Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Everett Rehabilitation and Medical Center,	)	DATE: January 28, 1997
	)	
Petitioner,	)	
	)	
v.	)	Docket No. C-96-108
	)	Decision No. CR455
Health Care Financing Administration.	)	
	)	

DECISION

I conclude that the effective date of the Medicare provider agreement is September 18, 1995, and no earlier, for Petitioner, Nursing Home, Inc., doing business as Everett Rehabilitation and Medical Center.

PROCEDURAL BACKGROUND

Petitioner is a skilled nursing facility (SNF) and a participating provider in Medicare. The requirements for participation in Medicare by SNFs are set forth in regulations contained in 42 C.F.R. Part 483. As a SNF, Petitioner is subject to the survey, certification, and remedies provisions of 42 C.F.R. Part 488. Petitioner's right to a hearing concerning an adverse determination by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (DHHS), made pursuant to 42 C.F.R. Parts 483 and 488, is established by 42 C.F.R. Part 498.

By letter dated November 21, 1995, HCFA notified Petitioner that September 18, 1995, was Petitioner's correct effective date of certification for Medicare. By letter dated January 19, 1996, Petitioner requested a hearing, contending that Petitioner is entitled to Medicare certification with an effective date of June 23, 1995.

A concise summary of the process at issue here is provided by Golden State Manor Nursing and Rehabilitation Center, DAB 1597 (1996):

> Title XVIII of the Social Security Act establishes a federally subsidized health insurance program for the elderly and disabled, commonly known as Medicare. Medicare provides reimbursement for certain services rendered by providers, such as SNFs [skilled nursing facilities], who participate in the Medicare program under "provider agreements" with the Department of Health and Human Services. In order to enter into such an agreement to participate in the Medicare program, SNFs must meet certain requirements imposed by applicable statute and regulations. [citations omitted]
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> The survey process is the means by which State surveyors on HCFA's behalf assess providers' compliance with these requirements. The State survey agency performs the surveys of SNFs and makes recommendations to HCFA on whether such facilities meet the federal requirements for participation in the Medicare program. The results of such surveys are used by HCFA as the basis for its decisions regarding a facility's initial or continued participation in the program. HCFA, therefore, makes the determination as to whether a facility is eligible to participate or to remain in the program.

Id. at 3.

The parties filed cross motions for summary judgment, supporting memoranda, and other documents. Also, the parties submitted their Stipulation on "Relocation of Colby Manor," which I incorporate herein and admit into evidence.

Petitioner submitted exhibits (P. Exs.) 1 through 37. I have marked the Declaration of Kim Hagen as P. Ex. 37. During the prehearing conference on June 3, 1996, HCFA indicated it did not object to P. Exs. 1 through 34 being admitted into evidence, and I admitted into evidence P. Exs. 1 through 34. HCFA does not object to P. Exs. 35 through 37 being admitted into evidence, and I admit into evidence P. Exs. 35 through 37.

HCFA submitted exhibits (HCFA Exs.) 1 through 52. During the prehearing conference on June 3, 1996, Petitioner indicated that it did not object to HCFA Exs. 1 through 40 being admitted into evidence, and I admitted HCFA Exs. 1 through 40 into evidence.

HCFA Exs. 42 and 43, the Third Declaration of Teresa Trimble, was marked by HCFA as HCFA Ex. 43, but HCFA's cover letter dated June 7, 1996 indicated that the Third Declaration of Teresa Trimble is HCFA Ex. 42. I then remarked the Third Declaration of Teresa Trimble as HCFA Ex. 42. Thereafter, I received the Declaration of David M. Haffie, marked as HCFA Ex. 42, and HCFA's cover letter dated July 23, 1996 indicated that the Declaration of David M. Haffie is HCFA Ex. 42. Consequently, I remarked the Third Declaration of Teresa Trimble as HCFA Ex. 43 and the Declaration of David M. Haffie as HCFA Ex. 42 [as HCFA had marked them originally].

Regarding HCFA Exs. 41 through 52, Petitioner does not object to HCFA Exs. 41 through 50 and HCFA Ex. 52 being admitted into evidence, but Petitioner does object to HCFA Ex. 51 being admitted into evidence. Petitioner's objection to HCFA Ex. 51 is overruled, as I do find it relevant to show, among other things, that HCFA never did assign Colby Manor's provider number to Petitioner. I admit into evidence HCFA Exs. 41 through 52.

