Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: June 6, 2008
St. Joseph Villa Nursing Center, (CCN: 28-5078), Petitioner,	)	Docket No. C-07-628
	)	Decision No. CR1800
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

The Centers for Medicare & Medicaid Services (CMS) has failed to show that Petitioner, St. Joseph Villa Nursing Center, was not in substantial compliance with program participation requirements based upon the survey of Petitioner's facility completed on May 3, 2007. Accordingly, CMS has not shown any basis for an enforcement remedy and no remedy is reasonable in this case.

I. Background

Petitioner, located in Omaha, Nebraska, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Medicaid program as a nursing facility (NF). Petitioner was subject to a survey by the Nebraska Health and Human Services System, Department of Regulation and Licensure, Section for Long Term Care and Assisted Living Facilities (the state agency), that was completed on May 3, 2007.

CMS notified Petitioner by letter dated June 6, 2007, that based on regulatory violations, i.e. deficiencies, found by the May 3, 2007 survey, CMS was imposing a per instance civil money penalty (CMP) of $8000; a denial of payment for new admissions (DPNA) beginning on June 21, 2007 and continuing until Petitioner returned to substantial compliance; termination of Petitioner's provider agreement on November 3, 2007, if Petitioner did not return to substantial compliance before that date; and that Petitioner's authority to conduct a Nurse Aide Training and Competency Evaluation Program

(NATCEP) was withdrawn. Request for Hearing (RFH) at 1-2; RFH Exhibit (RFH Ex.) A. The state agency conducted a revisit survey in July 2007 and determined that Petitioner returned to substantial compliance as of May 30, 2007. RFH at 2; RFH Ex. C. The DPNA and termination remedies were never effectuated.

Petitioner requested a hearing by pleading dated August 2, 2007. The request for hearing was assigned to me for hearing and decision on August 7, 2007. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction. On November 2, 2007, I issued a notice of hearing setting this case for hearing from April 1 through 4, 2008, in Omaha, Nebraska.

On March 31, 2008, D. Samuel Borin, Chief Counsel, Region VII, U.S. Department of Health and Human Services, Office of General Counsel (OGC) advised the staff attorney assigned to assist me with this case, that the attorney from his office assigned to represent CMS in this case would not be present at the hearing to be convened the next morning on April 1, 2008. On March 31, 2008, a prehearing telephone conference was convened with Mr. Borin, one of the other attorneys on his staff, Michael Frye, and counsel for Petitioner. The substance of the prehearing conference and my ruling denying postponement of the hearing set to begin the next morning, is recorded in my Ruling Denying Centers for Medicare & Medicaid's Request for Postponement dated March 31, 2008 (Ruling Denying Postponement).

A hearing was convened in this case at 9:09 a.m. on April 1, 2008. Petitioner appeared represented by counsel. No representative for CMS appeared. Petitioner's exhibits (P.Exs.) 1 through 39 were admitted without objection. Transcript (Tr.) 27.

II. Discussion

A. Findings of Fact

1. A notice of hearing was issued in this case on November 2, 2007, setting this case for hearing in Omaha, Nebraska beginning on April 1, 2008 at 9 a.m. Central Time and concluding not later than April 4, 2008.

2. On March 31, 2008, Chief Counsel for Region VII, OGC, advised me that no attorney from his office would appear at hearing on April 1, 2008 to represent CMS.

3. On April 1, 2008, a hearing in this case was convened in Omaha, Nebraska.

4. On April 1, 2008 when the hearing was convened, no counsel or other representative appeared on behalf of CMS except that counsel did appear by telephone for the limited purpose of offering CMS exhibits.

5. On April 1, 2008, no CMS exhibits were delivered to the hearing site and CMS offered no documents or other evidence.

B. Conclusions of Law

1. Petitioner's hearing request was timely and I have jurisdiction.

2. CMS failed to present any evidence at hearing and thus failed to make a prima facie showing of any statutory or regulatory violation by Petitioner.

3. There is no basis for the imposition of an enforcement remedy in this case.

4. No enforcement remedy is reasonable in this case.

C. Issues

The issues in this case are:

> Whether there is a basis for the imposition of an enforcement remedy; and,
>
> Whether the remedy imposed is reasonable.

D. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary of Health and Human Services (the Secretary) with authority to impose civil money penalties against a long-term care facility for failure to comply substantially with federal participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28 and 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a per instance or per day CMP against a long-

term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408 and 488.438. The upper range of CMP, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i) and (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1000 to $10,000 for a per instance CMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv) and 488.438(a)(2).

