Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Renaissance Hospital Terrell,
(CCN: 450683),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-614

Decision No. CR3198

Date: April 10, 2014

DECISION

Petitioner, Renaissance Hospital Terrell, was a hospital, located in Terrell, Texas, that participated in the Medicare program until February 2013. Effective February 12, 2013, the Centers for Medicare & Medicaid Services (CMS) terminated its Medicare participation, based on a survey completed January 10, 2013. CMS subsequently learned that Kaufman County officials had seized the hospital building and property for back taxes and that the hospital was no longer operational. Based on this information, CMS added those factors as bases for the termination and asked that I add these new issues to Petitioner's pending appeal. CMS moved for summary judgment based on the new issues. Petitioner does not claim to be operational, but opposes summary judgment nevertheless and has filed a cross-motion for summary judgment.

After working my way through the procedural morass that this case has become, I grant CMS's motion. As discussed below, the undisputed evidence establishes that, since prior to the date of its termination, Renaissance Hospital did not meet the statutory definition of "hospital" and was not in substantial compliance with Medicare conditions of participation. CMS is therefore authorized to terminate its Medicare provider agreement.

Background

A hospital is an institution that, among other requirements, primarily engages in providing to inpatients, "by or under the supervision of physicians," (A) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or (B) rehabilitation services for injured, disabled, or sick persons. Social Security Act (Act) § 1861(e). It may participate in the Medicare program as a provider of services, if it meets the statutory definition and complies with regulatory requirements, called conditions of participation. Act § 1861(e); 42 C.F.R. Part 482; 42 C.F.R. § 488.3. If a provider fails to comply substantially with the provisions of section 1861 of the Act or the regulations governing its program participation, CMS, acting on behalf of the Secretary of Health and Human Services (Secretary), may terminate its provider agreement. Act § 1866(b)(2); 42 C.F.R. § 489.53(a)(1).

The Secretary contracts with state survey agencies to survey providers "as frequently as necessary" to ascertain compliance with program requirements and to confirm the correction of deficiencies. 42 C.F.R. § 488.20(b).

Here, on January 10, 2013, the Texas Department of State Health Services (state agency) completed an onsite survey and determined that Renaissance Hospital was not in substantial compliance with an astonishing number of Medicare conditions of participation – fifteen – as well as with the medical screening examination requirements of the Emergency Medical Treatment and Labor Act (EMTALA). In a letter dated January 28, 2013, CMS advised Renaissance Hospital that, because it did not meet the requirements for program participation, its Medicare provider agreement would terminate on February 12, 2013. The letter also advised Petitioner of its hearing rights. Petitioner timely requested a hearing. Hearing Request (March 29, 2013) and attachments. The case was assigned to me, and I issued an acknowledgment and pre-hearing order on April 4, 2013.

While this matter was pending, CMS purportedly reopened and revised its initial determination, as authorized by 42 C.F.R. §§ 498.30 and 498.32. *See also* 42 C.F.R. § 498.56(a) (authorizing the administrative law judge (ALJ), at the request of either party or on her own motion, to consider new issues). In a second notice letter, dated May 8, 2013, CMS explained that it was adding additional bases for terminating the hospital's program participation: Kaufman County officials had served a tax warrant on the hospital management and seized its property; the hospital had no patients, no employees, and was not operational, which put it out of substantial compliance with the statute and

eleven conditions of participation. This notice letter, which was electronically delivered to Petitioner's counsel on May 8, advised Petitioner of its appeal rights.[1]

In filings dated June 7, 2013, CMS, citing 42 C.F.R. § 498.56(a), asked that I consider as a new issue the facts related to the hospital's closure. CMS then moved for summary judgment. (CMS MSJ). With its motion, CMS submitted two exhibits (CMS Exs. 1-2). Petitioner opposes and filed a cross-motion for summary judgment, but no additional exhibits. (P. Resp. to CMS MSJ).

In a letter dated July 11, 2013, Petitioner responded to the May 8 notice and requested an ALJ hearing to contest its termination. By letter dated July 17, 2013, administrative staff for the Civil Remedies Division acknowledged receiving the request and advised Petitioner that, because it requested review of a determination that had already been appealed, we would not open a new case, but would add the submission to the pending appeal.

