Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Boone County Hospital
(CCN: 16-5558),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-588

Decision No. CR2526

Date: April 12, 2012

DECISION

There is no basis for the termination of the provider agreement of Petitioner, Boone County Hospital, and its participation in Medicare as a distinct part skilled nursing facility (SNF).

I. Background

Petitioner is a hospital located in Boone, Iowa, that participates in Medicare as a critical access hospital under 42 C.F.R. Part 485.[1] Petitioner also has a provider agreement, first granted in 2005, to participate in Medicare as a 14-bed distinct part SNF. Petitioner was subject to an initial survey in 2005 and to annual surveys in 2006, 2007, and 2008. In September 2009, surveyors of the Iowa Department of Inspections and Appeals (the state agency) attempted to conduct an inspection of the distinct part SNF but could not complete the survey, as there were no residents in the distinct part SNF. On October 14,

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[1] References are to the 2009 revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the termination action, unless otherwise indicated.

2009, the distinct part SNF had four residents, and the state agency surveyors completed a survey. The October 14, 2009 survey cited one deficiency, but that survey is not at issue before me. Transcript (Tr.) at 38-39, 54; P. Ex. 25, at 1-2, ¶¶ 1-11 (the parties' Joint Stipulation of Fact); P. Exs. 14; 15. On November 16, 2009, two federal surveyors from the Centers for Medicare and Medicaid Services (CMS) attempted to conduct a federal monitoring survey but found no residents in the distinct part SNF. P. Ex. 25, at 2, ¶ 12.

CMS notified Petitioner of its decision to terminate Petitioner's provider agreement and participation in Medicare as a distinct part SNF by letter dated February 23, 2010. CMS Exhibit (CMS Ex.) 2. The parties stipulated that the termination was based on the fact that the distinct part SNF had few residents for over a year, which caused CMS to conclude that the distinct part SNF was not providing services to the community on an ongoing basis. P. Ex. 25, at 4, ¶ 26; CMS Ex. 2, at 2. CMS terminated the provider agreement for Petitioner's distinct part SNF effective March 31, 2010. P. Ex. 25, at 4, ¶ 29; CMS Ex. 2, at 2.

Petitioner requested a hearing before an administrative law judge (ALJ) on March 17, 2010. The case was assigned to me for hearing and decision on April 5, 2010, and an Acknowledgement and Prehearing Order was issued at my direction. On March 8, 2011, a hearing was convened in Des Moines, Iowa, and a 241-page transcript of the proceedings was prepared. CMS offered CMS exhibits (Exs.) 1 through 10. CMS withdrew page 22 of CMS Ex. 2 and also withdrew CMS Exs. 4; 5; 6; 7; 8; and 10. Tr. at 19-24. CMS Exs. 1; 2 (pages 1 through 21, 23, and 24); 3; and 9 were admitted as evidence. Tr. at 24. Petitioner offered P. Exs. 1 through 26, and all were admitted as evidence. Tr. at 30. Petitioner's printed Power Point® presentation, which was used during opening statement, was marked as P. Ex. 27 for identification but not admitted as evidence. Tr. at 99-101. CMS called the following witnesses: Surveyor Christina McCuen, RN; and Paul Shumate, Branch Manager, Division of Survey and Certification, Kansas City Regional Office of CMS. Petitioner called the following witnesses: Joseph S. Smith, Chief Executive Officer for Petitioner; David Mellett, Chief Financial Officer for Petitioner; and Sandra Puntenney, Petitioner's Director of Nursing (DON) during the relevant period. The parties filed post-hearing briefs (CMS Br. and P. Br., respectively) and post-hearing reply briefs (CMS Reply and P. Reply, respectively).

II. Discussion

A. Issues

> Whether there is a basis for the termination of Petitioner's participation in Medicare as a distinct part SNF, including termination of Petitioner's provider agreement and revocation of Petitioner's billing privileges.

B. Applicable Law

There is no dispute that, since 2005, Petitioner has been certified to participate in Medicare, with a provider agreement and billing privileges, as a distinct part SNF located within the Boone County Hospital. P. Ex. 25, at 1, ¶¶ 1, 3.

