Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Riverview Psychiatric Center
Docket No. A-14-45
Decision No. 2586
August 4, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Riverview Psychiatric Center (Riverview) appeals the dismissal of its hearing request by an Administrative Law Judge (ALJ) pursuant to 42 C.F.R. 498.70(b). *Ruling Dismissing Petitioner's Request for Hearing*, ALJ Ruling No. 2014-18 (January 3, 2014)(ALJ Ruling). The ALJ dismissed the hearing request on the ground that Riverview had no right to a hearing on the decision of the Centers for Medicare & Medicaid Services (CMS) not to reopen its determination to terminate Riverview's participation in the Medicare program. We affirm the ALJ Ruling.

Legal Background

Provider Requirements and Grounds for Termination

To participate in Medicare, a psychiatric hospital must meet the statutory definition of "psychiatric hospital" and satisfy specified requirements for all hospitals, including the requirement that the hospital "meet such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution." Social Security Act (Act) §§ 1861(e),(f), 1871 (42 U.S.C. §§ 1395x(e),(f), 1395hh). *See also* Act § 1866 (42 U.S.C. § 1395cc)(terms and conditions of provider agreements); 42 C.F.R. §§ 482.1 et seq. (statutory basis and scope of conditions for participation of hospitals), 488.3(a)(stating basic requirement to meet applicable statutory definition and conditions of participation). The requirements the Secretary found necessary for psychiatric hospitals participating in Medicare are the conditions in 42 C.F.R. Part 482, which include the special conditions that apply to psychiatric hospitals, in sections 482.60-62, as well as the conditions for hospitals generally in sections 482.1-482.23 and 482.25-482.57. *See* 42 C.F.R. § 482.60(b).

CMS may "deem" a psychiatric hospital to meet Medicare conditions of participation (except for specified requirements not relevant here) if the hospital is accredited by an approved accreditation organization, but CMS may require a validation survey of an accredited psychiatric hospital if CMS receives a substantial allegation of a deficiency.

42 C.F.R. §§ 488.5, 488.7(a), 488.8(c). If the validation survey finds the psychiatric hospital not in substantial compliance with a Medicare participation condition, CMS no longer deems the hospital to meet any Medicare condition, and the hospital is subject to the participation and enforcement requirements applicable to all providers found out of compliance following a State agency survey under section 488.24, including termination of its provider agreement under section 489.53 and any applicable intermediate sanctions.[1] 42 C.F.R. § 488.7(d).

Each condition of participation represents a broad category of services, contained in a single regulation divided into subparts called standards. *See* 42 C.F.R. § 488.26(b). State survey agencies, under agreements with the Secretary, survey psychiatric hospitals and make certifications to CMS, which administers the Medicare program for the Secretary, as to whether the hospitals are in substantial compliance with the applicable conditions of participation. Act § 1864 (42 U.S.C. § 1395aa); 42 C.F.R. §§ 488.10-30. Certifications by the State survey agency "represent recommendations to CMS" based on which "CMS will determine whether . . . [the psychiatric hospital] . . . is eligible to participate in . . . the Medicare program." 42 C.F.R. § 488.12. The surveyors assess the manner and degree to which the provider satisfies the standards within the condition, 42 C.F.R. § 488.26(b), and "will certify that a provider . . . is not or is no longer in compliance with the conditions of participation . . . where the deficiencies are of such character as to substantially limit the provider's . . . capacity to furnish adequate care or . . . adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b).

The Secretary is authorized to terminate the Medicare provider agreement of a psychiatric hospital that "fails substantially to meet the applicable provisions of section 1861 [of the Act]," including the conditions of participation the Secretary has adopted to implement the statute. Act § 1866(b)(2)(B) (42 U.S.C. §1395cc(b)(2)(A),(B)), 42 C.F.R. § 489.53(a)(1),(3). CMS may afford a psychiatric hospital having "standard" level deficiencies an opportunity to avoid termination by correcting the deficiencies, provided the hospital submits an acceptable plan for timely correcting the deficiencies and the deficiencies individually or in combination do not jeopardize the health and safety of patients or seriously limit the hospital's capacity to render adequate care. 42 C.F.R. § 488.28.