During the prehearing conference on July 9, 1996, I scheduled July 30, 1996, as the date the record would close. During the July 9th conference, HCFA advised me that it would comment by July 30, 1996 on Petitioner's submissions, which it did. HCFA commented also on Petitioner's non-submissions. HCFA included a copy of a Decision and Order for my consideration. Petitioner has moved to strike at least part of HCFA's July 30, 1996 submission [see Petitioner's letter dated July 31, 1996]. Petitioner's Motion to Strike is overruled, as I find HCFA's July 30, 1996 submission to be timely and appropriate.

I find that no facts of decisional significance are in dispute, and consequently there is no need for an in-person hearing.[1] Based on the evidence in the written record and the law, in light of the parties' written arguments,[2] I

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[1] The documentary evidence appeared to be sufficient for my decision, so I did not hold the in-person hearing that was scheduled to occur in Seattle, Washington during the week of June 17, 1996. An in-person hearing could address the limited issue of whether Petitioner met Medicare participation requirements on September 11, 1995. Following a telephone conference with the parties on November 4, 1996, I again decided to rely on the documentary evidence.

[2] Petitioner filed the following documents: Motion for Summary Judgment and Supporting Memorandum;

(continued...)

affirm HCFA's determination that the effective date of Petitioner's Medicare provider agreement is September 18, 1995.

ISSUE

The issue is whether Petitioner is entitled to an effective date of its Medicare provider agreement any earlier than September 18, 1995.

STIPULATION ON "RELOCATION OF COLBY MANOR"[3]

1. Consumer Homes, Inc., d/b/a Colby Manor, had a Medicare provider agreement to provide SNF services.

2. During the pertinent time period, Consumer Homes, Inc. was owned 100 percent by Tom Brown.

3. Prior to January 1, 1994, Nursing Home, Inc. was also owned 100 percent by Tom Brown. The two corporations were sister corporations.

4. The Washington State Department of Health issued a Certificate of Need (CON) in April 1992 to Nursing Home, Inc., to replace the 69 beds at Colby Manor, Everett, and combine those beds with 31 beds being acquired from Aurora-Edmonds Nursing Homes, Edmonds, to construct a 100-bed nursing home.

5. Consumer Homes, Inc. ceased operating Colby Manor as a SNF at the end of June 1995.

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[2](...continued)
Response to HCFA's Summary Judgment Motion; Memorandum on Agency; Reply Memorandum on Agency; Motion for Subpoena; Response to HCFA Comments on HCFA Exs. 44-47.

HCFA filed the following documents: Motion for Summary Judgment and Memorandum in Support; Reply Memorandum, Opposing Petitioner's Motion for Summary Judgment; Memorandum on Agency; Memorandum in Opposition to Subpoena; Comments on HCFA Exs. 44-47; Memorandum in Response to Kim Hagen Declaration.

[3] I adopt the stipulation as executed by the parties but have modified it according to the style of the DAB.

6. Nursing Homes, Inc. did not purchase the stock of Consumer Homes, Inc. and did not purchase the Colby Manor plant or building.

7. Consumer Homes, Inc. is not Nursing Homes, Inc.

8. Tom Brown is not Sunrise Healthcare, Inc.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner is a corporation, Nursing Home, Inc., doing business as Everett Rehabilitation and Medical Center. P. Exs. 1, 15.

2. On June 23, 1995, Petitioner opened for business in a newly built physical plant and began providing skilled nursing facility services in Everett, Washington.

3. Petitioner was a "new facility" in several respects:

(a) the physical plant Petitioner was occupying was newly built;

(b) Petitioner's license from the State to operate a SNF was newly issued;

(c) Petitioner was newly utilizing its 100-bed nursing home CON from the State; and

(d) Petitioner was to become a new participant in Medicaid and Medicare.

4. Petitioner did not purchase or otherwise acquire the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor.

5. Between June 23 and 26, 1995, all Colby Manor residents, including one Medicare patient,[4] relocated from Colby Manor to Petitioner's newly built physical plant. P. Exs. 11, 31.

6. A transfer of a Medicare patient does not constitute transfer of a Medicare provider agreement.

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[4] The Medicare patient's initials are M. D. See P. Ex. 28.

7. What transpired between June 23 and 26, 1995, between Consumer Homes, Inc., doing business as Colby Manor, and Petitioner, may be termed a "relocation" in two respects:

(a) all Colby Manor residents relocated from Colby Manor to Petitioner's newly built physical plant; and

(b) Colby Manor's 69-bed nursing home CON from the State "relocated" to Petitioner.