Congress established requirements for SNFs and the quality of care they are to deliver. [2] A SNF is an institution or a distinct part of an institution that is primarily engaged in providing its residents skilled nursing care and related services or rehabilitation services. A SNF may not be primarily for the care and treatment of mental diseases. A SNF must have a transfer agreement with one or more hospitals authorized to participate in Medicare. A SNF must also meet other specific requirements set forth in the Social Security Act (Act) related to the provision of services, resident's rights, and administration. Act § 1819(a)-(d) (42 U.S.C. § 1395i-3(a)-(d)). The Secretary of Health and Human Services (the Secretary) has promulgated regulations in accordance with section 1871 of the Act (42 U.S.C. § 1395hh), establishing participation requirements for SNFs. The regulatory requirements for participation as a SNF are at 42 C.F.R. Part 483, subpart B.

The definition of a "distinct part" SNF and related requirements are at 42 C.F.R. § 483.5(b):

> (1) *Definition*. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that

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[2] Long-term care facilities authorized to participate in Medicare are referred to as SNFs, and those authorized to participate in Medicaid are referred to as nursing facilities (NFs). Participation of a NF in Medicaid is governed by section 1919 of the Social Security Act (42 U.S.C. § 1396r). Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section.

(2) *Requirements*. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:

(i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:

(A) The SNF or NF is wholly owned by the institution of which it is a distinct part.

(B) The SNF or NF is subject to the by-laws and operating decisions of a common governing body.

(C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.

(D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.

(ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part.

(iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.

(iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report.

(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.

(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.

(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.

(C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

The Act requires that the Secretary issue regulations that establish a process for the enrollment of providers and suppliers,[3] including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). The

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[3] A "supplier" furnishes items or services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities,
(Footnote continued next page.)

procedures for enrollment are found at 42 C.F.R. Part 424, subpart P. Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. A provider, such as a SNF, must also enter a provider agreement with CMS as described in 42 C.F.R. Part 489, subpart B.

Congress established an enforcement process to ensure that SNFs maintain compliance with the participation requirements established by section 1819(b), (c), and (d) of the Act. Congress granted the Secretary authority to impose enforcement remedies, including termination of participation in Medicare, to ensure compliance or to remove noncompliant providers and suppliers from participation. Act § 1819(h). The Act provides that the Secretary may terminate a provider agreement for several reasons, including a provider's failure to comply substantially with the provisions of the Act and regulations, or the terms of the provider agreement. Act § 1866(b)(2).

The regulations establish a procedure for the survey and certification of long-term care facilities and delegate the Secretary's authority to enforce compliance to CMS. 42 C.F.R. Part 488, subpart F. State survey agencies on behalf of CMS, or CMS surveyors, survey facilities that participate in Medicare to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose, in addition to termination of participation, if a facility is not in substantial compliance with Medicare participation requirements. 42 C.F.R. § 488.406. Pursuant to 42 C.F.R. § 488.456(b), CMS may terminate a facility's provider agreement for noncompliance with statutory or regulatory participation requirements, among other reasons. The regulation requires that CMS give the provider notice prior to the termination. 42 C.F.R. § 488.456(c). The procedures for termination are those specified by 42 C.F.R. § 489.53. 42 C.F.R. § 488.456(d)(1). A facility has a right to request review of the termination decision by an ALJ and the Departmental Appeals Board (the Board) and to judicial review of a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3.

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(Footnote continued.)

home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)); 42 C.F.R. § 498.2. The distinction between providers and suppliers is important, as they are treated differently under the Act for some purposes.

The Secretary has delegated authority to CMS to terminate provider agreements on the grounds listed in 42 C.F.R. § 489.53. Grounds for termination include, inter alia: failure to comply with the participation requirements established by the Act and regulations; failure to comply with the terms of the provider agreement; and revocation of Medicare enrollment. 42 C.F.R. § 489.53(a)(1), (3), and (15). A provider must be given advance notice of termination of its provider agreement. 42 C.F.R. § 489.53(d). A provider may obtain review by an ALJ, with an appeal to the Board, and judicial review. 42 C.F.R. § 489.53(e).

The Secretary has also delegated authority to CMS to revoke Medicare enrollment, billing privileges, and any related provider agreement. 42 C.F.R. § 424.535(a). Authorized grounds for revocation of billing privileges include a determination by CMS after an on-site review that the provider or supplier is no longer operational to deliver Medicare covered items or services or is not meeting participation requirements under the Act and regulations. 42 C.F.R. § 424.535(a)(5).

