Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Humility of Mary Health Partners d/b/a St. Elizabeth Boardman Health Center, (CCN: 36-0276),	)	Date: June 24, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-676
	)	Decision CR1965
Centers for Medicare and Medicaid Services.	)	
	)	

DECISION

I affirm the decision of the Centers for Medicare & Medicaid Services (CMS) to certify Petitioner, Humility of Mary Health Partners d/b/a St. Elizabeth Boardman Health Center, for participation in the Medicare program effective August 9, 2007, over Petitioner's assertion that an earlier certification date of August 1, 2007 is warranted.

I. Background

Petitioner is an acute care hospital located in Boardman, Ohio, that sought certification for participation in the Medicare program. Petitioner submitted an application for Medicare enrollment to participate in the Medicare program as an acute care hospital in early May 2007. CMS notified Petitioner by letter dated October 1, 2007 of its acceptance into the Medicare program effective August 9, 2007. On November 21, 2007, Petitioner filed a request for reconsideration of CMS's initial determination regarding the August 9, 2007 effective date. CMS informed Petitioner on June 18, 2008 that it affirmed the initial determination establishing the Medicare certification effective date of August 9, 2007.

Petitioner timely filed a request for hearing before an administrative law judge (ALJ) at the Departmental Appeals Board (Board) by letter dated August 11, 2008, asserting that the certification effective date should be August 1, 2007, not August 9, 2007. On August

21, 2008, the matter was assigned to me for hearing and decision. On that date, I issued an initial Order directing, among other things, the filing of any potentially dispositive motions within 60 days.

On November 14, 2008, CMS filed a Motion for Summary Disposition (CMS Br.). CMS's motion was accompanied by 10 exhibits identified as CMS Ex. 1 through CMS Ex. 10. A telephone pre-hearing conference was convened with the parties on November 21, 2008. During the conference, Petitioner indicated that it would be filing a response to CMS' motion for summary disposition. Additionally, Petitioner stated that this matter could be decided based on the parties' written submissions. Based on the parties' representations that they wished to proceed on the dispositive motions, a briefing scheduled was issued. *See* Order dated December 5, 2008. On December 19, 2008, Petitioner filed its response opposing CMS's motion and its own cross-motion for summary disposition (P. Br.). Petitioner's response was accompanied by 15 exhibits identified as P. Ex. A through P. Ex. O. On January 23, 2009, CMS filed a reply (Reply) to Petitioner's response. Petitioner chose not to file a sur-reply. There being no objections, I am admitting CMS Exs. 1-10 and P. Exs. A-O into evidence.

After consideration of the written arguments submitted by the parties as well as the entire record in this matter, I grant CMS's motion for summary disposition. In doing so, I find that Petitioner is not entitled to a Medicare certification date earlier than August 9, 2007 – the date CMS certified Petitioner as a Medicare participating provider.

II. Applicable Law and Regulations

Section 1866 of the Social Security Act (Act) requires that a prospective provider enter into a provider agreement with CMS in order to participate in the Medicare program. Before CMS will accept an agreement from a prospective provider, the prospective provider must meet the conditions of participation relevant to that provider. 42 C.F.R. §§ 488.3(a)(2) and 489.10(a).

The participation requirements for a hospital, such as Petitioner, to participate in Medicare are set forth at 42 C.F.R. Part 482. CMS and its agents (such as state survey agencies or a national accreditation organization) determine whether a prospective provider is complying with applicable federal requirements pursuant to the survey and certification process set forth at 42 C.F.R. Part 488. 42 C.F.R. §§ 488.11(a), (d); 488.12; 488.26(c)(1).

The regulation at 42 C.F.R. § 489.13 establishes the general rule for determining the effective date of a provider agreement for a prospective provider. A prospective provider may qualify for a participation agreement if CMS finds the entity in compliance based on a survey of the facility by a state survey agency. 42 C.F.R. § 489.13(a)(1). In the alternative, a prospective provider may qualify for a participation agreement based on

accreditation "by an accrediting organization whose program has CMS approval at the time of [the] accreditation survey and accreditation decision." 42 C.F.R. § 489.13(a)(1)(ii).