8. What transpired between June 23 and 26, 1995, between Consumer Homes, Inc., doing business as Colby Manor, and Petitioner, was not a relocation in two pivotal respects:

(a) the business entity itself, Consumer Homes, Inc., doing business as Colby Manor, did not relocate; and

(b) the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor, were not transferred to Petitioner.

9. "Relocation" of a Medicare provider cannot apply to an entity that has no Medicare provider agreement and no Medicare provider number. HCFA Exs. 41, 43.

10. The transaction may have been a "relocation" insofar as the residents and the CON were concerned, but the transaction was not a relocation with regard to any entity having a Medicare provider agreement and Medicare provider number.

11. If the move had been a relocation of a Medicare provider, the effective date of Petitioner's Medicare provider agreement would have been June 23, 1995.

12. Colby Manor did not change its address. Colby Manor closed. Colby Manor did not transfer its Medicare provider agreement or its Medicare provider number.

13. On May 19, 1995, Tom Brown, as President of Colby Manor, anticipating completion and licensure for occupancy of the new Everett Medical and Rehabilitation Center, wrote to Kamla Mehta, Manager, District 3, of the State, to give notice of the termination of the Medicare and Medicaid contracts of Consumer Homes, Inc., doing business as Colby Manor. P. Ex. 12.

14. On May 22, 1995, Kamla Mehta of the State called Tom Brown to tell him that he had to withdraw his letter giving notice of the termination of the Medicare and Medicaid contracts of Consumer Homes, Inc., doing business as Colby Manor; that Everett Rehabilitation Center was a replacement

facility, and residents had a right to move into the new building. P. Ex. 11; HCFA Ex. 38 at 5-6.

15. When Consumer Homes, Inc., doing business as Colby Manor, terminated its business at the end of June 1995, it still had its Medicare provider agreement and Medicare provider number.

16. A provider who ceases providing services is deemed to have terminated voluntarily its Medicare provider agreement. 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. 42 C.F.R. § 489.52(b)(3).

17. Petitioner had no Medicare provider agreement and no Medicare provider number when it opened for business on June 23, 1995.

18. The State's certification for Medicare and Medicaid coverage effective June 23, 1995 was based upon a mistake -- the State erroneously asserted that Colby Manor had moved to a new location.

19. Whether Petitioner knew the State was mistaken when the State termed the transaction a relocation of a Medicare provider is irrelevant for purposes of this Decision.

20. Pursuant to the regulations, the effective date of Petitioner's Medicare provider agreement can be no earlier than September 18, 1995. Findings 21-29.

21. Petitioner applied to become a Medicare SNF provider on September 6, 1995. HCFA Ex. 6; HCFA Ex. 32 at 3.

22. Petitioner's administrator signed copies of the Medicare provider agreement on September 8, 1995. P. Ex. 19.

23. Medicare regulations require direct observations of patient care prior to certification. 42 C.F.R. § 488.26.

24. The on-site survey to determine whether Petitioner was in substantial compliance with Medicare participation requirements occurred on September 5-8 and September 11, 1995. HCFA Exs. 7, 8, 12, 15.

25. The effective date of the Medicare provider agreement is the date the on-site survey is completed, if all Medicare participation requirements are met on that date. Otherwise, it is the earlier of: (a) the date on which the deficiencies were corrected or (b) the date on which the provider

submitted a plan of correction acceptable to HCFA. 42 C.F.R. § 489.13(a), (b)(3).

26. Petitioner was found not to be in substantial compliance with Medicare participation requirements, specifically, Quality of Care and Resident Assessment. HCFA Exs. 12, 15.

27. On September 18, 1995, Petitioner submitted a plan of correction acceptable to HCFA for the deficiencies found during the on-site survey.

28. When a provider is found not to be in substantial compliance, correction of the deficiencies or submission of a plan of correction acceptable to HCFA is a condition precedent to the SNF's ability to begin its participation in the Medicare program. 42 C.F.R. § 489.13(b)(3).

29. Petitioner's Medicare provider agreement was approved effective September 18, 1995. HCFA Exs. 19, 20.

30. On June 26, 1995, Kamla Mehta of the State wrote Petitioner's administrator to indicate approval for occupancy in the new location effective June 23, 1995 and an increase to 24 Medicare beds. P. Ex. 2.