> *Operational* means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

42 C.F.R. § 424.502. Pursuant to 42 C.F.R. § 424.535(b), revocation of a provider's billing privileges terminates any provider agreement effective the date of revocation of the billing privileges. A provider or supplier has a right to ALJ review of the CMS revocation decision, with further review by the Board, and judicial review. 42 C.F.R. § 424.545(a). When both the revocation of billing privileges and the termination of the provider agreement are at issue, the regulations provide that the procedures related to revocation of billing privileges apply. 42 C.F.R. § 424.545(a)(1)(ii).

The procedures for ALJ and Board review are set forth in 42 C.F.R. Part 498. The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense.

Batavia Nursing & Convalescent Inn, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[4] The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

CMS notified Petitioner by letter dated February 23, 2010, of its decision to terminate Petitioner's participation in Medicare as a distinct part SNF. CMS cited the following findings of fact as the bases for its determination:

- On November 16, 2009, no survey could be performed as there were no residents. Information provided by Petitioner showed that during a 13 month period, Petitioner had no residents 198 days and had residents 198 days;

- On October 14, 2009, a survey was conducted and four residents were present;

- Medicare Cost Report data for the facility's fiscal year ended June 30, 2009, showed only 456 patient/resident days of a total possible 5,110 patient/resident days,[5] a utilization rate of 8.9%;

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[4] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id.*, at 1625.

[5] The 5,110 possible patient/resident days was determined by multiplying the 14 beds in the facility x 365 days. Tr. at 69-70.

- Petitioner's documents showed that there was no Registered Nurse (RN) serving as Director of Nursing (DON) for the facility who worked 35 hours per week;

- Petitioner's policy provided that the RN/DON position would be staffed only as needed;

- Petitioner's work schedule for September 27 through October 24, 2009, showed that there was no 24-hour RN coverage for 20 of 29 days;

- Petitioner's infection control policies and procedures did not direct staff on the proper cleaning and/or disinfecting procedures for resident multi-use items;

- Petitioner's documents did not show that an Administrator was designated;

- Petitioner's documents did not show that the DON, a physician, and three other staff met quarterly to review quality issues; and

- Petitioner's abuse policy and procedure did not include provisions related to the protection of residents during investigation of alleged abuse and neglect.

CMS Ex. 2, at 1-2.

CMS also cited the following conclusions in its notice:

- Petitioner has had few residents over a year and has not been providing services to the community on an ongoing basis;

- Petitioner has not been operating as a fully functioning business on a continuous basis;

- Petitioner has not admitted residents for an extended period of time; and

- Petitioner cannot demonstrate that it fully meets the conditions for participation in Medicare, with specific reference to staffing requirements.

CMS Ex. 2, at 2.

Based upon the findings and conclusions, CMS notified Petitioner that its participation in Medicare was terminated effective March 31, 2010. Although not specifically stated in the CMS notice, the initial determination to terminate Petitioner's provider agreement as

a distinct part SNF also terminated Petitioner's billing privileges and Petitioner's enrollment in Medicare as a distinct part SNF.[6]

CMS argues to me that termination of Petitioner's provider agreement was appropriate on only two grounds:

- Petitioner was not primarily engaged in providing certain nursing services (CMS Br. at 1-12; Tr. at 56); and

- Petitioner did not have a designated full-time DON as required by 42 C.F.R. § 483.30(b)(2) (CMS Br. at 12-13).

1. The fact that Petitioner had no SNF residents for periods of time is not alone a sufficient basis for termination of Petitioner's provider agreement, or revocation of Petitioner's enrollment in Medicare and billing privileges.

2. Petitioner was primarily engaged in providing skilled nursing services or rehabilitation services and was a SNF within the meaning of section 1819(a) of the Act.

3. Petitioner was operational within the meaning of 42 C.F.R. § 424.535(a)(5).

4. CMS has not made a prima facie showing of noncompliance with requirements for participation under the Act or regulations.

5. There were no bases for termination of Petitioner's provider agreement or revocation of Petitioner's enrollment and billing privileges.

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[6] Act § 1866(a)(1) (to be eligible to participate in Medicare and to be eligible to receive payments from Medicare, a provider, including a SNF, must have a provider agreement); 42 C.F.R. §§ 424.505 (provider must be enrolled, have billing privileges; and be issued a valid billing number); 424.535(b) (revocation of billing privileges terminates any related provider agreement); 489.53(a)(15) (revocation of enrollment in accordance with 424.535 is grounds to terminate the provider agreement), 489.55 (payment is available for certain providers up to 30 days after the effective date of termination but not for SNFs).

a. Facts

The material facts of this case are not disputed.