CMS then moved to dismiss the July hearing request as untimely, pointing out that Petitioner filed its appeal more than 60 days after CMS served counsel with its notice of revised determination. With that motion, CMS filed one additional exhibit, CMS Ex. 3. Petitioner asks me to strike CMS's motion; to set aside the termination; and to sanction the agency and its counsel for purportedly violating my orders; for adopting illegal positions; and for generally demonstrating bias against Renaissance Hospital. [2]

Discussion

1. ***Petitioner preserved its right to appeal its termination by timely appealing CMS's January 28 initial determination.***[3]

As the above-discussion shows, this case presents some complicated procedural issues. Among them:

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[1] Because the hospital no longer existed, CMS could not serve that entity. In an email accompanying the notice, CMS asked counsel to provide the hospital owner's contact information.

[2] Although this case presents some thorny procedural issues, not all of the issues raised are difficult to decide. Petitioner's motions to strike CMS's motion to dismiss; to sanction the agency; to remove CMS counsel; and to set aside the termination proceeding are wholly without merit, in fact, frivolous. Accordingly, I deny Petitioner's motions.

[3] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

- Did CMS, in fact, revise its initial determination?

- What impact did its May 8 action have on Petitioner's pending appeal?

- Did Petitioner's March 2013 hearing request preserve its right to challenge the termination, or was it obligated (as CMS suggests) to file an additional hearing request in response to the May 8 notice letter? If so, did CMS adequately serve that notice, and was Petitioner's July 11 hearing request timely?[4]

CMS's January 28, 2013 determination to terminate Petitioner's Medicare participation was an initial determination, and Petitioner preserved its appeal rights, at least temporarily, when it timely requested review. 42 C.F.R. §§ 498.3(b)(8), 498.5(b).

CMS may reopen an initial determination within twelve months after the date of the notice of the initial determination. 42 C.F.R. § 498.30. CMS must give the affected party notice of the reopening and of any revision of the reopened determination. It must state the basis or reason for the revised determination. 42 C.F.R. § 498.32. The affected party may request a hearing within 60 days from its receipt of the notice of the revised determination. 42 C.F.R. § 498.40(a). The regulations, however, do not address the status of pending appeals when a determination is reopened. 42 C.F.R. §§ 498.30, 498.32.

Here, although CMS characterizes its May 8 action as "reopening and revising" the January 28 determination, the initial determination itself remained the same. CMS Ex. 1 at 1-3. CMS simply added some additional facts to the pending appeal. Further, CMS did not move to vacate the January 28 determination nor to dismiss the pending appeal.[5] It asked to add additional (underlying factual) issues pursuant to 42 C.F.R. § 498.56(a). CMS MSJ at 2. Because the January 28 determination was neither revoked nor revised, I find that Petitioner's appeal rights were preserved without regard to the timeliness of its July 11 hearing request.[6] *See Britthaven of Goldsboro*, DAB No. 1960, at 6 (2005)

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[4] Curiously, Petitioner has not asked that I find good cause to extend the time for filing. 42 C.F.R. § 498.40(c)(2).

[5] CMS moved to dismiss the subsequent appeal, which, in its view, was not timely filed.

[6] Because I find that CMS did not revise its initial determination and Petitioner preserved its appeal rights, I need not address the parties' arguments as to whether CMS properly served its May 8 notice; whether Petitioner's July 11 hearing request was timely; and whether CMS was obligated to comply a second time with the notice requirements of 42 C.F.R. § 489.53(d) and give the already-terminated hospital an additional 15-days advance notice of termination (which, in any event, seems completely unworkable).

(noting that CMS's changing its choice of remedy "cannot be within the scope of a revision to an initial determination.").

2. CMS properly raised new issues for my consideration – facts establishing that the hospital stopped operating prior to the date of its termination – and provided Petitioner with adequate notice of those issues.

With its motion for summary judgment, CMS asked that I consider, as new issues under section 498.56(a), facts related to the hospital's non-operational status, noting that these facts "arose before the termination and affected the party's rights." CMS MSJ at 2.

The regulations governing these appeals allow me to consider new issues, even if they arose after the hearing request was filed, so long as they arose before the effective date of the termination of the hospital's provider agreement. 42 C.F.R. §§ 498.56(a), 498.56(b)(1). Here, the hospital's closure occurred before the termination date, so the issues can be added, so long as the affected party is afforded adequate notice and an opportunity to respond. 42 C.F.R. § 498.56(c).

CMS provided Petitioner with adequate notice of the new factual issues. Petitioner had ample opportunity to respond to them, and, in fact, addressed them when it responded to CMS's motion for summary judgment.

3. CMS is entitled to summary judgment, because the undisputed evidence establishes that Renaissance Hospital stopped operating prior to its date of termination; it therefore did not meet the statutory definition of "hospital" and did not comply with Medicare conditions of participation.

