concerning "health care professional shortage areas," the I.G. argues that Petitioner was not excluded pursuant to section 1156 of the Act, which permits health care providers practicing in a "health professional shortage area" to seek a pre-exclusion ruling by an administrative law judge on whether they pose a serious risk to patients. I.G. Br. at 7 - 8, n.7 (citing section 1156(b)(1)(B)(5)). The designation of "health professional shortage area" does not indicate that alternative sources of health care are unavailable. Id. Nor does the designation bar the imposition of an exclusion under sections 1128(b)(3) or 1156 of the Act. Id.

---

[6](...continued)
C.F.R. §§ 1001.401(c)(2)(iii), 1005.20(b); section 1128(f) of the Act (incorporating section 405(b) of the Act). However, the I.G. has not argued that Petitioner's exclusion should be for longer than three years. Therefore, I will not address the effect of this aggravating factor of record in this decision.

ANALYSIS

I. The regulations limit the issues before me.

I begin my analysis by making clear what the parties have acknowledged implicitly in their delineation of the issues.

Given Petitioner's stipulation that he was convicted within the meaning of section 1128(b)(3) of the Act, the contents of the regulation at 42 C.F.R. § 1001.401 are binding upon me in deciding whether the three-year exclusion imposed and directed by the I.G. is reasonable. 42 C.F.R. § 1001.1(b)(1993)(58 Fed. Reg. 5617, 5618 (Jan. 22, 1993)). Under the regulations, three years is the benchmark period for all exclusions imposed and directed under section 1128(b)(3) of the Act. 42 C.F.R. § 1001.401(c)(1). I may reduce the three-year benchmark period only if at least one of the criteria specified in the regulation is applicable. 42 C.F.R. § 1001.401(c)(3). However, I cannot set the exclusion at zero where I find that an individual has committed an act proscribed in section 1128(b) of the Act. 42 C.F.R. § 1005.4(c)(6).

I am also not authorized to review the manner in which the I.G. has exercised her discretion in deciding whether to exclude an individual under section 1128(b) of the Act, and the law does not permit me to readjudicate the facts that have resulted in criminal convictions. 42 C.F.R. §§ 1001.2007(d), 1005.4(c)(5). I note that Petitioner has placed before me his arguments concerning the events that led to his conviction even though Petitioner also acknowledges that they are not among the mitigating factors specified by regulation. Because the above cited regulations are binding on me (42 C.F.R. § 1001.1(b)(1993)), I do not give any legal effect to such arguments.

In addition, even though Petitioner may be the capable, hard-working, and caring health care provider described by his witnesses (e.g., P. Ex. 5 at 2), his skills and competency are not at issue before me. Petitioner's exclusion did not result from any conviction for the abuse or neglect of patients, or from any licensure revocation proceeding relating to his professional skills, for example. See sections 1128(a)(2) and (b)(4) of the Act. The I.G. had the discretion to weigh factors such as Petitioner's work history and professional skills when she was deciding whether or not to impose and direct an exclusion against Petitioner under section 1128(b)(3) of the Act. However, I cannot now use the professional

competency of Petitioner in lieu of a mitigating factor specified by regulation. See, e.g., 42 C.F.R. § 1005.4(c)(5). Nor can I give any weight to Petitioner's professional attitude or competency in deciding whether there exists alternative sources of health care where, as here, there is not even an allegation that other health care providers are less caring, less hard-working, or less capable than Petitioner. Therefore, I do not find material the quality of care he is capable of rendering were he allowed to participate in the Medicare and Medicaid programs.

II. Petitioner has failed to prove by a preponderance of the evidence that alternative sources of the type of health care services he provides are not available.

Petitioner has the burden of coming forward with evidence and proving that alternative sources of the type of health care services he provides are not available. March 18, 1994 Order and Schedule for Filing Briefs and Documentary Evidence. The standard of proof in this proceeding is the preponderance of the evidence. Id.; 42 C.F.R. § 1001.2007(c). I find that Petitioner has failed to establish by a preponderance of the evidence that the mitigating factor he cites is applicable to his situation.

To define the phrase "alternative sources . . . are not available," I adopt the plain-language approach applied by other administrative law judges. For example, Administrative Law Judge Edward Steinman defined "alternative" as "affording a choice of two or more things, propositions, or sources of action," and he defined "available" as "suitable or ready for use or service; at hand." James H. Holmes, M.D., DAB CR270 at 13 (1993). Thus, under this definition, an alternative source must be a source which offers patients a comparable alternative to the services furnished by Petitioner, and obtaining the services of the alternative source must not represent an unreasonable hardship. Id. at 13 - 14.