The parties stipulated that Petitioner is a licensed Iowa hospital that is enrolled in Medicare as a critical access hospital.[7] Petitioner is also enrolled in Medicare to operate a 14-bed distinct part SNF that is located in the hospital. The parties stipulated that Petitioner has authority under state and federal law to use its hospital beds for hospital patients and as "swing-beds" for providing skilled nursing care. P. Ex. 25, at 1, ¶¶ 1-3.

The evidence shows that Petitioner applied for and was issued a Certificate of Need by the Iowa Department of Health in February 2005. Petitioner was at that time licensed for 49 hospital beds using swing beds as necessary to provide skilled nursing care for patients. Petitioner proposed to become a critical access hospital with 25 acute and/or swing beds and 14 beds in a distinct part SNF. Petitioner's stated goals were to increase its financial viability by qualifying for the higher rate of reimbursement as a critical access hospital while also continuing to provide skilled nursing services to the population served. The application and the decision granting the Certificate of Need show that Petitioner's distinct part SNF was not intended for long-term delivery of skilled nursing and rehabilitation services. Rather, the distinct part SNF was intended for short-term rehabilitation stays. The application and decision show that Petitioner's hospital at the time had many days with an acute care census in the low to mid-twenties. The application and decision show that the hospital's skilled care patients had an average length stay of just 14.8 days, and the patients typically: were recovering from hip or knee replacement, hip fracture, or stroke; needed skilled care to regain activities of daily living; or required the care of a registered nurse or therapist following an acute illness or surgery. P. Exs. 1; 2; Tr. at 200.

The parties stipulated that: Petitioner's SNF had its initial survey on May 9 through 11, 2005, with recertification surveys in July 2006, July 2007, October 2008, and October 2009; any deficiencies identified during those surveys were corrected; and Petitioner was certified to be compliant with participation requirements as a SNF. P. Ex. 25, at 1-2, ¶¶ 4-9. The evidence shows that Petitioner was never cited by the state agency for any deficiency related to staffing.

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[7] Critical access hospitals are limited to a total of 25 beds including both critical care beds and swing beds (those used for extended skilled care). Beds that are part of the distinct part SNF are not counted against the total beds permitted. Act §§ 1820(f), 1861(mm); 42 C.F.R. §§ 485.620, 485.645; Tr. at 103.

The parties stipulated that, in September 2009, state surveyors attempted to conduct a survey but could not, as there were no residents. On October 14, 2009, the state surveyors returned, Petitioner's SNF had four residents, and a survey was completed. P. Ex. 25, at 2, ¶¶ 10-11. The evidence shows that Surveyor Christine McCuen, RN, who testified at hearing, participated in all the surveys of Petitioner's distinct part SNF. P. Exs. 3-15; CMS Ex. 1; CMS Ex. 2, at 23-24; Tr. at 37-38. Surveyor McCuen stated in her declaration dated April 13, 2010, and she testified at hearing, that most surveys required multiple attempts because no residents were present in Petitioner's SNF. She testified that she had no reason to think that the nursing facility was not open to the public in September 2009. Surveyor McCuen testified that she did not view the rooms during the unsuccessful attempt to survey Petitioner in September 2009. However, when she viewed the SNF rooms during the October 2009 survey, she saw that the rooms were equipped as SNF rooms would normally be equipped, and she had no question regarding the serviceability of the equipment and furnishings she saw. Surveyor McCuen testified that the only deficiency cited during the October 2009 survey related to failure to do employee background checks prior to employment. CMS Ex. 2, at 23; Tr. at 39, 46, 49-50. The Statement of Deficiencies for the survey that ended on October 14, 2009, cites only a violation of 42 C.F.R. § 483.13(c) that allegedly posed a risk for more than minimal harm, based on Petitioner's failure to obtain a criminal and abuse background check prior to hiring one employee. CMS Ex. 1, at 22-23.

On November 16, 2009, when two federal surveyors attempted to conduct a federal monitoring survey, no residents were present in Petitioner's SNF. P. Ex. 25, at 2, ¶ 12; P. Ex. 26; Tr. at 27-28.

The parties stipulated that all the services provided to residents by Petitioner's SNF were skilled nursing and related care and services. P. Ex. 25, at 4, ¶ 30. The parties stipulated that a registered nurse was assigned to the SNF when residents were present but not on days when no residents were present. The parties also stipulated that the same registered nurse served as the DON for the hospital and the SNF on a full-time basis. P. Ex. 25, at 4, ¶ 31-33.