In this case, the state agency withdrew Petitioner's approval to conduct a NATCEP. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have taken a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements established by the Secretary and a process for reviewing and reapproving those programs using criteria set by the Secretary. Pursuant to sections 1819(f)(2) and 1919(f)(2) the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1) a state may not approve and must withdraw any prior approval of a NATCEP offered by a skilled nursing or nursing facility that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. §§ 483.13 (Resident Behavior and Facility

Practices), 483.15 (Quality of Life), or 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and is without actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also,* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP amount that could be collected by CMS or impact upon the facility's NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

E. Analysis

The Board has addressed the allocation of the burden of persuasion and the burden of production of going forward with the evidence in past cases, in the absence of specific statutory or regulatory provisions. Application of the Board's analysis and approach is not disputed in this case and is appropriate.

When a penalty is proposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. "Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted. *Black's Law Dictionary* 1228 (8th ed. 2004). In *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman*

Rehabilitation Center v. HHS, No. 98-3789 (GEB), slip op. at 25 (D. N.J. May 13, 1999), the Board described the elements of the CMS prima facie case in general terms as follows:

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

DAB No. 1611, at 11. Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to terminate is legally sufficient under the statute and regulations. To make a prima facie case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the provider; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by the provider; and (3) show how the deficiencies it found amount to noncompliance that warrants an enforcement remedy.

In *Evergreene Nursing Care Center*, DAB No. 2069 (2007), the Board explained as follows:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Ctr. v. HHS*, No. 98-3789 (GEB) (D. N.J. May 13, 1999); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004), *aff'd*, *Batavia Nursing and Convalesent Center v. Thompson*, No. 04-3687 (6th Cir. 2005); *Guardian Health Care Center*, DAB No. 1943 (2004); *Fairfax Nursing Home, Inc.*, DAB No. 1794 (2001), *aff'd*, *Fairfax Nursing Home v. Dep't of Health & Human Srvcs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 2003 WL 98478 (Jan. 13, 2003).

> CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. *Hillman Rehabilitation Center*, DAB No. 1663, at 8 (1998), *aff'd*, *Hillman Rehabilitation Ctr. v. HHS*, No. 98-3789 (GEB) (D. N.J. May 13, 1999); *see also Guardian Health Care Center*. A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. *Tri-County Extended Care Center*, DAB No. 1936 (2004). "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 4 (quoting *Western Care Management Corp.*, DAB No. 1921 (2004)).

DAB No. 2069, at 7-8.

The prior decisions of the Board are clear that, where as here the findings cited by CMS as the basis for imposing an enforcement remedy are disputed, CMS has the burden of going forward with the evidence. CMS is obliged to show by competent evidence the factual basis for the alleged violations for which the enforcement remedy is imposed. The CMS evidence must be sufficient, without consideration of Petitioner's evidence, to support a decision in its favor.

In this case, during the conference call the day prior to hearing, the Chief Counsel for Region VII advised counsel for Petitioner and me that the attorney from his office assigned to represent CMS would not appear at hearing. Regional Counsel further advised that he would not appear or send other counsel from his office. I treated the Regional Counsel's comments as a request for postponement. Counsel for Petitioner objected to postponement on grounds that counsel for Petitioner was prepared to proceed, Petitioner's representative was already traveling to attend the hearing, Petitioner's witness were scheduled and prepared to appear. I denied the request for postponement. Ruling Denying Postponement.

Subsequent to the prehearing conference and prior to my convening the hearing on April 1, 2008, Petitioner agreed that it would not oppose CMS offering its exhibits by telephone, while not waiving objections to specific CMS exhibits. Tr. 9-10. After the hearing was convened, Petitioner advised me that it was prepared to proceed and call witnesses if the CMS exhibits were offered and admitted. Tr. 10-11. Counsel for CMS, Harry Mallin, appeared by telephone. Mr. Mallin stated that his appearance was for the

limited purpose of offering CMS exhibits 1 through 16 and not to examine or cross-examine witnesses. However, according to Mr. Mallin, the CMS exhibits had been shipped to Omaha by Federal Express and the exhibits were in Memphis not Omaha. Tr. 21-23.

Petitioner objected to proceeding without the CMS exhibits as Petitioner asserted it had no burden to go forward with the evidence, and CMS failed to make a prima facie showing of any regulatory violation. Tr. 24-25. I denied Petitioner's motion for judgment, ruling that I would wait to receive the CMS exhibits. Tr. 26. Mr. Mallin was instructed to locate the CMS exhibits and advise me regarding their delivery to the courthouse. Tr. 27-32. After approximately 30 minutes (Tr. 32), Petitioner renewed its objection to proceeding absent the CMS exhibits and requested judgment. Tr. 37-38. I reconsidered my ruling denying Petitioner's motion for judgment and entered judgment for Petitioner on grounds that CMS failed to make a prima facie showing of any regulatory or statutory violation. Tr. 41-43.

III. Conclusion

For the foregoing reasons, I conclude that CMS has failed to make a prima facie showing of any regulatory or statutory violation that provides a basis for the imposition of an enforcement remedy and no such remedy is reasonable in this case.

/s/
Keith W. Sickendick
Administrative Law Judge