31. Petitioner fully expected to receive Medicare payments for the care Petitioner provided to Medicare patients, based on Kamla Mehta's advice during the May 22, 1995 meeting and Kamla Mehta's letter dated June 26, 1995.

32. One Medicare patient relocated to Petitioner from Colby Manor on June 26, 1995, and soon thereafter Petitioner began to accept and provide care for additional Medicare patients. P. Ex. 28.

33. Petitioner has been notified that it will not receive Medicare payments accrued prior to September 18, 1995, the effective date of its Medicare provider agreement.

34. From June 26, 1995 until September 18, 1995, Petitioner provided care to Medicare patients, for whom Medicare reimbursement "accrued" in the amount of nearly one-half million dollars, which Petitioner has been notified HCFA will not pay.

35. There were two sources of delay in Petitioner's obtaining approval as a Medicare provider -- Petitioner and the State.

36. HCFA did not contribute to the delay in Petitioner's obtaining approval as a Medicare provider.

37. HCFA cannot delegate its decision-making powers. Charter Hospital of Indianapolis, OHA Docket No. 000-51-7186 (1991) [hereinafter Charter Hospital]. HCFA Memorandum on Agency at 1-3, plus Attachment A.

38. The State survey agency should ascertain whether a SNF meets the requirements of participation and make its recommendations to HCFA. 42 C.F.R. § 489.10(d). Mountain View Hospital District and Nursing Home, OHA Docket No. 000-01-7036 (1990) [hereinafter Mountain View]. HCFA Declaration in Response to Kim Hagen at 2, plus attachment.

39. The State has no decision-making authority regarding a provider's Medicare agreement. The State merely recommends; HCFA decides. HCFA Ex. 48; Mountain View; Charter Hospital.

40. Estoppel is an equitable principle which, if applied here, would conflict with the regulations.

41. An administrative law judge does not have the authority to relieve Petitioner of the requirements under the regulations for beginning its Medicare participation.

DISCUSSION

I. Petitioner thought it had a Medicare provider agreement and provider number, effective June 23, 1995.

Petitioner's representatives had planned carefully the opening of Everett Rehabilitation and Medical Center. On April 26, 1995, Petitioner's representatives met with Carolyn Enloe of the State. P. Exs. 30, 31. During the April 26, 1995 meeting, Petitioner's representatives were advised of the process for a new SNF provider to obtain a Medicare provider agreement, that is, for the facility to be surveyed after patients (usually private pay patients) had been admitted, so that the care given could be assessed.

This process has been termed the "Richmond Beach" process, because Petitioner's representatives had been involved in obtaining a Medicare provider agreement in that way for their Richmond Beach facility the year before. HCFA Ex. 36; P. Exs. 32, 33.

On April 28, 1995, Petitioner's representatives applied for a State license to operate a 100-bed nursing home. P. Ex. 15. Petitioner's representatives had previously acquired, when they bought the stock of Nursing Home, Inc., a Certificate of Need from the State for 100 nursing home beds (to replace Colby Manor's 69 beds and to add 31 more beds from Aurora-

Edmonds Nursing Homes). P. Ex. 14. The exhibits do not contain an updated Certificate of Need.

Petitioner's representatives purposely did not acquire an already existing Medicare provider agreement and provider number. As a new provider, Petitioner was entitled to a higher rate of reimbursement than that of Colby Manor. HCFA Exs. 42, 52. See 42 C.F.R. §§ 413.13, 413.30(e)(2). Consequently, Petitioner's representatives chose not to obtain the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor. HCFA Exs. 42, 52.

On the morning of May 22, 1995, Petitioner's representatives met with Kamla Mehta of the State. P. Exs. 30, 31. During the May 22, 1995 meeting, Petitioner's representatives were advised by Kamla Mehta that Petitioner was a replacement facility for Colby Manor, and that the current Medicare and Medicaid certification for Colby Manor would transfer with the patients and begin June 23, 1995, the date the patient transfer would begin. HCFA Ex. 38; P. Exs. 32, 33.

On May 31, 1995, Petitioner signed a Medicaid contract with the State. Petitioner was identified in the contract as Nursing Home, Incorporated, doing business as Everett Rehabilitation and Medical Center. HCFA Ex. 47.

On June 23, 1995, the State licensed Petitioner and certified it for Medicare and Medicaid, including 24 Medicare beds. The Medicare and Medicaid Certification and Transmittal is signed by Kamla Mehta, Manager, District 3, of the State. P. Ex. 17.