Until a hospital has been assessed and certified, and until its agreement has been approved based on that assessment, its status is that of a "prospective provider." 42 C.F.R. § 498.2. Section 1865(a) of the Act provides that if CMS finds that accreditation of a hospital by a national accreditation organization provides reasonable assurance that Medicare participation requirements are met, CMS may then treat the prospective provider as meeting the requirements. 42 C.F.R. § 488.10(d).

Under 42 C.F.R. § 489.13(d)(2) if the provider is accredited by a CMS-approved national accrediting organization at the time of the accreditation survey and decision, and CMS deems the provider to meet the applicable federal participation requirements, then a retroactive effective date for a participation agreement is available. Section 498.13(d)(2) permits an effective date that is retroactive for up to one year to encompass dates on which the provider furnished to a Medicare beneficiary covered services for which it has not been paid.

III. Issues, Findings of fact and conclusions of law

A. Issues

The issues in this case are:

1. Whether summary judgment is appropriate;

2. Whether the effective date of Petitioner's participation is August 9, 2007, or an earlier date; and

3. Whether I have authority based on the principle of equitable estoppel to order CMS to certify Petitioner for participation in the Medicare program on a date prior to August 9, 2007.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision to grant CMS's motion for summary disposition. Each finding is noted below in bold face and italics, followed by a discussion of each finding.

1. Summary judgment is appropriate in this case because there are no disputed issues of material fact.

An ALJ may decide a case on summary judgment, without an evidentiary hearing, if the case presents no genuine issue of material fact and the undisputed facts clearly demonstrate that one party is entitled to judgment as a matter of law. *Crestview Parke Care Center v. Thompson,* 373 F.3d 743, 750 (6th Cir. 2004); *Livingston Care Center v. Dep't of Health & Human Services*, No. 03-3489, 2004 WL 1922168, at *3 (6th Cir. 2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). The movant, or party seeking summary judgment, bears the initial burden of showing the basis for its motion and identifying the portions of the record that it believes demonstrate the absence of a genuine factual dispute. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The nonmoving 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) (quoting Federal Rules of Civil Procedure 56(e)); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918. To accomplish this, the nonmoving party must go beyond mere allegations, and must come forward with factual evidence that creates a genuine issue of material fact. In deciding a summary judgment motion an ALJ may not make credibility determinations or weigh conflicting evidence but must instead view the entire record in the light most favorable to the nonmoving party, and make all reasonable inferences drawn from the evidence in that party's favor. *Wade Pediatrics,* DAB No. 2153, at 16-17 (2008), citing *U.S. v. Diebold, Inc.,* 369 U.S. 654, 655 (1962); *Pollock v. American Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd Cir. 1986); *Innsbruck HealthCare Center*, DAB No. 1948 (2004); *Madison Health Care, Inc*., DAB No. 1927 (2004).

Under Federal Rules of Civil Procedure 56 (Rule 56), a "material fact" is a fact which, if it exists, may affect the outcome of a case. A "genuinely disputed" material fact exists when opposing parties advance different versions of an event. The concept of a genuine dispute as to the facts is critical to understanding how summary judgment works. A fact offered by a party is not in dispute simply because the opposing party asserts that it is in dispute. In order for there to be a dispute as to the facts the opposing party must offer a version of events that differs materially from the version offered by the moving party. Additionally, a disagreement between parties as to the meaning of facts is not an impediment to summary judgment under Rule 56. The trier of fact always has the authority to draw conclusions from facts, whether the case is disposed of by summary judgment, or after a hearing. Thus, arguments about the meaning of facts – as opposed to disputes as to what facts exist – constitute no impediment to granting summary judgment in a case.

Both parties in this matter have moved for summary judgment and I find that this case is appropriate for summary judgment. Here, the parties agree on the essential facts of when Petitioner was surveyed, by whom, and for what purpose. Their difference lies in what

legal significance, in light of the applicable law and regulations, should be attributed to those facts. With no genuine dispute as to any material fact, I find summary judgment is appropriate in this case. The central legal issue in this case is whether CMS correctly certified Petitioner to participate in Medicare on August 9, 2007. In evaluating the parties' submissions, I find that even if I construe the entire record in the light most favorable to Petitioner, as discussed below, I find that CMS correctly certified Petitioner to participate in Medicare on August 9, 2007.