The parties stipulated that, from 2005 to March 31, 2010, the SNF operated continuously, in the same location, with the same configuration, with the same policies and practices, with the same staffing assignments, and with similar occupancy. P. Ex. 25, at 4, ¶ 27. The parties stipulated that, during Petitioner's fiscal year from July 1, 2008 through June 30, 2009, the SNF had residents in beds only 456 out of 5,110 possible resident-days (14 beds multiplied by 365 days yields 5,110 possible resident-days). The parties also stipulated that from October 2008 through October 2009, there were only 198 days when the SNF had at least one resident, and 198 days when the SNF had no residents. P. Ex. 25, at 2-3, ¶¶ 13-16. Uncontested data that Petitioner presented, as summarized in the following table, shows that: from July 2008 through October 2009, there were only two months when the SNF had no residents; on average, Petitioner had at least one resident in

the SNF 46.31% of the time; 671 resident-days were used of a total available resident-days of 6,832, an average rate of use of 9.82%; and for 12 of 16 months use exceeded 5% (2 months exceeded 20% use, 6 months exceeded 10% use).

	Days In Month	Days With At Least One Resident	%	Available Resident Days (14 Beds x No. Days in Month)	Resident Days Used	%
2008						
July	31	0	0.00%	434	0	0.00%
August	31	15	48.39%	434	38	8.76%
September	30	30	100.00%	420	103	24.52%
October	31	15	48.39%	434	35	8.06%
November	30	6	20.00%	420	23	5.48%
December	31	9	29.03%	434	17	3.92%
2009						
January	31	0	0.00%	434	0	0.00%
February	28	21	75.00%	392	55	14.03%
March	31	7	22.58%	434	17	3.92%
April	30	15	50.00%	420	28	6.67%
May	31	19	61.29%	434	82	18.89%
June	30	11	36.67%	420	31	7.38%
July	31	22	70.97%	434	46	10.60%
August	31	9	29.03%	434	24	5.53%
September	30	20	66.67%	420	80	19.05%
October	31	27	87.10%	434	92	21.20%
Totals	488	226	46.31%	6832	671	9.82%

P. Ex. 16; CMS Ex. 3, at 1-19. A data summary in P. Ex. 18 includes data that is inconsistent in some respects with the data found in P. Ex. 16. I treat the data in P. Ex. 16 as more reliable than that in P. Ex. 18 based on the fact that the source of the data in P. Ex. 16 is Petitioner's patient accounts department and Petitioner's chief financial officer. Petitioner prepared the data summary in P. Ex. 18 for submission to CMS during the survey process, the data reflected is more favorable for Petitioner than that at P. Ex. 16, and the source of the data in P. Ex. 18 is not disclosed. Nurse Puntenney prepared the data that appears in P. Ex. 18, and she agreed during her testimony that some of the data was inconsistent. Tr. at 213-19, 223-24.

Paul Shumate, the CMS decision-maker, testified that the longest period that Petitioner had no SNF residents was 76 days. Tr. at 72, 77. According to CMS Ex. 3, at 12-14, the 76 days to which Mr. Shumate referred were after the October 2009 survey, from October 31, 2009 through January 14, 2010. According to Petitioner's data, other periods of more than 30 days between July 1, 2008 and October 31, 2009, during which Petitioner had had no SNF residents were: 47 days from July 1, 2008 through August 16, 2009; 32 days from October 16, 2008 through November 16, 2008; 53 days from December 17, 2008

through February 7, 2009; and 31 days from March 8, 2009 through April 7, 2009. CMS Ex. 3; P. Ex. 16.

The evidence shows that the distinct part SNF is in an area of the hospital apart from the critical access hospital. The distinct part is on the third floor of the hospital, a single hall of 14 rooms with 14 beds and a nurse's station. Directions to the distinct part SNF are clearly marked, and signs and directions to the distinct part SNF are located by the elevators and on the third floor. Tr. at 43-45, 186-87. Joseph Smith, Chief Executive Officer for Boone County Hospital, testified: that nurses that staffed the SNF were the hospital nurses; that the ratio of residents to registered nurses was at worst ten to one but usually three or four to one; physical therapy, occupational therapy, and speech therapy were all present on the same floor as the SNF; SNF residents had access to a common activity and dining room; the hospital emergency room was several floors away with an emergency physician on duty at all times; wound care nurses were available; pharmacy services were in the hospital; infection control, quality control, safety, nursing education, and the dietary department were all administered through the hospital. Tr. at 107-14. He testified that there was always a registered nurse on duty when there was a resident in the SNF. He testified that there was a DON for the SNF who was also the DON for the hospital. Mr. Smith testified that hospital staff was designated to operate the SNF, and DON Puntenney agreed with him that it only took 30 to 60 minutes to get the distinct part SNF ready for occupancy when a patient was ready for transfer. Tr. at 114-15, 132, 185-86. Mr. Smith's testimony is credible and unrebutted.