Under the regulation, the availability of alternative sources of health care services is relevant only as it applies to Medicare and Medicaid beneficiaries and recipients. The exclusion statutes are intended to safeguard the welfare of Medicare beneficiaries and Medicaid recipients. By its very terms, an exclusion imposed and directed against an individual has no impact on his ability to bill for services to patients who do not receive health care under the Medicare or Medicaid

programs. Therefore, I emphasize that the regulation permits me to reduce the period of exclusion only if the exclusion would adversely affect Medicare beneficiaries and Medicaid recipients. Id. at 14.

The mitigating factor contained in 42 C.F.R. § 1001.401(c)(3)(ii) is established only when Petitioner proves by a preponderance of the evidence that, if he is excluded for the period imposed and directed by the I.G., (1) there will be no other health care provider in the geographical area served by Petitioner reasonably accessible to Medicare beneficiaries and Medicaid recipients, or (2) a significant portion of Medicare beneficiaries and Medicaid recipients will be deprived of reasonable access to comparable health care services.

To establish this mitigating factor, a provider must prove significant adverse changes in the previously available services to program beneficiaries and recipients. If, for example, an individual had served very few program beneficiaries or recipients prior to his exclusion, his exclusion may have no real impact on the access of program beneficiaries or recipients to previously available health care providers in the same area. In such a situation, reducing the period of an exclusion is unlikely to be of any advantage to Medicare beneficiaries or Medicaid recipients.

Moreover, the mitigating factor does not apply where an exclusion does no more than reduce the number of available health care providers in a community. Mere diminution of previously available health care services is insufficient. Clearly, every exclusion of a health care provider has that potential effect. The three-year benchmark period specified by the regulation would be rendered meaningless if the mere diminution of previously available services were construed to satisfy the mitigating factor identified at 42 C.F.R. § 1001.401(c)(3)(ii). Holmes, DAB CR270 at 14.

Petitioner's evidence and arguments are insufficient to establish that his exclusion for three years will have the requisite impact on the delivery of health care services to Medicare beneficiaries or Medicaid recipients. Petitioner has proved that Prescott and Pinconning need more health care providers, and that his employer may have a difficult time replacing him. He has not proved that Medicare and Medicaid beneficiaries and recipients will face unreasonable hardship in obtaining comparable primary care services. Indeed, I agree with the I.G. that the evidence offered by Petitioner itself identifies alternative sources of services to which

Medicare beneficiaries and Medicaid recipients have access.

Petitioner contends that no other providers of Physician's Assistant services will be available because other Physician's Assistants will be unwilling to take his place. The relevant statements by Mr. Berner (P. Ex. 1 at 2) and Dr. Capuson (P. Ex. 5 at 2) constitute some evidence that health care services may become less available as a result of Petitioner's exclusion. However, I note that the low pay offered by the Clinics to Physician's Assistants was a major deterrent cited by Mr. Berner, the Clinics' business manager, and the low pay was determined by the Clinics for business reasons unrelated to this proceeding. Moreover, the Act and regulations permit the I.G. to conclude that persons with convictions for the unlawful prescription of controlled substances should be excluded for a period of three years due to the risks they pose to the interests of the programs and to the safety of program beneficiaries and recipients. These risks are not significantly reduced where, as here, an individual is willing to work for less money.

In addition, Petitioner's contention that no other Physician's Assistant will replace him overlooks the fact that his colleague John Russell continues to treat patients at the Pinconning and Prescott Clinics. Petitioner argues that Mr. Russell cannot care for the clinics' Medicare and Medicaid patients alone. The evidence does not support this argument. According to Mr. Berner, Petitioner had a total caseload of 160 patients per week before the exclusion. Berner Letter. In the absence of any contrary information, I assume that Mr. Russell and Petitioner each used to have 50 percent of the clinics' total caseload before Petitioner's exclusion took effect; because Petitioner used to see 160 patients per week before his exclusion, I estimate that the two Physician's Assistants saw a total of approximately 320 patients each week prior to Petitioner's exclusion. Petitioner's exclusion should not have the effect of increasing the total of number of patients visiting the two clinics.