2. The effective date of Petitioner's participation agreement may not be any earlier than August 9, 2007, the date it became accredited by a CMS-approved national accrediting organization.

Petitioner appeals the effective date of its certification to participate as a hospital in the Medicare program. Petitioner asks that I find that it satisfied all conditions of Medicare participation as of August 1, 2007, and that I require CMS to retroactively certify it on that date. P. Br. at 1. Petitioner contends that it is entitled to a certification date of August 1, 2007 based on its receipt of a preliminary accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) effective July 25, 2007, and receipt of its bed registration as a hospital from the Ohio Department of Health (ODH) on July 31, 2007. Petitioner maintains that these two events entitles it to Medicare certification as of August 1, 2007. Further, Petitioner argues that this case is distinguishable from other unsuccessful appeals for two reasons: (1) it had an established track record of sustained clinical performance; and (2) it had been given "contradictory" and "confusing" directives from ODH, JCAHO, and CMS which it relied upon to its own detriment. P. Br. at 2.

CMS maintains that based on Petitioner's accredited status with JCAHO and its acceptable application (CMS-855A), CMS certified Petitioner as a Medicare provider as of August 9, 2007 − the date CMS maintains Petitioner meet all participation requirements. CMS Br. at 6. CMS further maintains that even though Petitioner provided services to Medicare beneficiaries during the period from August 1 through 8, 2007, it cannot be reimbursed for those services as CMS had no assurances that Petitioner met all federal participation requirements during that time. CMS asserts that it was not until JCAHO indicated to CMS that Petitioner had met the applicable federal participation requirements that CMS could certify Petitioner as a Medicare provider with an effective date of August 9, 2007. CMS Reply at 1-2.

The undisputed facts show that:

> (1) In early May 2007, Petitioner filed its application for Medicare certification (CMS-855A). The application was received by the fiscal intermediary, National Government Services, on May 3, 2007. P. Br. at 4; P. Ex. D at 61; CMS Br. at 3; CMS Ex. 1, at 5, 48.

(2) On July 11, 2007, ODH notified Petitioner that it had received its application to participate in the Medicare program as a hospital, and asked Petitioner when its facility would be ready for a survey. The notice instructed Petitioner that its effective date of participation would be based on the criteria found at 42 C.F.R. § 489.13. The notice also requested that Petitioner notify ODH if it was opting for deemed status through an approved accreditation agency. P. Br. at 5; P. Ex. F; CMS Br. at 3; CMS Ex. 2.

(3) Petitioner sought accreditation with JCAHO through the early survey process. P. Br. at 6-7; CMS Br. at 3; CMS Ex. 4.

(4) On July 24, 2007, Petitioner underwent a first survey with JCAHO and Petitioner was granted a preliminary accreditation by JCAHO on July 27, 2007. P. Br. at 6, 7, 11; P. Ex. G; CMS Br. at 4; CMS Ex. 4.

(5) By letter dated July 31, 2007, Petitioner advised ODH that it was opting for deemed status through JCAHO for Medicare certification purposes. P. Br. at 7; P. Ex. H; CMS Br. at 3; CMS Ex. 3.

(6) By notice dated July 31, 2007, ODH notified Petitioner that it had met the necessary hospital registration requirements and was therefore registered with the ODH. P. Br. at 7; P. Ex. I; CMS Br. at 4; CMS Ex. 5.

(7) Petitioner commenced admitting patients on August 1, 2007. P. Br. at 7.

(8) Petitioner underwent the second survey by JCAHO on August 6 through 8, 2007. P. Br. at 7-8; CMS Br. at 6.

(9) On August 10, 2007, CMS was notified by JCAHO that Petitioner had been granted an accreditation decision, and the accreditation cycle was effective August 9, 2007. P. Br. at 8; P. Ex. J; CMS Br. at 4; CMS Ex. 6.

(10) By letter dated October 1, 2007, CMS notified Petitioner that it was certified as a Medicare provider as of August 9, 2007. P. Br. at 8; P. Ex. L; CMS Br. at 5; CMS Ex. 7.

