**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Guild Home for the Aged Blind
(CCN: 33-5512),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-691

Decision No. CR2437

Date: September 26, 2011

# DECISION

Petitioner, Guild Home for the Aged Blind ("Guild Home"), was a skilled nursing facility (SNF) located in Yonkers, New York, that participated in the Medicare program as a provider of services. The Centers for Medicare and Medicaid Services (CMS) determined that Petitioner was no longer providing SNF services to the community and advised Petitioner that CMS was terminating its Medicare provider agreement. Petitioner now seeks review of that determination, and CMS has moved to dismiss Petitioner's hearing request, or, in the alternative, asks that I grant summary disposition in its favor.[1]

I deny CMS's motion to dismiss, but I grant its motion for summary disposition because the undisputed evidence establishes that Guild Home stopped furnishing SNF services to

[1] Petitioner filed its hearing request (H.R.), along with four exhibits (P. Exs. A - D). CMS filed its motion and brief (CMS Br.), along with two exhibits. (CMS Exs. 1-2). Petitioner filed its brief in response (P. Br.) which did not include additional exhibits. Absent objection, I admit all proposed exhibits to the record.

residents and therefore CMS had the authority to terminate its Medicare provider agreement. 42 C.F.R. § 489.53.

## I. Applicable Law

The Social Security Act ("Act") allows certain health care providers to participate in the Medicare program if they have in effect provider agreements with the Secretary of Health and Human Services (Secretary). *See generally* Section 1866 of the Act. Section 1866 of the Act defines an eligible "provider of services" to include a "skilled nursing facility."

In order to participate in the Medicare program, a provider must execute a "provider agreement" and undergo surveys to certify its compliance with program requirements. 42 C.F.R. §§ 488.20, 489.11. The provider agreement contains assurances that the provider meets, and will continue to meet, applicable conditions for Medicare participation and also reflects CMS's acceptance of the provider's eligibility to participate in the program. 42 C.F.R. §§ 489.11(a), 489.20.

A provider agreement may be terminated by either the provider or by CMS. Termination by the provider (an event referred to as "voluntary termination") is governed by 42 C.F.R. § 489.52, which provides:

> § 489.52 Termination by the provider.
>
> (a) *Notice to CMS*. (1) A provider that wishes to terminate its agreement must send CMS written notice of its intent.
>
> . . .
>
> (b) *Termination date*. (1) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the provider's notice of intent.
>
> . . .
>
> (3) A cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community.

The Act empowers the Secretary to refuse to enter into an agreement or to refuse to renew or terminate such an agreement upon notice after the Secretary –

> (A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

> [or]
>
> (B) has determined that the provider fails substantially to meet the applicable provisions of section 1861. . . .

Section 1866(b)(2) of the Act. In this case, the "applicable provision" of section 1861 is section 1861(j), cross-referencing section 1819(a), which provides in relevant part:

> In this title, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which —
>
> (1) is primarily engaged in providing to residents —
>
> (A) skilled nursing care and related services for residents who require medical or nursing care, or
>
> (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,
>
> and is not primarily for the care and treatment of mental diseases . . . .

Sections 1861(j) and 1819(a) of the Act.

The implementing regulations specify that CMS may terminate a provider agreement when the provider is not complying with Title XVIII of the Act, with applicable regulations, or with terms of the provider agreement itself, or no longer meets the relevant conditions for participation. 42 C.F.R. § 489.53(a)(1) and (3). Section 489.53(c)(1) states that CMS "gives the provider notice of termination at least 15 days before the effective date of termination[.]" Section 489.53(c)(3) provides that the notice of termination "states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date[.]" Section 489.53(d) states that a provider may appeal the involuntary termination of its provider agreement by CMS in accordance with 42 C.F.R. Part 498.

Once a provider has been terminated, the Act prohibits that provider from filing another provider agreement "unless the Secretary finds that the reason for the termination or nonrenewal has been removed and that there is reasonable assurance that it will not recur." Section 1866(c)(1), as implemented by 42 C.F.R. § 489.57.