Notice and Appeal Rights

Except when there has been an immediate jeopardy determination, CMS must give notice that it is terminating a provider agreement under section 489.53 at least 15 days before the effective date of the termination, and the notice must include the effective date of the termination and the reasons for the termination. 42 C.F.R. § 489.53(d). A provider may

[1] We note that section 488.7(d) contains a typographical error, citing the termination authority as "section 439.53 . . . ." Section 488.7(c) correctly cites section 489.53 as the termination authority.

appeal the termination in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 489.53(e). The Part 498 regulations provide appeal rights for "initial determinations" made by CMS. 42 C.F.R. § 498.3(a)(1), (b). A CMS determination to terminate a Medicare provider agreement pursuant to 42 C.F.R. § 489.53 is specifically listed as an "initial determination." 42 C.F.R. § 498.3(b)(8). A provider has 60 days from the date it receives a termination notice to file a written hearing request, unless the ALJ grants an extension of time for good cause shown. 42 C.F.R. § 498.40. An ALJ may dismiss a hearing request where there is no right to a hearing. 42 C.F.R. § 498.70(b).

Case Background

Riverview was a "deemed status" psychiatric hospital owned and operated by the State of Maine that participated in the Medicare program. ALJ Ruling at 2; CMS Exs. 1, at 4; 2. In March and May 2013, the Maine Department of Health and Human Services, Division of Licensing and Regulatory Services (Maine State agency), conducted two surveys at Riverview to determine whether it was in substantial compliance with Medicare participation requirements. ALJ Ruling at 2, citing CMS Ex. 2; CMS Ex. 3. On both surveys, the Maine State agency found that Riverview was not in substantial compliance and so notified CMS. *Id*. On June 4, 2013, CMS sent Riverview a letter notifying the hospital of CMS's determinations that the hospital was not in substantial compliance and that its Medicare provider agreement was being terminated effective September 2, 2013. *Id*., citing CMS Ex. 3. The letter also notified Riverview that it could avoid termination if it submitted an acceptable plan of correction (POC) and a follow-up survey found that it had corrected its deficiencies. *Id*.

Riverview submitted two POCs that CMS found unacceptable, one on June 14 and the other on July 18, 2013. *Id*., citing CMS Ex. 4; CMS Ex. 12; *see also* CMS Ex. 5 (July 29, 2013 letter stating that the July 18 POC was acceptable for some but not all deficiencies and warning that failure to submit an acceptable POC would not delay the effective date of the termination). In a letter dated August 14, 2013, CMS notified Riverview that it would proceed with the termination effective September 2, 2013. *Id*., citing CMS Ex. 6. The letter notified Riverview of its right to appeal the termination. CMS Ex. 6, at 2. The letter also gave Riverview a chance to "immediately" submit a final POC and stated that if CMS found the POC acceptable, "the [State agency] and the CMS psychiatric hospital contract surveyors may conduct a revisit survey to determine whether compliance has been achieved."[2] CMS Ex. 6, at 3. The letter warned Riverview that this opportunity to submit a final POC and the possibility of another survey "should not be interpreted as an extension to the termination date of September 2, 2013." *Id*.

[2] The ALJ cited this letter but inaccurately described it as stating that "a survey would be conducted . . ." if the hospital submitted an acceptable POC. ALJ Ruling at 2 (emphasis added).

On August 16, 2013, Riverview submitted another POC, which it later supplemented. ALJ Ruling at 2, citing CMS Ex. 8, at 1, CMS Ex. 12, at 3. CMS found this POC acceptable and conducted another survey at Riverview on September 17, 2013, after the termination had gone into effect. Based on the results of this survey, CMS decided not to reopen or revise its initial determination to terminate Riverview's provider agreement and so notified Riverview in a letter dated September 27, 2013. *Id*., citing CMS Ex. 9. Riverview filed a hearing request on October 11, 2013 and requested an expedited hearing which the ALJ granted. CMS moved to dismiss Riverview's hearing request or, in the alternative, for summary judgment. *Id*. Petitioner opposed the motion to dismiss and cross-moved for summary judgment. *Id*. Neither party contended there were disputes of material fact. *Id*.

On January 3, 2014, the ALJ granted CMS's motion to dismiss, concluding that Riverview had no right to a hearing because it did not timely file a hearing request challenging CMS's initial determination to terminate its provider agreement, of which Riverview was notified on June 4, 2013, and had no right to a hearing on CMS's declination to reopen or revise that initial determination. The ALJ noted that even the appeal Riverview filed October 11, 2013, did not challenge the initial determination but only challenged CMS's decision not to reopen that determination.