Sections 488.4 and 488.5 of the regulations allow CMS to designate an entity to conduct certification surveys on its behalf. Petitioner had a choice to qualify for a Medicare participation agreement in one of two ways: based on a survey by the state survey agency; or where CMS "deems" it to be in compliance with conditions for participation based on its accreditation by a national accrediting organization. 42 C.F.R. § 489.13(a)(1)(i) and (ii). CMS has designated JCAHO as an entity authorized to conduct

Medicare certification surveys. 42 C.F.R. § 488.5. For a "deemed" status, for which Petitioner opted, the effective date of Petitioner's agreement is the date on which it meets all applicable federal participation requirements. 42 C.F.R. § 489.13(d)(1).

Petitioner acknowledges that it opted for the early survey process with JCAHO. P. Br. at 2, 6-7; P. Ex. H; CMS Ex. 3. The selection of the early survey process required Petitioner to undergo two onsite surveys – the first or initial survey prior to Petitioner providing patient care, and the second survey after it was operational. P. Br. at 6. The initial survey was initiated on July 24, 2007, and Petitioner was granted a preliminary accreditation by JCAHO on July 27, 2007. P. Br. at 6; P. Ex. G. The second survey of Petitioner's hospital was completed on August 8, 2007. P. Ex. J.

On August 10, 2007, JCAHO then notified CMS that it had granted accreditation to Petitioner for all services with an effective date of August 9, 2007. P. Br. at 8; P. Ex. J. As outlined at 42 C.F.R. §§ 489.13(a)(1)(ii) and 489.13(b), the certification date for a prospective provider seeking accreditation is the date CMS deems it as meeting all relevant federal requirements. The provider agreement is effective on the date of the survey if the provider meets all applicable federal requirements. In the case before me, I find that the second JCAHO survey finding that Petitioner's accreditation cycle was effective August 9, 2007, is the date that Petitioner met all applicable Medicare participation requirements.

3. ODH's state registration of Petitioner did not equate to a survey to certify a prospective provider for Medicare participation.

Petitioner asserts that while ODH does not issue state licenses it does require providers to undergo a bed registration which requires adherence to standards pertaining to building, operations, medical staff, quality assurance and patient care. P. Br. at 11. Petitioner asserts that it met state registration requirements prior to August 1, 2007, and infers that this should be construed to partially fulfill the requirements for Medicare participation. P. Br. at 11. Petitioner maintains that "[w]hile a state registration may not be enough standing alone, a registration in combination with a flawless comprehensive survey is enough to meet all Federal requirements." *Id.* However, Petitioner's reliance on this assumption is unsupported by the regulations or case law, and is incorrect. The inspection conducted by ODH was for the sole purpose of assessing Petitioner for bed registration and not Medicare participation requirements. It is well established that CMS cannot base Medicare certification on a state licensing survey or on the date of issuance of a state license. *Arbor Hospital of Greater Indianapolis*, DAB No. 1591, at 7-8 (1996). Moreover, the regulation states specifically that a provider must be inspected and found to be in compliance with Medicare participation requirements before certification will be granted. 42 C.F.R. § 489.13.

Petitioner is also misguided in its assumption that the preliminary accreditation survey performed at its hospital in July 2007 by JCAHO sufficed to establish Petitioner as having met all federal participation requirements as a hospital for the purpose of participation in the Medicare program. *See* P. Br. at 11. I find CMS's assertions persuasive that Petitioner's preliminary accreditation was conditional upon the second JCAHO survey being successfully completed. CMS Reply at 6-7; CMS Ex. 10 (fact sheet from JCAHO comparing the first and second survey processes).

I find that based upon notice from JCAHO of Petitioner's full accreditation status and upon Petitioner's acceptable application, CMS made a finding that Petitioner met all Medicare participation requirements. Thus, CMS correctly certified Petitioner as a Medicare provider as of August 9, 2007, the date Petitioner met all participation requirements.

4. The "Special Rule" (42 C.F.R. § 489.13(d)(2)) does not apply to Petitioner because it was not an accredited provider at the time it applied for participation in the Medicare program.

