DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Office of the Administrator

[redacted]

VIA HAND-DELIVERY AND CERTIFIED MAIL

[redacted]

Re: Notice of Proposed Exclusion for [redacted]

Dear [redacted]

The Centers for Medicare and Medicaid Services ("CMS") of the Department of Health and Human Services ("HHS") is proposing to exclude [redacted] "You" or "Your") from participation in Medicare, Medicaid, and all other Federal health care programs (as defined in section 1128B(f) of the Social Security Act ("Act"), 42 U.S.C. § 1320a-7b(f)), for a period of five (5) years. This action is being taken under section 1128(b)(7) of the Act, 42 U.S.C. § 1320a-7(b)(7), and the October 9, 2026, Delegation of Authority (Delegation) from the HHS Secretary to the CMS Administrator. The exclusion is based on Your submission of claims to Medicaid for items or services that You knew or should have known were not provided as claimed or were false or fraudulent.

I. STATUTORY AND REGULATORY BASIS FOR THE PROPOSED EXCLUSION

CMS is authorized to exclude any individual or entity from participating in Medicare, Medicaid, and all other Federal health care programs pursuant to section 1128(b)(7) of the Act, if that individual or entity has committed an act that is described in the Civil Monetary Penalties Law ("CMPL"), section 1128A of the Act, 42 U.S.C. § 1320a-7a. See 42 U.S.C. § 1320a-7(b)(7).

The CMPL prohibits knowingly presenting, or knowingly causing to be presented, to any officer, employee, or agent of the United States or any department or agency thereof, or of any State agency, a claim that the Secretary determines is for a medical or other item or service that the person knows or should know was not provided as claimed. 42 U.S.C. § 1320a-7a(a)(1)(A). Additionally, the CMPL prohibits knowingly presenting, or

knowingly causing to be presented, to any officer, employee, or agent of the United States or any department or agency thereof, or of any State agency, a claim that the Secretary determines is for a medical or other item or service that the person knows or should know is false or fraudulent. 42 U.S.C. § 1320a-7a(a)(1)(B).

CMS follows HHS's applicable policies, procedures, guidelines, and regulations, including regulations promulgated by the HHS Office of Inspector General ("OIG") at 42 C.F.R. § 1001.2001 et seq.

FACTUAL BASIS FOR THE PROPOSED EXCLUSION

[redacted] knowingly presented or caused to be presented to New York Medicaid claims for items or services that [redacted] knew or should have known were not provided as claimed, or were false or fraudulent, which constitutes an act described in the CMPL (42 U.S.C. § 1320a-7a(a)(1)(A)–(B)) and subjects You to exclusion under 42 U.S.C. § 1320a-7(b)(7).

For dates of service from [redacted] presented or caused to be presented claims to New York Medicaid for adult day health care services using procedure code S5102 when [redacted] did not provide those services. [redacted] billed [redacted] to New York Medicaid for these adult day health care services.

II. LENGTH OF EXCLUSION

[redacted] will be excluded from participation in Medicare, Medicaid, and all other Federal health care programs for a period of 5 years. Exclusion under section 1128(b)(7) of the Act is appropriate based on [redacted] actions as described in sections 1128A(a)(1)(A)–(B) of the Act. In determining the length of exclusion, CMS has considered the factors in accordance with 42 C.F.R. § 1001.901, and applied the following relevant factors:

A. The Nature and Circumstances Surrounding the Action That Are the Basis for the Liability

[redacted] knowingly submitted or caused to be submitted claims to New York Medicaid for services that [redacted] knew or should have known were false, fraudulent, or not provided as claimed. [redacted] billed [redacted] to New York Medicaid for claims for adult day health care services that were never provided.

B. The Degree of Culpability

[redacted] is highly culpable because for more than two years, it repeatedly billed for adult day health care services when it knew or should have known that those services were not rendered.