Since Petitioner's exclusion took effect, Mr. Russell should have taken over the full Medicare-Medicaid caseload of 60 percent at Prescott Clinic and 70 percent

at Pinconning Clinic.[7] If Mr. Russell were to treat only the Medicare and Medicaid patients at the two clinics, his caseload would increase only 10 to 20 percent over the 50 percent of patients I assume he was treating before Petitioner's exclusion. Despite his exclusion, Petitioner can be utilized for the remaining 30 to 40 percent of the two clinics' caseload. Even though Mr. Russell now spends 40 minutes a day to travel between the two clinics, some travel time was no doubt also expended by the Physician's Assistants before Petitioner's exclusion took effect because Petitioner and Mr. Russell staffed both clinics. I therefore conclude that Mr. Russell represents an alternative source of Physician's Assistant services available to Medicare and Medicaid patients in Prescott and Pinconning.

Petitioner argues that alternative sources of primary care services will not be available because his exclusion will force his employer to close one clinic or reduce each clinic's hours by 50 percent. I find that the decision to close of one clinic or to reduce the hours for both clinics turns on factors unrelated to Petitioner's exclusion from the programs. Since Petitioner is currently working as a manager at the Prescott Clinic and sharing duties as a Physician's Assistant with Mr. Russell at the Pinconning Clinic (P. Br. at 2), I conclude that Petitioner's employer has not assigned Petitioner the 40 percent non-Medicare and non-Medicaid caseload of Prescott Clinic; instead, the employer has assigned Mr. Russell considerably more work than the Medicare and Medicaid cases of the two clinics that had to be taken away from Petitioner due to his exclusion. Whereas before his exclusion, Petitioner used to see 160 patients per week (Berner Letter), Mr. Russell now sees 60 to 80 patients a day (P. Ex. 5 at 2 - 3), or 300 to 400 patients each week. Mr. Russell is now seeing as many or more patients than he and Petitioner did together before Petitioner's exclusion took effect. The foregoing factors do not add up to the conclusion that, due to the additional work and travel time for Mr.

---

[7] The percentages of Medicare and Medicaid patients at the clinics are drawn from Mr. Berner's letter dated February 3, 1994. Mr. Berner's letter was written approximately six months after the Pelton Clinics closed and Petitioner began working at the Prescott and Pinconning Clinics. Therefore, I infer that the patient population figures cited in Mr. Berner's letter would reflect whatever additional patients had transferred to Prescott or Pinconning because the Pelton Clinics had closed.

Russell that have resulted from Petitioner's exclusion, one Clinic will need to be closed down or each clinic will need to reduce its hours by one half.

In addition to the services provided by Mr. Russell at the Pinconning and Prescott Clinics, Petitioner has also identified at least two primary care physicians, Dr. Capuson and Dr. Smeltzer, who practice in Pinconning and Prescott. Moreover, the presence of Standish Community hospital implies that there are doctors with privileges to practice at the hospital who also maintain practices in the surrounding areas.

Petitioner's evidence establishes that Dr. Capuson is the acting physician on duty at Standish Hospital's emergency room and walk-in urgent care center. The evidence does not suggest that he is the only physician on the medical staff of Standish hospital, that he is the only health care provider who works in the emergency room and Urgent Care center, or that the individuals identified in Petitioner's evidence (Dr. Capuson, Mr. Russell, Dr. Smeltzer, and Petitioner) are the only ones willing and able to care for the Medicare beneficiaries and Medicaid recipients who currently receive services from the Prescott Clinic and the Pinconning Clinic. Nor is there any evidence showing that, on referrals by the Prescott or Pinconning Clinics, no other doctor or health care professional practicing in or around Standish will be willing to provide appropriate services to the Medicare and Medicaid patients of the Prescott and Pinconning Clinics.

According to Petitioner, the total driving time between Prescott Clinic and the Pinconning Clinic is 40 minutes, and the two towns are located in a line to the north and south of Standish. P. Ex. 5 at 1 - 2. These facts imply that the driving time from each of the two clinics to Standish would be much less than 40 minutes. Under these circumstances, it was incumbent upon Petitioner to prove that those program beneficiaries or recipients traveling to Pinconning Clinic or Prescott Clinic are unable to travel some minutes more to Standish, if nowhere else, to obtain alternative health care services. Petitioner has failed to do so.

A map of the State shows that, in addition to Standish, there are other communities, towns, and cities (including Bay City) in the proximity of Prescott or Pinconning. See P. Ex. 7 - 11. Petitioner's evidence is merely that the community hospital nearest to both Prescott and Pinconning is located in Standish. P. Ex. 1 at 2. Similarly, Petitioner's evidence is simply that

Pinconning has two clinics and Prescott has one clinic. P. Ex. 1 at 1. There is no evidence establishing the absence of any other hospitals, clinics, or like facilities located outside of Standish but close to Prescott or Pinconning. Nor has Petitioner alleged that no health care providers are located in area towns or communities other than Standish, Prescott, or Pinconning to provide comparable services to some of the program beneficiaries and recipients who have been cared for by Petitioner at the Prescott Clinic or Pinconning Clinic.