Standard of Review

The Board's standard of review concerning a disputed finding of fact is whether the finding is supported by substantial evidence on the record as a whole. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. The Board's standard of review concerning a disputed conclusion of law is whether the conclusion is erroneous. *Id.* "The standard of review for an ALJ's exercise of discretion to dismiss a hearing request where such dismissal is committed by regulation to the discretion of the ALJ is whether the discretion has been abused." *High Tech Home Health, Inc.*, DAB No. 2105, at 7-8 (2007), *aff'd*, *High Tech Home Health, Inc. v. Leavitt*, Civ. No. 07-80940 (S.D. Fla. Aug. 15, 2008). However, where an ALJ dismisses a hearing request because it addresses only issues that as a matter of law are not initial determinations, and, thus, are not matters within the ALJ's review authority, the standard of review is whether the ALJ erred in dismissing the hearing request. DAB No. 2105, at 12-13.

Discussion

The ALJ correctly concluded that Riverview had no right to a hearing and dismissed its appeal.

An ALJ is authorized to dismiss a hearing request where the party requesting a hearing has no right to one. 42 C.F.R. § 498.70(b). The ALJ concluded here that Riverview had no right to a hearing as a matter of law because its hearing request did not appeal the initial determination made by CMS to terminate Riverview's Medicare participation agreement based on the findings of noncompliance on the March and May 2013 surveys but, instead raised matters that were not initial determinations and, therefore, carried no appeal rights. These matters were Riverview's challenge to CMS's September 27, 2013 decision not to reopen or revise its initial determination and Riverview's argument that CMS effectively reopened and revised its initial determination or made another initial determination by accepting its POC and then, according to Riverview, finding it failed to properly implement that POC. ALJ Ruling at 3-4.

We agree with the ALJ that Riverview's hearing request did not seek review of the initial determination to terminate communicated to Riverview on June 4 and reiterated on August 14, 2013 or the findings of noncompliance underlying that initial determination. Riverview's request for review to the Board also does not challenge the ALJ's finding that it did not seek review of that initial determination. Instead, Riverview states in its request for review here that it "seeks review of two issues: 1) whether the ALJ erred in determining that Riverview is not entitled to obtain review of CMS's determination that Riverview failed to properly implement the Plan of Correction CMS previously accepted; and 2) if the ALJ did so err, whether the Board . . . should proceed to address the merits and hold that CMS was wrong as a matter of law when it concluded that Riverview failed to implement the accepted POC properly." Request for Review (RR) at 2-3. With respect to the first issue, Riverview argues that the ALJ "erred by failing to recognize that, notwithstanding the characterization chosen by CMS, the September 27 determination was <u>not</u> one refusing to reopen or revise an earlier determination [but] [r]ather, CMS had revised its earlier determination on August 29, when it accepted Riverview's POC." *Id*. at 2 (emphasis in original). Riverview specifically states that it "does not seek review of any factual findings" made by the ALJ. *Id*. at 3.

We conclude for the reasons discussed below that the ALJ did not err in dismissing Riverview's hearing request on the ground that it did not appeal the only initial determination made by CMS but, rather, raised issues that as a matter of law could not be appealed to an ALJ. Accordingly, we do not reach Riverview's second challenge, which goes to the merits of CMS's decision on a matter for which there are no appeal rights.

A. CMS made an initial determination to terminate Riverview's provider agreement based on findings of noncompliance during the March and May 2013 surveys, and that determination became final because the hearing request Riverview filed did not challenge it.

Riverview did not dispute below, and does not dispute here, that CMS made an initial determination to terminate its provider agreement effective September 2, 2013 based on Riverview's failure to be in substantial compliance with the conditions of participation for psychiatric hospitals, as determined based on the March and May 2013 surveys. Riverview also did not deny below, and does not deny here, that CMS notified it of that determination in a letter dated June 4, 2013 and reiterated the determination in a letter dated August 14, 2013, which also gave Riverview notice that it had the appeal rights set forth in 42 C.F.R. § 498.40 et seq. Riverview also does not dispute that these letters stated that the basis for the termination involved findings of noncompliance with conditions of participation made during the March and May 2013 surveys, specified the areas of noncompliance and enclosed statements of deficiencies for each survey. *See* CMS Exs. 2, 3.