Petitioner argues that 42 C.F.R. § 489.13(d)(2) entitled it to a retroactive effective date based on its provision of services to Medicare beneficiaries from August 1 though August 8, 2007. P. Br. at 13-14. The regulation Petitioner cites provides a special rule which affords a retroactive effective date to a provider for up to one year to cover dates upon which the provider furnished services to a Medicare beneficiary for which it was not paid. However, the provider must also satisfy subsection (d)(1) of the regulation which states:

> If the provider . . . is ***currently*** accredited by a national accrediting organization . . . and on the basis of accreditation, CMS has deemed the provider . . . to meet Federal requirements. . . .

42 C.F.R. § 489.13(d)(1) (emphasis added). The regulation is clear on its face that the provider is required to be *currently* accredited by a CMS-approved national accrediting organization. Therefore, Petitioner's reliance on the special rule is misplaced, as the special rule does not apply to Petitioner because it was not an accredited provider at the time it applied for participation in the Medicare program as explicitly required by 42 C.F.R. § 489.13(d)(1). Here, Petitioner did not obtain its accreditation status with JCAHO as a hospital until August 9, 2007. CMS Ex. 6.

Petitioner asserts that its case is unique in that it had a track record of sustained clinical performance and had been surveyed by JCAHO seven months earlier as a satellite outpatient facility of St. Elizabeth Center. P. Br. at 2. However, Petitioner's argument fails. Petitioner acknowledged it was a satellite facility prior to that date and not an acute care hospital. P. Br. at 4. Based on Petitioner's application to enroll in the Medicare program as an acute care hospital, JCAHO had to determine that Petitioner met all

applicable federal requirements for hospitals before it could grant Petitioner the status of accreditation. St. Elizabeth's full accreditation from JCAHO did not apply to Petitioner's pending application and certification before CMS as a hospital under the Medicare program.

A provider who seeks a participation agreement based on its "deemed status" simply may not participate unless and until it is accredited. JCAHO did not complete its accreditation survey of Petitioner's hospital for assessment as to its adherence to Medicare participation requirements until August 8, 2007. The on-site JCAHO survey on August 8, 2007 determined that Petitioner met participation requirements as of August 9, 2007 – there is no prior certification survey to calculate the retroactive effective date which Petitioner now seeks. Petitioner just did not meet the necessary participation requirements until August 9, 2007.

Even if I accept, *arguendo,* Petitioner's assertion that St. Elizabeth's full accreditation was applicable to Petitioner, thus qualifying Petitioner as an accredited provider rather than a prospective provider, the "Special Rule" exception would still not benefit Petitioner here because, although retroactive certification is permitted by the regulation, it is not required. *Oak Lawn Endoscopy*, DAB No. 1952 (2004). Here, CMS chose not to grant retroactive certification to Petitioner and an ALJ cannot require or compel CMS to use its discretion to certify a retroactive effective date. The regulation Petitioner relies on specifically states:

> *Special rule: Retroactive effective date.* If a provider or supplier meets the requirements of paragraphs (d)(1) and (d)(1)(i) or (d)(1)(ii) of this section, the effective date *may* be retroactive for up to one year to encompass dates on which the provider or supplier furnished, to a Medicare beneficiary, covered services for which it has not been paid.

42 C.F.R. § 489.13(d)(2) (emphasis added). The discretion to grant or deny retroactivity as to a certification date clearly lies exclusively with CMS. The regulation at 42 C.F.R. § 489.13, as construed by the Board, clearly confers discretion on CMS to decide whether or not to grant retroactivity based on the facts of each individual case. *Oak Lawn Endoscopy*, DAB No. 1952, at 14 n.7; *see also Puget Sound Behavioral Health*, DAB No. 1944, at 12-14 (2004) (the Board concluded that the regulatory drafters of section 489.13(d)(2) intentionally used the phrase "may be retroactive" to evidence CMS's discretion to retroactively apply the "Special Rule" when it deemed appropriate.); 62 Fed. Reg. 43,933 (Aug. 18, 1997).