DON Puntenney testified that she was the DON for both the hospital and the SNF. She testified that she handled staffing and another nurse supervised nursing care. She testified that there was always a registered nurse on duty in the SNF when there was a resident present. She testified that staffing the SNF was not a problem as the hospital had nurses who worked part-time and wanted the additional time, and contract nurses were also used as needed. Tr. at 179-81, 204. DON Puntenney testified that the SNF was cleaned and maintained even if no residents were present. Tr. at 186. She testified that nurses and therapists maintained their skills and competency even when the SNF was closed because they worked in the hospital. Tr. at 203-04. She testified that she did not spend 35 hours per week doing SNF work, but she estimated that she split her time 60 percent to the hospital and 40 percent to the SNF when there were residents and 90 to 95 percent to the hospital and 5 to 10 percent to the SNF when there were no SNF residents. Tr. at 206-07. DON Puntenney's testimony is unrebutted and credible.

b. Analysis

To participate in Medicare a SNF must:

- Meet the statutory definition of a SNF in section 1819(a) of the Act[8] and, in this case, the regulatory definition of a distinct part SNF at 42 C.F.R. § 483.5(b)(1);

- Be enrolled in Medicare pursuant to 42 C.F.R. §§ 424.505, 424.510, 424.516;

- Be issued billing privileges pursuant to 42 C.F.R. § 424.505;

- Continuously be in substantial compliance with statutory and regulatory participation requirements found in section 1819(b), (c), and (d) of the Act and 42 C.F.R. Part 483; and

- Enter and continuously substantially comply with the terms of a provider agreement with the Secretary pursuant to 42 C.F.R. Part 489, subpart B.

Pursuant to a delegation of Secretarial authority, CMS is granted authority to terminate a provider's or supplier's participation in Medicare pursuant to section 1866(b)(2) of the Act, 42 C.F.R. § 488.456(b),42 C.F.R. § 489.53(a)-(c), and 42 C.F.R. § 424.535(b). CMS argues in this case that Petitioner was no longer primarily engaged in providing skilled nursing or rehabilitation services as required by section 1819(a)(1) of the Act and that termination was appropriate on that basis. CMS Br. at 3-12. CMS concedes that the termination of Petitioner's provider agreement in this case was not pursuant to 42 C.F.R. § 424.535. CMS Br. at 14-15. CMS does not argue and the evidence does not show that Petitioner's provider agreement was terminated for: failure to comply with enrollment requirements; not having or abusing billing privileges; not being in substantial compliance with program participation requirements; or failure to have a provider agreement.

CMS argues in its brief that Petitioner failed to meet staffing requirements of 42 C.F.R. § 483.30(b)(2), because Petitioner did not have a DON that worked 35 hours per week on SNF business. CMS Br. at 12-13. However, I do not construe that argument to be that Petitioner was terminated because it was not in substantial compliance with the program participation requirement established by 42 C.F.R. § 483.30(b)(2). Petitioner was never

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[8] *A.M. Home Health Servs., Inc.*, DAB No. 2354 (2010); *United Med. Home Health Care, Inc.*, DAB No. 2194 (2008); *Arizona Surgical Hosp., LLC*, DAB No. 1890 (2003).

cited by a survey for inadequate staffing in violation of 42 C.F.R. § 483.30(b)(2), and there is no evidence that a surveyor ever concluded that a staffing violation posed a risk for more than minimal harm to any resident. CMS points to no evidence that, if there was a violation of 42 C.F.R. § 483.30(b)(2), the violation posed a risk for more than minimal harm to any resident. Evidence that violation of a program participation requirement posed a risk for more than minimal harm is necessary for CMS to make a prima facie showing that Petitioner was not in substantial compliance, which is necessary to trigger the CMS authority to impose enforcement remedies such as termination.[9] Furthermore, Mr. Shumate, the CMS official who made the decision to terminate Petitioner, explained in his testimony that he inferred based upon the periods when Petitioner had no SNF residents that Petitioner did not have a full-time DON, and he considered that as evidence that Petitioner was not primarily engaged in providing SNF care and services. Mr. Shumate did not testify that Petitioner was terminated because it was not in substantial compliance with 42 C.F.R. § 483.30(b)(2). Tr. at 70-74.