CMS is entitled to summary judgment if it has: 1) made a prima facie showing that Petitioner was not in substantial compliance with one or more program requirements; and 2) demonstrated that there is no dispute about any material fact supporting its prima facie case and that it is otherwise entitled to summary judgment as a matter of law. *Jewish Home of Eastern Pennsylvania*, DAB No. 2451, at 5 (2012) (citing *Windsor Health Center v. Leavitt*, 127 F. App'x 843, at 846 (6th Cir. 2005). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *Jewish Home*, DAB No. 2451, at 5-6.

> [I]f CMS in its summary judgment motion has asserted facts that would establish a prima facie case that the facility was not in substantial compliance, the first question is whether the facility has in effect conceded those facts.

Jewish Home, DAB No. 2451, at 6, quoting *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918, at 5 (2004).

CMS has come forward with evidence that a Texas State Court issued a tax warrant against Renaissance Hospital on February 7, 2013. CMS Ex. 1 at 5-9. Kaufman County officials seized the hospital property on February 11, at which time the hospital's patient census was zero. CMS Ex. 1 at 1, 10, 14. At the same time, the hospital's landlord, the City of Terrell, terminated the hospital's lease effective February 11 (ten days from the February 1 notice). CMS Ex. 1 at 11-13.

Petitioner objects to the quality of CMS's evidence, claiming "lack of proper authentication as required by Fed. R. Civ. P. 901." P. Resp. to CMS MSJ at 5. CMS's evidence includes: photocopies of the state court's order for tax warrant and the tax warrant itself, a court registry listing those actions, a photograph of the "notice of seizure" posted at the hospital premises, correspondence from counsel for the landlord terminating the hospital's lease, and a press account of the tax seizure/license revocation/ Medicare termination.

First, the federal rules of evidence do not apply to these proceedings, and I am authorized to admit evidence that might be inadmissible under those rules. 42 C.F.R. § 498.61.

Moreover, Petitioner has not come forward with any evidence suggesting that this evidence is unreliable, and does not even allege that it disputes any of the underlying facts established by these documents. Indeed, its July 11 hearing request acknowledges that the hospital closed prior to February 12, 2013. Hrg. Request at 2 (July 11, 2013). "Under [such] circumstances, . . . CMS [is not obligated] to submit additional corroborative proof . . . to carry its initial burden as the party moving for summary judgment." *Guardian Health Care Center*, DAB No. 1943, at 15 (2004), citing *Florence Park Care Center*, DAB No. 1931 (2004) (holding that CMS is required to submit evidence only with respect to facts that are in dispute) and *Celotex Corp. v. Catrett*, 477 U.S. 317, at 325 (1986).

Because Renaissance Hospital had no patients or staff, it could not be engaged ("primarily" or otherwise) in providing diagnostic and therapeutic services to inpatients, as required by section 1861(e)(1) of the Act. It did not provide 24-hour nursing services, as required by section 1861(e)(5). These undisputed facts justify the entry of summary judgment here, because they show that, as of February 11, 2013 – the day before its scheduled termination – Renaissance Hospital did not meet the statutory definition of hospital. *Arizona Surgical Hospital, LLC*, DAB No. 1890, at 4 (2003) ("Given Petitioner's inability to comply with the statutory definition, the ALJ was not required to take additional evidence.").

Moreover, these undisputed facts also mean that Renaissance Hospital is not in substantial compliance with essentially all of the conditions of participation. Because it had no staff, it could not meet the staffing requirements of 42 C.F.R. §§ 482.22 (medical staff), 482.23 (nursing services), or 482.25 (pharmaceutical services). Nor was it capable of providing other required services, such as laboratory services (42 C.F.R. § 482.27), food services (§ 482.28), surgical services (§ 482.51), anesthesia services (§ 482.52), outpatient services (§ 482.54), and emergency services (§ 482.55).

Thus, the undisputed evidence establishes that, prior to the date of its termination, Petitioner no longer met the statutory definition of hospital, because it no longer existed as a hospital. Nor did it meet any of the conditions of participation cited by CMS in its notice letters. CMS therefore justifiably terminated the hospital's program participation. Act § 1866(b)(2); 42 C.F.R. § 489.53(a)(1).

Conclusion

Because the undisputed evidence establishes that Renaissance Hospital did not meet the statutory definition of "hospital" and did not comply with Medicare conditions of participation, CMS properly terminated its program participation. I therefore grant CMS's motion for summary judgment and deny Petitioner's.

/s/
Carolyn Cozad Hughes
Administrative Law Judge