The Act establishes that "an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) of [Section 1866, quoted above] shall be entitled to a hearing thereon by the Secretary (after reasonable notice) . . . ." Section 1866(h)(1) of the Act. The

regulations define an "affected party" with appeal rights under Medicare as "a provider [or] prospective provider . . . affected by an initial determination . . ." and set out the initial determinations by CMS that are subject to appeal. 42 C.F.R. §§ 498.2 and 498.3. The involuntary termination of a provider agreement for reasons set out in 42 C.F.R. § 489.53 is one of the appealable CMS initial determinations. 42 C.F.R. § 498.3(b)(7).

## II. Discussion

The following facts are undisputed. Petitioner is a skilled nursing facility subsidiary of The Jewish Guild for the Blind, a non-profit organization that provides a number of services to persons of all ages who are visually impaired or blind and who may have additional disabilities. At the times important to this decision, it participated in the Medicare program. New York State authorities developed a commission to identify and eliminate excess capacity in the health care delivery system. In response to the commission's goals, Petitioner submitted a proposal to the New York State Department of Health (NYSDOH). Petitioner proposed to voluntarily close its physical facility and decertify 181 of its Medicare-certified 219 beds. The remaining 38 beds were to be relocated to another unrelated facility, Jewish Home and Hospital, that would, in turn, eliminate its 38 certified beds. In essence, Petitioner would close its 219-bed facility, transferring the remaining residents to the smaller, new facility along with its Medicare certification. P. Br. at 1-2.

The NYSDOH approved Petitioner's proposal on December 17, 2007. Petitioner then began emptying its beds in the old location and transferred 35 of its residents to Jewish Home and Hospital. Petitioner's 35 residents were transferred to Jewish Home and Hospital and enrolled as new admissions on February 15, 2008. Petitioner has not provided skilled nursing facility care for a single resident since February 15, 2008. Because of a number of impediments Petitioner encountered, including difficulties in reaching an agreement with the NYSDOH on its Medicaid reimbursement rate, and challenges selling its real property located at Petitioner's original site, the NYSDOH did not issue a revised operating certificate, and did not conduct a pre-opening survey. "It was always the intention of Guild Home to open and operate the beds at the new location." P. Br. at 3. Jewish Home and Hospital has yet to decertify any of its beds.

On January 28, 2010, about two years since Petitioner ceased providing skilled nursing services to residents, CMS issued a notice stating that "[b]ased upon information received from the NYSDOH, Petitioner voluntarily discontinued providing Medicare-certified skilled nursing services effective February 15, 2008." P. Ex. A. The notice explained that the "basis for this termination is found in" 42 C.F.R. § 489.52 (cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community) and in 42 C.F.R. § 489.53(a)(1) and (3) (termination by CMS for failing to comply with applicable statutes and regulations or conditions of participation.) P. Ex. A. The notice further explained that although "CMS

is aware of the Guild[']s project, we find it necessary to take this action due to the lack of progress and the significant period of time." P. Ex. A.

Petitioner requested that CMS hold its termination in abeyance for approximately one month while Petitioner and NYSDOH established a Medicaid rate. "Once the rate is set, and the beds become active, [CMS's] concern about cessation of [Petitioner's] business will be fully addressed." P. Ex. C. CMS responded to Petitioner's request by letter dated March 15, 2010. P. Ex. D. CMS explained that the basis for the termination action outlined in the January 28, 2010 notice remained as explained earlier and that termination was effective February 15, 2008. P. Ex. D.

### *A. Petitioner is entitled to review because its termination is in accordance with 42 C.F.R. § 489.53 and is therefore a reviewable initial determination.*[2]

CMS argues that Petitioner voluntarily terminated its provider agreement by ceasing to do business as a provider of skilled nursing services. Because the governing regulations do not provide appeal rights for voluntary terminations, CMS requests that I dismiss this case for cause pursuant to 42 C.F.R. § 498.70(b). CMS Br. at 9-12. Petitioner, on the other hand, contends that it never intended to terminate its agreement with Medicare and that by its very nature a voluntary termination must be intentional and CMS has no authority to order a termination "voluntary by gunpoint." P. Br. at 4-6.

I need not address whether a finding of voluntary termination creates appeal rights in this context. 42 C.F.R. § 489.52. The record is explicit: CMS involuntarily terminated Petitioner's provider agreement while simultaneously finding that Petitioner had voluntarily terminated the agreement. P. Exs. A, D. Consequently, I must deny the CMS motion to dismiss because involuntary termination is an appealable initial determination subject to my review. 42 C.F.R. §§ 489.53(b)(7), 498.3(b)(8).