III. EFFECT OF PROGRAM EXCLUSION AND APPEAL RIGHTS

Information related to the effect of program exclusion and Your right to appeal this action is provided for Your reference in enclosures 1 and 2.

Sincerely,

Kimberly Brandt
Deputy Administrator

Enclosures
1. The Effect of Program Exclusion
2. Appeal Rights

Please read carefully and retain this important information about Your proposed exclusion.

You will be excluded from participation in all Federal health care programs (FHCPs), as defined in section 1128B(f) of the Social Security Act (Act). See 42 U.S.C. § 1320a-7b(f). The Act defines a FHCP as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (except the Federal Employees Health Benefits Program). State health care programs are defined in section 1128(h) and include plans and programs under titles XIX, V, XX, and XXI.

The effect of Your proposed exclusion is that no payment may be made by any FHCP (including but not limited to Medicare, Medicaid, and TRICARE) for any items or services furnished, ordered, or prescribed by You, including services that do not directly involve patient care. You would also be prohibited from submitting or causing claims to be submitted to FHCPs for items or services You furnish, order or prescribe. This prohibition would apply regardless of whether You receive payment directly from any FHCP or whether payments are received by an employer.

A violation of Your exclusion may subject You to criminal prosecution and/or the imposition of civil monetary penalties and the denial of Your reinstatement to the programs. See 42 U.S.C. § 1320a-7a(a)(1)(D); 42 U.S.C. § 1320a-7b(a)(3).

If You are excluded, HHS is required to notify all applicable State health care program agencies and state licensing agencies of Your exclusion. Such agencies may impose additional sanctions under their own authorities. In addition, Your exclusion would be posted on the HHS's List of Excluded Individuals/Entities, https://exclusions.oig.hhs.gov/.
The proposed exclusion does not affect Your rights or the rights of Your family members to collect benefits to which You or they may be entitled as a beneficiary under any Federal program such as Medicare, Medicaid, or Social Security.

Reinstatement to FHCP participation is not automatic. You would not be reinstated at the conclusion of Your period of exclusion unless You apply to HHS and are granted reinstatement. Upon receipt of a request for reinstatement, HHS will notify You of the information and documentation required to reach a decision on Your reinstatement. **Obtaining a state license to provide health care or a provider number from a Medicare contractor, a State Medicaid agency, or other Federal health care program does not reinstate Your eligibility to participate in FHCPs.**

HOW TO APPEAL YOUR EXCLUSION

The exclusion authorized by section 1128(b)(7) of the Act, 42 U.S.C. § 1320a-7(b)(7), and as set forth in this notice, will automatically become effective 65 days after the date of this letter unless You submit a timely request for a hearing. See 42 C.F.R. § 1001.2003.

You may appeal Your exclusion and file a request for a hearing before an administrative law judge (ALJ). A request for hearing must be made in writing within 60 days of receiving CMS's notice of exclusion. The date of receipt of the notice will be presumed to be five (5) days after the date of such notice unless there is a reasonable showing to the contrary. See 42 C.F.R. § 1005.2(c).

Your request for hearing must be accompanied by: (1) a copy of CMS's proposed exclusion action; (2) the specific issues or statements in the notice with which You disagree; (3) the basis for that disagreement; (4) the defenses on which reliance is intended; (5) any reasons why the proposed length of exclusion should be modified; and (6) reasons why the health or safety of individuals receiving services under Medicare or any of the State health care programs does not warrant the exclusion going into effect prior to the completion of an ALJ proceeding. See 42 C.F.R. §§ 1001.2003(a), 1005.2(d). Your request for a hearing should be filed with the Departmental Appeals Board through the Electronic Filing (E-Filing) System. Access to the E-Filing System and additional information regarding E-Filing instructions, procedures, and filing deadlines may be found at https://dab.efile.hhs.gov.

In the event You are unable to file a hearing request using the DAB E-Filing System, You may submit all of the required information by mail to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, DC 20201