Although Riverview does not dispute that these CMS letters gave it notice of an initial determination based on findings of noncompliance on the March and May 2013 surveys which it could have appealed, Riverview's hearing request, filed on October 11, 2013, did not challenge that initial determination or any of these findings of noncompliance. Instead, Riverview's hearing request challenged CMS's September 27, 2013 conclusion (based on the September 17, 2013 revisit) that it "will not re-open and revise its initial determination to terminate Riverview Psychiatric Center's Medicare provider agreement." CMS Ex. 9, at 1. The ALJ aptly summarized as follows the silence of Riverview's hearing request on the findings of noncompliance from the March and May 2013 surveys and the termination action based on those findings:

> Petitioner waited until October 11, 2013 to file a hearing request that challenged something entirely different than CMS's termination of its provider status. On that date, Petitioner challenged CMS's declination to reopen its initial determination based on Petitioner's August 16, 2013 plan of correction and the September 17, 2013 survey of Petitioner. In short, Petitioner did not file a hearing request timely in which it denied CMS's initial findings of noncompliance that are the basis for the termination of Petitioner's provider status. Rather, it challenged CMS's refusal to rescind those findings as a consequence of CMS's declination to accept certain corrective actions that Petitioner allegedly took subsequently.

ALJ Ruling at 3-4.

In reaching the conclusion that Riverview had not challenged the findings of noncompliance on the material surveys of March and May 2013, the ALJ noted, "Petitioner now argues that it would challenge the merits of CMS's initial determination if these are relevant to the outcome of this case." ALJ Ruling at 4. (The ALJ's reference is to a footnote in Riverview's hearing request that states, "In the event that CMS claims that the March and May deficiencies are somehow relevant to this appeal, [Riverview] reserves the right to seek review of these issues." Hearing Request at 2, n.2.) However, the ALJ went on to state,

> But, in fact, Petitioner has offered no challenge to those findings. It has never argued that the substantive findings of noncompliance made by the Maine State agency surveyors at the March and May 2013 surveys were incorrect. It has offered no evidence to show that those findings were incorrect and it has not represented that it would offer such evidence if given the opportunity to do so. So, this case rests on unchallenged findings of condition-level noncompliance by Petitioner. CMS's determination to terminate . . . based on those findings is unchallenged and Petitioner never timely filed a hearing request challenging those findings.

ALJ Ruling at 4. We have reviewed the record carefully and agree that neither Riverview's hearing request nor any other document of record shows that Riverview challenged before the ALJ the findings of noncompliance on the March and May 2013 surveys.[3] Indeed, the record shows that Riverview did not make any argument challenging those findings even after CMS directly addressed Riverview's footnote before the ALJ. After noting the language in the footnote, CMS stated that, "[p]rior to, and during the . . . case conference with the . . . [ALJ], . . . counsel informed counsel for Riverview that CMS' position is that the March and May findings are the relevant findings because they formed the predicate basis for CMS' initial determination to terminate Riverview's provider agreement" but that "[t]here has been no timely challenge to these findings." Motion to Dismiss at 6-7. In its response to this motion, Riverview continued to address only the findings of noncompliance from the September 17, 2013 revisit. *See* Petitioner's Motion for Summary Judgment With Incorporated Memorandum of Law, and Opposition to CMS' Motions to Dismiss and for Summary Judgment.

[3] Since we agree with the ALJ (and Riverview does not dispute) that Riverview's hearing request did not challenge CMS's initial determination to terminate Riverview's provider agreement based on the findings of noncompliance on the March and May 2013 surveys, we need not decide whether Riverview's hearing request was filed in time to make such a challenge.

Moreover, on appeal, Riverview expressly concedes that it "had no interest in appealing the original deficiency findings, and instead committed to developing a POC." RR at 16-17. Riverview also states that "as the ALJ correctly recognized that none of the material facts is in dispute . . . , Riverview does not seek review of any factual findings." RR at 3. Accordingly, we affirm the ALJ's conclusion that the initial determination CMS made based on findings of noncompliance during the March and May 2013 surveys has not been appealed and is final.

B. The ALJ correctly concluded that CMS's September 27, 2013 decision not to reopen or revise its initial determination was not an initial determination and, therefore, conveyed no appeal rights.