### *B. CMS is entitled to summary disposition in its favor because the undisputed facts establish that Petitioner was no longer "primarily engaged" in providing services to residents when it stopped furnishing SNF services in February 2008.*

Summary disposition is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

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

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Center v. Department of Health and Human Services,* 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary disposition, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Electric Industries Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Center,* DAB No. 1918 (2004).

> To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . .

*Illinois Knights Templar,* DAB No. 2274 at 4; *Livingston Care Center*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary disposition, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Center,* DAB No. 2132 at 2, 9 (2007); *Livingston Care Center*, 388 F.3d at 172; *Guardian Health Care Center,* DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 ([E]ntry of summary judgment upheld where inferences and views of non-moving party are not reasonable.). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Center*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

Petitioner does not dispute that it ceased to do business as a skilled nursing facility, the basis for its provider agreement. Petitioner argues that did not cease operations because it continued to provide services through its operation of adult day care centers. While Petitioner contends that there are disputes of fact present, there simply are no material facts in dispute here. Rather, this matter involves the parties' differing interpretations of the applicable law. It is a question of law as to whether Petitioner's operation of adult day care centers would constitute continuing business under the applicable statutes and regulations.

Section 1866(b)(2)(B) authorizes the Secretary to terminate a provider agreement when he has determined that the provider "fails substantially to meet the applicable provisions

of section 1861." In this case, the "applicable provision" of section 1861 is section 1861(j), cross-referencing 1819(a), which defines a skilled nursing facility as an entity that has or meets enumerated criteria, which include that the entity is "primarily engaged in providing to residents-- skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases . . . ." Reading sections 1866(b)(2)(B) and 1861(j) together, the provider agreement may be terminated by the Secretary if the provider "fails substantially to meet" one or more of the definitional elements or criteria in section 1861(j), including the "primarily engaged" criterion in section 1861(j).

Petitioner does not dispute that it has not provided residents skilled nursing or rehabilitation services. Petitioner has cared for no residents since mid-February 2008. These facts establish that in February 2008, the Medicare-certified SNF stopped treating residents. It was therefore no longer "primarily engaged" in providing skilled nursing, or rehabilitation services, and no longer met the statutory definition of a SNF. CMS therefore properly terminated its program participation. Act § 1866(b)(2), 42 C.F.R. § 489.53(a)(1); *United Med. Home Care, Inc.*, DAB No. 2194 (2008) (holding that CMS properly terminated the Medicare participation of an HHA that treated no patients between February 9 and August 23, 2005); *see Cornerstone Family Healthcare,* DAB No. 2319 (2010) (affirming Medicare termination of a rural health clinic that was no longer providing services); *Arizona Surgical Hosp., LLC*, DAB No. 1890 (2003) (upholding Medicare termination of a hospital that did not provide in-patient services for 39 days and therefore did not meet the provisions of section 1861(e) of the Act).

There is absolutely no evidence that adult day health care services meet the criteria for SNF services under section 1861(j). Evidence and logic point to quite a different finding — adult day health care services are wholly different from SNF services. To begin with, the obvious basic fact is that adult day care is not a residential program, but is by definition a day program. Petitioner has provided no evidence or argument for me to interpret otherwise, no matter how favorable a view I may try to take of its overall position.

I further note that a SNF is subject to a survey to ensure that it meets the Medicare conditions of participation, including requirements intended to ensure the quality of the care provided and the protection of residents' rights. Act § 1819; 42 C.F.R. Part 488, subpart A. If the SNF is not providing services to any residents, it is not possible to conduct a survey to see that it is providing those services according to the statutory and regulatory requirements. 42 C.F.R. § 489.53(a)(3); *A.M. Home Health Services, Inc.*, DAB No. 2354 (2010); *United Medical Home Care, Inc.*, DAB No. 2194 (2008). In fact, it is not disputed that the state survey agency had been unable to survey Petitioner's SNF since February 2008 because Petitioner had no residents. *See* CMS Br. at 7 n.2.