Mr. Shumate testified that his decision was not based upon consideration of the grounds for termination authorized by 42 C.F.R. § 424.535. Tr. at 77-79. Therefore, the CMS argument regarding whether Petitioner was operational within the meaning of 42 C.F.R. § 424.535(a)(5) (CMS Br. at 15-16) does not merit consideration, as that was admittedly not the basis for the CMS action in this case and Petitioner was not notified of that basis for revocation.

Mr. Shumate testified that Petitioner's provider agreement was not terminated based on a quality of care issue. He admitted that there was no dispute that Petitioner provided SNF care and services when residents were in the unit. Tr. at 79-80. The fact that CMS admits that the SNF had no uncorrected quality of care issues related to caring for residents supports my conclusion that Petitioner was compliant with the participation requirements of section 1819(b), (c), and (d) of the Act and 42 C.F.R. Part 483.

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[9] "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance, i.e., a regulatory or statutory violation and a risk for more than minimal harm. 42 C.F.R. § 488.301.

I conclude that the narrow issue before me is whether there is a basis for termination of Petitioner's provider agreement, with resulting termination of its participation in Medicare and its authority to bill Medicare, because Petitioner was not primarily engaged in providing skilled nursing, rehabilitation, and related services to covered individuals as required for a provider to be a SNF under section 1819(a)(1) of the Act.[10]

Section 1866(b)(2)(B) of the Act authorizes the Secretary to terminate a provider agreement if it is determined that the provider does not "substantially" meet the provisions of section 1861 of the Act. *United Med. Home Care, Inc.*, DAB No. 2194, at 3. Section 1861(j) of the Act is the applicable provision in this case and provides that a SNF is defined by section 1819(a) of the Act. Section 1819(a)(1) of the Act provides that a SNF is an institution or a distinct part of an institution that is "primarily engaged" in providing to residents skilled nursing care and related services or rehabilitation services, but not primarily the care and treatment of mental diseases. The Secretary has delegated authority to CMS to terminate a provider agreement on the grounds that the provider is not complying with the applicable provisions of the Act and regulations or the terms of the provider agreement. 42 C.F.R. §§ 489.53(a)(1), 424.535(a)(5).

The Act and regulations provide no definition or explanation of the phrase "primarily engaged."[11] The Board has considered the phrase in three cases and did not provide a definition but rather looked to the facts to decide in two cases that the ALJs properly granted summary judgment against a hospital and a home health agency and in the third to decide that the ALJ's decision that the home health agency was not primarily engaged was supported by substantial evidence. *A.M. Home Health Servs., Inc.*, DAB No. 2354; *United Med. Home Health Care, Inc.*, DAB No. 2194; *Arizona Surgical Hosp., LLC*, DAB No. 1890. In this case the issue of whether Petitioner was "primarily engaged" in providing residents skilled nursing care and related services or rehabilitation services also turns on the facts. CMS urges two facts as sufficient to support a conclusion that Petitioner was not primarily engaged as a SNF: (1) the fact that there were multiple periods when Petitioner's SNF had no residents; and (2) the fact that Petitioner did not

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[10] CMS has never asserted that Petitioner did not have a transfer agreement in effect as required by section 1819(a)(2) of the Act.

[11] CMS argues that its interpretation should be given deference citing *Auer v. Robbins*, 519 U.S. 452, 462 (1997) and *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984). CMS Br. at 5; CMS Reply at 2. CMS overlooks the fact that it is no longer the final decision-maker on behalf of the Secretary when review of its initial decision is requested. 42 C.F.R. §§ 498.74(b), 498.90(a), 498.103(b).

have a full-time RN as DON but shared nursing staff. Neither fact is disputed. Although these undisputed facts could be viewed as sufficient to raise an inference that Petitioner was not "primarily engaged," consideration of all the facts leads to the conclusion that Petitioner was primarily engaged as a SNF, despite periods without residents and the sharing of registered nursing staff.