As stated above, Riverview's appeal challenges CMS's September 27, 2013 decision not to reopen or revise its initial determination based on the findings of noncompliance found on the September 17, 2013 revisit survey (as communicated to Riverview in CMS's letter of September 27, 2013), not CMS's initial determination to terminate its provider agreement based on the findings of noncompliance made on the March and May 2013 surveys. Riverview contends that CMS's September 27, 2013 decision was another initial determination for which it has appeal rights. Riverview characterizes CMS's September 27 decision as an initial determination that Riverview had failed to implement the POC that CMS had accepted. RR at 12-17. The ALJ rejected this characterization and the argument that CMS's September 27, 2013 decision was another initial determination. The ALJ found that the decision CMS communicated to Riverview in its September 27, 2013 letter was a decision not to reopen or revise its initial determination to terminate Riverview's Medicare participation agreement and concluded that "CMS's declination to accept those remedial actions cannot be a basis for hearing rights because it is not an initial determination defined at 42 C.F.R. § 498.3(b)." ALJ Ruling at 2, 4.

The ALJ correctly rejected Riverview's characterization and argument. After referring to the termination "effective September 2, 2013," the September 27, 2013 letter states,

> CMS has reviewed these findings and concluded that it will not re-open and revise its initial determination to terminate [Riverview's] Medicare provider agreement. Accordingly, the termination action remains effective as of September 2, 2013.

CMS Ex. 9, at 1. This language unambiguously states a decision not to reopen or revise a pre-existing initial determination, and there is no legal basis for concluding that the September 27, 2013 letter was another initial determination. Section 498.3(b) sets forth the administrative actions or decisions made by CMS that constitute initial determinations for the purpose of conveying appeal rights. Section 498.3(a) states, "This part sets forth procedures for reviewing initial determinations that CMS makes with respect to the matters specified in paragraph (b) of this section . . . ." Section 498.3(b)

states that "CMS makes initial determinations with respect to the following matters:" and then lists the matters that are initial determinations. Relying on this language, the Board noted in *North Ridge Care Center*, "By its very terms, Part 498 provides appeal rights only for these listed actions." DAB No. 1857, at 8 (2002). *See also Capitol House*, DAB No. 2252 (2009), at 2 ("[A]dministrative actions that are not CMS initial determinations are not subject to appeal."); *High Tech Home Health, Inc*. at 12(upholding dismissal of hearing request that did not "identif[y] any cognizable dispute regarding CMS's initial determination" to terminate High Tech's Medicare provider agreement based on two surveys but instead raised claims that "[a]re [n]ot [m]atters [a]ppealable [u]nder [s]ection 498.3(b)").

Riverview does not dispute the ALJ's conclusion that Part 498 determines which administrative actions by CMS constitute initial determinations. Under Part 498, CMS's decision to terminate Riverview's provider agreement based on Riverview's noncompliance with conditions of participation for psychiatric hospitals, as found on the March 29 and May 10, 2013 surveys, clearly was an initial determination because the CMS actions designated as "initial determinations" in Part 498 include "the termination of a provider agreement in accordance with § 489.53." 42 C.F.R. § 498.3(b)(8); *see also* 42 C.F.R. § 498.5(b)("Any provider dissatisfied with an initial determination to terminate its provider agreement is entitled to a hearing before an ALJ."). Conversely, and just as clearly, CMS's September 27, 2013 letter communicating the unfavorable results of the post-POC revisit and CMS's decision not to reopen or revise the initial determination was not an initial determination under Part 498 because, as Riverview does not dispute, the CMS actions designated as "initial determinations" in section 498.3(b) do not include CMS's decision not to reopen or revise an initial determination.

There is no merit to Riverview's argument that CMS's September 27, 2013 letter was somehow transformed into an initial determination simply because it referred Riverview to CMS's August 14, 2013 letter "for information about requesting a hearing before an Administrative Law Judge . . . under the procedures specified at 42 C.F.R. Part 498." RR 11, 13 (quoting Sept. 27, 2013 letter). The existence of an appeal right here turns on the regulation itself. Riverview's appeal rights under 42 C.F.R. § 498.3(b) are not altered by any language in CMS's September 27, 2013 letter. Furthermore, the August 14, 2013 letter merely stated that the determination reiterated in that letter (the same determination originally stated in CMS's June 4, 2013 letter) could be appealed: "If you disagree with this determination, you . . . may request a hearing before an ALJ . . . ." CMS Ex. 6, at 1.