### *1. The CMS January 28, 2010 notice was sufficient to establish termination; however, the effective date of termination is February 12, 2010 as a matter of law.*

Petitioner argues that involuntary termination is improper because it did not receive proper notice. Petitioner argues that the January 28, 2010 notice states clearly that it is a voluntary termination. P. Br. at 8. Petitioner however misreads the clear language in the notice stating that CMS received information that Petitioner had "voluntarily discontinued providing Medicare certified skilled nursing services effective February 15, 2008." P. Ex. A. Whether Petitioner voluntarily discontinued providing services is a different issue from the voluntary termination of its provider agreement. Furthermore, the January 28 notice specifies the *bases* for the termination as *both* 489.52 ("voluntary termination") *and* 489.53 ("involuntary termination"). P. Ex. A.

Although the January 28, 2010 notice included a retroactive date to February 15, 2008, and involuntary termination requires notice at least 15 days before the effective date of termination of the provider agreement, this does not constitute insufficient notice to overturn the termination. *See* P. Br. at 8-9.

The Board has addressed Petitioner's argument that its notice of termination was not provided in accordance with the formal notice requirement and therefore should not be applied. The Board explained that:

> nothing in section 489.53 indicates that failure to provide the required notices will, in itself, render CMS's termination action invalid or void. The chief purpose of section 489.53(c)'s notice requirements is to ensure that a provider is afforded due process to challenge a termination decision by CMS. Cf. 59 Fed. Reg. 56,116, 56,216 (Nov. 10, 1994)(noting that the "purpose of the notice [required by section 489.53(c)(1)] is not for a facility to make last minute corrections, but for the government to help fulfill its duty to provide due process to facilities before termination"). The Board has consistently held that a federal agency's failure to comply with formal pre-hearing notice requirements may be remedied by giving the adversely affected party an opportunity to challenge the agency's position in the ensuing administrative appeal. *See, e.g., West Virginia Department of Health and Human Resources*, DAB No. 2185, at 9 (2008); *Recovery Resource Center*, DAB No. 2063, at 7-8 (2007); *District of Columbia Department of Human Services*, DAB No. 1005, at 10 n.5 (1988); *Alden Town Manor Rehabilitation & HCC*, DAB No. 2054, at 17-18 (2006) (noting that the purpose of the Statement of Deficiencies generated by a nursing home survey is to give notice of the basis for CMS's imposition of enforcement remedies but that such notice may also be provided in the course of "pre-hearing record development").

*United Medical Home Care, Inc.*, DAB No. 2194, at 13 (2008).

In the present case, the January 28, 2010 CMS notice, citing both voluntary termination under 489.52 and involuntary termination under 489.53(a)(1) and (3) as bases, clearly stated that CMS viewed the provider agreement as terminated, even if not voluntarily so. *United Medical Home Care, Inc.*, DAB No. 2194, at 13-14. Considerably more vague notice has been found sufficient by the Board in similar circumstances. Petitioner has had sufficient opportunity to challenge the agency's position through this administrative process. *United Medical Home Care, Inc.*, DAB No. 2194; *see Livingston Care Center*, DAB No. 1871, at 20 (2002), *aff'd, Livingston Care Center v. U.S. Department of Health and Human Services,* 388 F.3d 168 (6th Cir. 2004); *see also St. Anthony Hospital v. Secretary, Department of Health and Human Services,* 309 F.3d 680, 708 (10th Cir. 2002) ("To establish a due process violation [in an administrative proceeding], an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.").

Termination of a provider agreement by CMS becomes effective no sooner than 15 days after the notice of termination is issued. 42 C.F.R. § 489.53(c). Because the operative notice of termination occurred on January 28, 2010, the effective date of termination was February 12, 2010. Since Petitioner had sufficient notice as of January 28 that its provider agreement was being involuntarily terminated, the effect of the action is prospective, not retrospective. *See United Medical Home Care, Inc.*, DAB No. 2194, at 15-16.

## III. Conclusion

I grant summary disposition in favor of CMS because Petitioner ceased providing SNF services as a matter of law. CMS properly terminated Petitioner's Medicare provider agreement effective February 12, 2010. 42 C.F.R. § 489.53(a)(1) -(2), (d)(1).

/s/
Richard J. Smith
Administrative Law Judge