5. I do not have authority to provide Petitioner the relief it seeks through its equitable and constitutional arguments.

Petitioner advances several arguments based on equitable principles. First, Petitioner argues that CMS should be ordered to pay for the services Petitioner rendered to Medicare beneficiaries from August 1 though August 8, 2007 based on principles of equitable estoppel and unjust enrichment. P. Br. at 15-17. Petitioner also argues that the intervening period between when it opened for business and then underwent a full survey amounts to a regulatory taking which is prohibited under the Fifth Amendment. P. Br. at 17-20. My authority to decide these matters is outlined in the regulations under sections 42 C.F.R. §§ 498.13 and 498.5. The regulations do not grant me the authority to decide this case based on equitable principles or based on the constitutional arguments Petitioner advances. *Oklahoma Heart Hospital,* DAB No. 2183, at 16-17 (2008).

Petitioner claims it furnished to Medicare beneficiaries over $500,000 in services between August 1 and August 8, 2007, believing that the services would be covered. P. Br. at 16. Petitioner further claims that it was provided misinformation from ODH, JCAHO, and CMS, upon which it detrimentally relied. Petitioner maintains that it understood that it would be granted accreditation for all services with an effective date earlier than August 9, 2007. P. Br. at 2.

Petitioner's claim does not establish a need for an in-person hearing or preclude this matter from being decided on summary disposition. In fact, Petitioner has agreed that the case should be decided based upon written submissions. For the limited purposes of this discussion, I accept, *arguendo,* Petitioner's assertion that it was misled by the information provided by representatives from ODH, JCAHO, and CMS which Petitioner claims it relied upon to its own detriment. P. Br. at 2. But, in accepting the assertions, *arguendo*, I note that these questions of fact are immaterial to my resolution of this matter as such representations cannot bind CMS or estop CMS from following clear regulatory provisions. I cannot provide Petitioner with the relief it seeks under any equitable theory. Assuming the truthfulness of its assertions, Petitioner is still not entitled to monetary payments not otherwise permitted by law. This forum's well-established case law pertaining to equitable estoppel arguments in cases such as this one are clear − estoppel does not lie against the government even in cases where erroneous information from government employees was received.[1] A provider cannot rely on an alleged misrepresentation by a CMS representative regarding the regulatory deadline to request a

[1] *See Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Surgery Center of Southwest Kansas*, DAB CR619, at 6-7 (1999); *New Life Plus Center, CMHC*, DAB CR700, at 11-12 (2000); *Tenet HealthSystem Philadelphia, Inc.,* DAB CR663, at 8-10 (2000); *Ophthalmology Ltd. Eye Surgery,* DAB CR658, at 9 (2000); *Danville Health Care Surgery Center*, DAB CR892, at 6-8 (2002).

hearing in order to relieve itself of acting in accordance with the regulations. *See Knox County Nursing Home*, DAB CR1588, at 6-7 (2007); *Hamilton County Nursing Home*, DAB CR716, at 6 (2000). Case law has established that neither the doctrine of estoppel nor any other equitable remedy would entitle Petitioner to claim an earlier effective date. *Maher A.A. Axer (Florence Dialysis Center, Inc.)*, DAB CR994, at 6-7 (2003) quoting *Arbor Hospital of Greater Indianapolis*, DAB No. 1591 (1996) and *SRA D/B/A St. Mary Parish Dialysis Center*, DAB CR341 (1994). Moreover, it has been consistently held that ALJs do not have the authority to hear and decide claims of estoppel against CMS or the Secretary related to alleged dilatory processing of applications. *GranCare Home Health Service & Hospice*, DAB CR464 (1997); *The Rivers Health Care Resources, Inc.*, DAB CR446 (1996); *SRA, Inc. D/B/A St. Mary Parish Dialysis Center*, DAB CR341, at 18-19; *T.L.C. Mental Health Center*, DAB CR636, at 9 (1999); *Therapeutic Rehabilitation Centers, Inc*., DAB CR531, at 4 (1998).

The critical issue in this case is whether Petitioner met all applicable provider participation requirements for hospitals prior to August 9, 2007. The undisputed facts before me clearly establish that Petitioner was not granted the status of full accreditation by JCAHO until August 9, 2007, and CMS determined that Petitioner met all Medicare participation requirements as of that date.

IV. Conclusion

CMS is entitled to judgment as a matter of law. The date of Petitioner's participation agreement may not be any earlier than August 9, 2007, the effective date of its accreditation. CMS's motion for summary judgment is therefore granted.

/s/
Alfonso J. Montaño
Administrative Law Judge