Thus, in referring Riverview to information about requesting a hearing in the August 14 letter, the September 27 letter was simply reminding Riverview of its right to request a hearing on the termination decision addressed in the earlier letter.[4]

C. CMS's actions in accepting Riverview's POC and concluding, based on a revisit survey, that Riverview had not achieved substantial compliance did not constitute a reopening or revision of CMS's initial determination.

As indicated above, Riverview's argument that CMS's decision not to reopen or revise constituted another initial determination is based on an erroneous understanding of the meaning of CMS's acceptance of a POC. Riverview argues that CMS in effect "revised its first initial determination when it accepted Riverview's POC . . . [and that] [w]hen CMS then concluded that Riverview failed to implement the POC properly, this was an initial determination subject to review." RR at 12. The ALJ rejected this argument, stating as follows:

> There is nothing in the regulations that suggests that Petitioner's analysis is correct. "Acceptance" of a plan of correction doesn't mean, necessarily that deficiencies have been corrected; it means only that CMS is willing to evaluate a provider's performance based on what the provider has represented to CMS. There is no right to a hearing should CMS subsequently survey the facility and find that the facility has failed to comply with its own plan of correction. That finding is not an initial determination as is defined by 42 C.F.R. § 498.3.

ALJ Ruling at 5.

[4] We decline to admit to the record letters dated April 3 and 10, 2014, signed by the Associate Regional Administrator in CMS's Boston office, that Riverview submitted to the Board with a letter dated July 7, 2014, as supplemented by a motion to admit dated July 15, 2014. We also do not admit to the record a declaration by the CMS official who signed those letters, which CMS filed with its response objecting to admission of the letters. In support of its motion, Riverview argues that the April 3 letter "demonstrate[s] CMS' understanding that its September 27 determination was not one declining to 'reopen' an earlier determination . . . [but] [r]ather . . . a new determination based on alleged deficiencies identified during the September 17 survey." Riverview's July 7, 2014 letter at 2 (unnumbered). By regulation, "the Board may admit evidence into the record in addition to the evidence introduced at the ALJ hearing . . . if the Board considers that the additional evidence is relevant and material to an issue before it." 42 C.F.R. § 498.86. The alleged after-the-fact "understanding" of a CMS official who did not sign the CMS termination notice letters or the September 27, 2013 letter declining to reopen or revise that termination and who worked in a separate operating division of CMS which had no role in the termination action is not relevant or material to the issue for which Riverview submits the letters or any other issue properly before us. *Compare* CMS Exs. 3, 6 and 9 *with* Riverview's proposed Exs. A and B; *see also* proffered Declaration of Richard R. McGreal. Additionally, Riverview's motion acknowledges that the CMS official who signed the April 3 and 10, 2013 letters stated in the latter letter that "any 'suggestion' in his April 3 letter that Riverview's termination 'was based on the findings of noncompliance identified during the September 17, 2013 survey . . . was incorrect.'" Riverview's July 7, 2014 letter at 2. Riverview further acknowledges that the official "goes on to state that the termination was based on deficiencies identified during the March and May 2013 surveys." *Id*.

The ALJ did not err in rejecting Riverview's argument. We note at the outset that neither CMS's action in accepting a POC nor any action it subsequently takes with respect to evaluating whether the provider's actions toward implementing that POC resulted in its achieving substantial compliance is listed as an "initial determination" in section 498.3(b). Moreover, the regulations governing the POC and revisit surveys at issue here make it clear that CMS's action in accepting a POC is not a determination of compliance at all; nor is that action a commitment to finding the provider in substantial compliance with all participation requirements if the provider implements the POC. The regulations governing a psychiatric hospital's submission, and CMS's acceptance, of a POC provide in relevant part:

> If a provider or supplier is found to be deficient with respect to one or more of the standards in the conditions of participation . . . , it may participate in or be covered under [Medicare] only if the facility has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to the Secretary.

42 C.F.R. § 488.28(a).[5]

The regulations further provide for a revisit survey which is defined as follows:

> *Revisit survey* means a survey performed with respect to a provider or supplier cited for deficiencies during a . . . substantiated complaint survey and that is designed to evaluate the extent to which previously-cited deficiencies have been corrected and the provider . . . is in substantial compliance with applicable conditions of participation . . . .

42 C.F.R. § 488.30(a). [6] Hence, a revisit survey, which occurs after CMS accepts a POC, provides CMS with an opportunity to determine whether a provider has corrected its deficiencies and achieved substantial compliance.