Petitioner argues that the hospital emergency room and Urgent Care center cannot be viewed as comparable to the primary care services of a Physician's Assistant or family doctor. Petitioner relies on Dr. Capuson's opinions concerning the health risks and lack of treatment continuity if the Pinconning and Prescott Clinics' patients seek emergency room care as a substitute for the care they currently receive from practitioners who are familiar with their conditions, such as Petitioner. See P. Ex. 5 at 4. The evidence does not prove that Petitioner's exclusion will inevitably result in the undesirable situations described by Dr. Capuson.

The undesirable situations described by Dr. Capuson seem the likely result of the Clinics not referring some of their excess patients to other practitioners for regular care in the first instance. There is no proof that continuity of treatment cannot be obtained anywhere except at Pinconning and Prescott Clinics, or that other practitioners cannot become as familiar with the patients' conditions over time as Petitioner. I did not construe the I.G.'s reference to available health care at Standish Hospital (I.G. Br. at 8 - 9) as meaning that patients should seek emergency treatment for non-emergency conditions or that patients should ask the emergency room staff to satisfy all their health care needs.

Petitioner argues that the ratio of area patient population to primary care physicians, which resulted in the HPSA designation for Prescott and Pinconning in 1990 and 1991, supports his contention that no other practitioners are practicing in Prescott and Pinconning. Petitioner argues that the current ratios have probably become worse after Dr. Pelton's death. P. Br. at 2. Such ratios are relevant to the issue of whether alternative sources of health care are available within the meaning of the regulations. However, I find Petitioner's asserted conclusion unpersuasive because (1) it fails to account for practitioners in neighboring

communities not designated HPSAs; and (2) it relies on unsupported assumptions about the definitions of provider and patient populations.

The first problem with Petitioner's arguments concerning the HPSA designation is that the designation does not apply to communities near Pinconning and Prescott, where patients could presumably seek medical care. For example, Petitioner's evidence shows that the Pinconning Clinic is located in the Sterling/Standish health care service area of Bay County. While Petitioner has established that Pinconning Township and Pinconning City have the HPSA designation, I find that the HPSA designation does not apply to all parts of the Sterling/Standish Service Area or to all parts of Bay County. P. Ex. 4 at 1; P. Ex. 6 at 2 - 3. (Only four parts of that service area have the designation. P. Ex. 4 at 1.) Nor does Petitioner's evidence show that the HPSA designation applies to the cities of Standish and Sterling, for example, in the Sterling/Standish Service Area that includes Pinconning. P. Ex. 4.

Similarly, while Petitioner has established that Prescott Village has the HPSA designation, I find that the HPSA designation does not apply to all parts of Ogemaw County or to all parts of the health care service area to which Prescott Clinic belongs. P. Ex. 6 at 6. For the portion of the Hale/Whittemore/Prescott Service Area within Ogemaw County, the HPSA applies only to Logan and Richland Townships, which include Prescott Village. P. Ex. 3, 4 at 2. In neighboring Iosco County, but within the same service area as Prescott, the cities of Hale and Whittemore, for example, do not have the HPSA designation. P. Ex. 4, 10.

Second, Petitioner fails to define the terms "full-time equivalent primary care physicians" and "adjusted population" used in the HPSA designation. Petitioner has not shown if or to what degree he should be considered a "full-time equivalent primary care physician." Nor has he shown that the patient population statistics used for the HPSA designation coincide with those types of patients he would be serving through the Prescott and Pinconning Clinics. For example, it is reasonable to expect the patient-to-physician ratios generated for the HPSA designation to include people who have no insurance coverage, who cannot pay for services, and who either do not visit doctors for those reasons or receive services without paying for them. Petitioner's statements and his evidence indicate that the clinics employing him deliver services to patients who have private insurance, are insured under the Medicare program, or have Medicaid

coverage. P. Br. at 2, n.1; P. Ex. 1 at 2. There is no evidence that the clinics employing Petitioner deliver free services or accept patients who have no means of making payments.

Moreover, contrary to Petitioner's contention, the evidence does not show the ratio of primary care patients to physicians in Pinconning to be 4,246 to 1, and the ratio for Prescott shown by the evidence is not 7,708 to 1. P. Br. at 2. The former ratio cited by Petitioner accounts for all parts of Arenac County, specified parts of Bay County (including Pinconning), and specified parts of Gladwin County in 1991. P. Ex. 2. The latter ratio cited by Petitioner applies to the specified parts of Iosco County and Ogemaw County, which includes Prescott, in 1990. P. Ex. 3.