In the prior cases decided by the Board, the fact that the home health agency or hospital was not providing services for a period was a significant fact supporting the determination to terminate the provider agreement and participation in Medicare. However, the prior Board decisions involve significantly longer periods of inactivity by the provider than in the case before me. In *A.M. Home Health Servs., Inc.*, the home health agency had vacated its office location registered with CMS and it had not provided services for at least ten months. In *United Med. Home Health Care, Inc.*, the home health care agency had not provided home health services for six months. In *Arizona Surgical Hospital, LLC*, the state had barred the hospital from accepting inpatients for four months and the hospital failed to show it was providing any services to inpatients during the period. In the case of the SNF before me, the longest period without a resident identified by CMS was 76 days from October 31, 2009 through January 14, 2010. The evidence shows that the next longest period was 53 days from December 17, 2008 through February 7, 2009. The only other periods in excess of 30 days were: 47 days from July 1, 2008 through August 16, 2009; 32 days from October 16, 2008 through November 16, 2008; and 31 days from March 8, 2009 through April 7, 2009. CMS Ex. 3; P. Ex. 16; Tr. at 72, 77. Mr. Shumate testified that there is no requirement that a SNF always have residents and that there is no minimum rate of use under statute, regulation, or policy specified for participation by a SNF.[12] Tr. at 81, 86-88. The Board has never suggested that there is a minimum rate of use applicable to SNFs or that a SNF must always be

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[12] CMS has not persuasively explained away the possible inconsistency between its position in this case and 42 C.F.R. § 424.540. The regulation states that CMS "may deactivate a provider or supplier's Medicare billing privileges" if "[t]he provider or supplier does not submit any Medicare claims for 12 consecutive calendar months." 42 C.F.R. § 424.540(a)(1). Deactivation is distinguishable from revocation of billing privileges, and the regulation provides that deactivation has no effect on a provider agreement or the conditions of participation. 42 C.F.R. § 424.540(c). Petitioner argues that the regulation shows that a SNF may have no residents for periods of time and that periods of inactivity of up to 12 months are not a sufficient basis to conclude that a SNF is not primarily engaged in functioning as a SNF. P. Br. at 5. My decision does not turn on this potential inconsistency and I need not resolve it. However, Petitioner's argument has some logical appeal, as it seems unlikely that a SNF would be providing care and

(Footnote continued next page.)

delivering care and services to at least one resident. In *A.M. Home Health Servs., Inc.*, the Board expressed concern that in the absence of a resident a survey could not be performed. However, the evidence in this case, including the testimony of Surveyor McCuen who participated in every survey of Petitioner from 2005 through 2009, clearly shows that the brief periods Petitioner had no residents did not cause Petitioner not to timely receive its annual surveys.

In the case of the SNF before me, it is not disputed that the staff that worked the SNF were mostly the same staff that worked the hospital. The Boone County Hospital was not subject to a bar on admitting patients like Arizona Surgical Hospital. Thus, the Boone County Hospital and SNF staff continued to deliver care and services and were able to maintain their competency to deliver skilled nursing and rehabilitation services despite brief periods when there were no SNF residents. As Mr. Shumate admitted in his testimony, there were no issues of quality of resident care that he considered when he determined to terminate Petitioner. Tr. at 76, 79-80.

The fact that Petitioner did not have a full-time DON during periods when no residents were present, and shared a DON with the hospital when residents were present, is not determinative. Under the statute and the regulations, the issue is whether Petitioner was substantially compliant. Act § 1866(b)(2)(A) (stating Secretary may terminate if determines provider fails to comply substantially); 42 C.F.R. § 488.301 (noting substantial compliance is compliance to the extent that no identified deficiency poses a risk for more than minimal harm). CMS has pointed to no evidence of any risk for harm to residents due to Petitioner's staffing arrangement. The fact that no survey has ever alleged a deficiency related to staff that posed any risk for harm is also consistent with my conclusion that Petitioner's staffing arrangement did not amount to failure to substantially comply with program participation requirements or sufficient evidence to support a conclusion that Petitioner was not primarily engaged in providing SNF services.

The facts, when considered as a whole, show that Petitioner was engaged and primarily engaged in providing its residents skilled nursing care and related services or rehabilitation services within the meaning of section 1819(a)(1) of the Act. The brief periods without SNF residents do not alone establish that Petitioner was not primarily engaged as a SNF. Accordingly, I conclude that CMS had no basis to terminate

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(Footnote continued.)

services for a Medicare eligible beneficiary and simply not bill Medicare for 12 consecutive months.

Petitioner's participation in Medicare by termination of its distinct part provider agreement or revocation of the related billing privileges.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's participation in Medicare as a distinct part SNF should not have been terminated.

/s/
Keith W. Sickendick
Administrative Law Judge