[5] We note that this regulation is separate from the POC regulations for long-term care facilities, but the meaning of a POC is similar under both sets of regulations. *See* 42 C.F.R. § 488.401(defining POC for purposes of long-term care enforcement); 42 C.F.R. § 488.402(d)(1)(POC requirement for long-term care facilities); 42 C.F.R. § 488.412 (permitting CMS to allow a long-term care facility having no deficiencies that pose immediate jeopardy to resident health or safety to continue to participate in Medicare for no longer than six months from the last day of the survey under certain conditions, which include submission of a "[POC] and timetable for corrective action approved by CMS").

[6] "Revisit surveys include both offsite and onsite review." *Id*.

These regulations make it clear that in accepting a POC, CMS is not making any decision or commitment regarding the hospital's correction of deficiencies or achievement of compliance and, indeed, that such a decision, if any, will be made only in the future, after the "reasonable period of time acceptable to the Secretary" has expired and the Secretary verifies correction and compliance. Neither regulation states that if CMS finds the previously cited deficiencies have been corrected, CMS will necessarily find the hospital has achieved substantial compliance with all participation requirements. Nor does either regulation state or suggest that a CMS conclusion following a revisit survey that the facility has not achieved substantial compliance is an "initial determination" that can be appealed.

The Board has specifically held in the long-term care facility context that acceptance of a POC does not operate to convert a termination already imposed, as was the case with the termination here, into a termination contingent on the results of a revisit. *Beverly Health & Rehabilitation-Springhill*, DAB No. 1696 (1999); *cf. Concourse Nursing Home*, DAB No. 1856, at 5 (2002)(holding that a Statement of Deficiencies that is revised following informal dispute resolution "does not constitute a 'reconsideration or revised determination' within the meaning of 42 C.F.R. § 498.5 and creates no new appeal rights"). The Board also held in a skilled nursing home appeal that even a finding on revisit that previously cited deficiencies have been corrected (as was not the case here) "is not the same as a determination that a [provider] has achieved substantial compliance with all participation requirements." *Meadowbrook Manor-Naperville*, DAB No. 2173, at 13 (2008), *aff'd sub nom.*, *Butterfield Health Care v. Johnson*, No. 08-CV-3604 (N.D.Ill. April 16, 2009). Although these decisions occurred in the context of terminations of long-term care facility providers, rather than hospital providers, we find the holdings of these Board decisions applicable here. In either context, the holdings are consistent with the limitation of appeal rights to CMS initial determinations, as defined in Part 498.

Riverview's reliance on the ALJ decisions in *Nazareno Medical Hospice*, DAB CR386 (1995) and *Guaynabo Hospice Care, Inc.*, DAB CR374 (1995) is misplaced. As Riverview acknowledges, RR at 13, n.5, ALJ decisions are not binding precedent. Moreover, contrary to Riverview's suggestion, those ALJ decisions do not hold that ALJs have jurisdiction to review a provider's challenge to CMS's determination that a provider has failed to implement a POC submitted to correct deficiencies that resulted in an initial determination of noncompliance that the provider never appealed. As CMS asserts, at most, those decisions represent conclusions of the two ALJs in those cases regarding the scope of their review in the context of an otherwise valid appeal of an initial determination by CMS. *See* CMS Response at 24-25.

Thus, neither CMS's acceptance of Riverview's POC nor its determination following the revisit survey that Riverview had not corrected its deficiencies or achieved substantial compliance may, as a matter of law, be viewed either as a reopening or revision of CMS's initial determination to terminate Riverview's provider agreement based on the March and May 2013 surveys or as new initial determinations. We also note that CMS's August 14, 2013 letter reiterating CMS's decision to terminate Riverview's provider agreement effective September 2, 2013 expressly warned Riverview that although CMS might conduct a revisit survey if Riverview submitted acceptable POCs for the March and May surveys, "[t]his should not be interpreted as an extension to the termination date of September 2, 2013." CMS Ex. 6, at 3. Thus, Riverview could not reasonably have thought that by simply accepting the POC or making a determination regarding Riverview's compliance status following September 17, 2013 revisit survey, CMS had somehow revisited and revised the initial determination or made another initial determination.

Conclusion

For the reasons stated above, we uphold the ALJ Ruling.

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member