Petitioner has not explained why the 1990 and 1991 statistics applicable to areas much broader than Pinconning and Prescott should be construed as the equivalent of the ratios of patients to primary care physicians for Pinconning and Prescott. There is, for example, no evidence that Pinconning Clinic draws its patients from Gladwin and Arenac Counties. Nor did Petitioner offer evidence on the size of the geographical area from which the Pinconning and Prescott Clinics draw their Medicare and Medicaid patients, the distance already traveled by the majority of program beneficiaries and recipients to these two clinics, or the distance they would need to travel to other providers outside of Pinconning and Prescott. The 1990 and 1991 statistics in evidence do not support Petitioner's conclusion that the ratios of patients to primary care physicians for Pinconning and Prescott are worse than 4,246 to 1 and 7,708 to 1, respectively.

Petitioner's evidence regarding the HPSA designation is insufficient to establish the absence of other providers of primary care services in Prescott and Pinconning. That evidence also fails to support the contention that Petitioner's exclusion will result in unreasonable hardship to Medicare and Medicaid patients seeking care. First of all, the physician-to-patient ratios fail to specify the number of Medicare beneficiaries and Medicaid recipients within the relevant patient population. General patient population data does not persuasively establish that Medicaid beneficiaries and Medicaid recipients will suffer significant adverse impact due to Petitioner's exclusion. As I have earlier discussed, Petitioner's exclusion does not affect his ability to deliver services to non-Medicare and non-Medicaid patients.

Furthermore, I am unable to conclude that Petitioner's exclusion will represent an unreasonable hardship to Medicare and Medicaid patients because Petitioner has offered no evidence that he had cared for these patients while he was employed by the Pelton Clinics in the same area prior to August of 1993. At the most, Petitioner's evidence establishes that he had helped to deliver health care at the Prescott Clinic and Pinconning Clinic to their Medicare and Medicaid patients for a period of six months until his exclusion took effect. There is also no evidence establishing that the 60 percent Medicare/Medicaid caseload at Prescott Clinic or the 70 percent Medicare/Medicaid patient caseload at the Pinconning Clinic represent a significant increase from what these two Clinics used to have before Petitioner began his employment with them in August of 1993. Mr. Berner's affidavit indicates only a significant increase in the patient volume at his clinics since the Pelton Clinics were closed. P. Ex. 1 at 2.

Even assuming that Pinconning and Prescott Clinics will find it very difficult to maintain their current patient caseload and clinic hours during Petitioner's exclusion, this does not amount to proof that the Clinics' Medicare and Medicaid patients will be deprived of reasonable access to care. As discussed above, Petitioner has not proved that the Clinics will be unable to refer some of their Medicare and Medicaid patients to other comparable providers in the area.[8] While I appreciate the Clinics' interest in retaining all the Medicare and Medicaid patients within their existing caseload and Petitioner's usefulness to the Clinics towards that end, the issue before me is whether alternative sources of health care are reasonably available to program beneficiaries and recipients. The issue is not what difficulties the employing health care facility will experience in maintaining the status quo during the term of an exclusion. Petitioner's evidence is lacking on proof that reducing its current caseload by referrals would result in unreasonable barriers to care for Medicare and

---

[8] I do not imply that, due to Petitioner's exclusion, the Prescott or Pinconning Clinics are required to refer their Medicare and Medicaid patients elsewhere. I am merely addressing here Petitioner's contention that the Clinics have difficulty maintaining their current patient load. Certainly, the asserted patient load difficulties may be alleviated also by referring the privately-insured patients elsewhere if the Clinics wish to retain their Medicare and Medicaid patients.

Medicaid patients. Nor does the evidence prove that Medicare and Medicaid patients with potentially serious medical conditions will be forced by Petitioner's exclusion to wait a day or two to be seen by a Physician's Assistant. As I stated previously, the evidence shows only that waiting may be possible if the Prescott and Pinconning Clinics endeavor to retain all their current patients or if all their current patients choose not to be treated elsewhere.

In sum, Petitioner has not proved by a preponderance of the evidence that no alternative sources of the type of service provided by Petitioner are available within the meaning of the regulation. Therefore, Petitioner's current exclusion cannot be reduced due to any legally cognizable mitigating factor.

CONCLUSION

For the foregoing reasons, I uphold the three-year exclusion directed and imposed by the I.G.

/s/

Mimi Hwang Leahy
Administrative Law Judge