"Certification" is defined by the regulations as "a recommendation made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements (for SNFs and NFs), and conditions of coverage." 42 C.F.R. § 488.1.

The Medicare and Medicaid Certification by the State includes the following State Survey Agency Remarks (which are erroneous): "[e]ffective June 23, 1995 Colby Manor has moved to a new location, increased their total number of beds and changed its name to Everett Rehabilitation Medical Center. State agency approves occupancy." P. Ex. 17.

On June 26, 1995, Kamla Mehta of the State wrote Petitioner's administrator to indicate approval for occupancy in the new location effective June 23, 1995 and an increase to 24 Medicare beds. P. Ex. 2.

Petitioner fully expected to receive Medicare payments for the care Petitioner provided to Medicare patients, based on the State's Certification dated June 23, 1995. P. Ex. 17. One Medicare patient relocated to Petitioner from Colby Manor on June 26, 1995, and soon thereafter Petitioner began to accept and provide care for additional Medicare patients. P. Ex. 28.

From June 26, 1995 until September 18, 1995, Petitioner provided care to Medicare patients, for whom Medicare reimbursement "accrued" in the amount of nearly one-half million dollars, which Petitioner has been notified HCFA will not pay.

II. The move of Colby Manor residents to Petitioner's newly built physical plant was not a relocation of a Medicare provider.

The move of Colby Manor residents to Petitioner's newly built physical plant on June 23-26, 1995, was not a relocation of a Medicare provider. If the move had been a relocation of a Medicare provider, the effective date of Petitioner's Medicare provider agreement would have been June 23, 1995.[5] "Relocation" of a Medicare provider cannot apply to an entity that has no Medicare provider agreement and no Medicare provider number. HCFA Exs. 41, 43. Petitioner, Nursing Home, Inc., doing business as Everett Rehabilitation and Medical Center, had no Medicare provider agreement and no provider number when it opened for business in its newly built physical plant.

The entity that had a Medicare provider agreement and a provider number, Consumer Homes, Inc., doing business as Colby Manor, did not move into Petitioner's newly built physical plant. Neither did it transfer to Petitioner its Medicare provider agreement and provider number.

III. The State mistakenly certified Petitioner's Medicare coverage effective June 23, 1995.

On June 5 and 9, 1995, Petitioner was surveyed by the State. P. Ex. 2. The June 5 and 9, 1995 survey was a preoccupancy survey, one that does not include observations of patient care. HCFA Exs. 36, 37.

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[5] Petitioner's representatives chose not to acquire Colby Manor's Medicare provider agreement and provider number. A benefit of beginning anew is the higher rate of reimbursement. HCFA Exs. 42, 52. A disadvantage is the waiting period.

On June 23, 1995, the State licensed Petitioner and certified it for Medicare and Medicaid, including 24 Medicare beds.[6] The Medicare and Medicaid Certification and Transmittal is signed by Kamla Mehta, Manager, District 3, of the State. P. Ex. 17.

The State's certification for Medicare and Medicaid coverage effective June 23, 1995, was based upon a mistake. The State's finding that "[e]ffective June 23, 1995 Colby Manor has moved to a new location, increased their total number of beds and changed its name to Everett Rehabilitation Medical Center" was erroneous. P. Ex. 17.

Beginning in May 1995, the State mistakenly treated as a relocation of a Medicare provider the upcoming move of Colby Manor residents to Petitioner's newly built physical plant. One way that move could have been a relocation of a Medicare provider was for Petitioner to have obtained the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor. That is not, however, what the corporations involved had in mind. Petitioner bought the stock of the corporation that held the CON; Petitioner did not buy the stock of the corporation that had a Medicare agreement.

The State was mistaken when it determined that the transaction was a relocation of a Medicare provider. Whether Petitioner knew the State was mistaken is irrelevant for purposes of this Decision.

IV. Petitioner obtained a Medicare provider agreement, effective September 18, 1995.

Pursuant to the regulations, the effective date of Petitioner's Medicare provider agreement can be no earlier than September 18, 1995. Petitioner's requirements under the

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[6] Petitioner argues that it relied on the State's determinations that its Medicare and Medicaid coverage would begin when it opened its doors, June 23, 1995. Petitioner maintains that "HCFA's recourse is to make an initial survey a condition of continued Medicare participation." P. Reply Memorandum on Agency at 2. Petitioner's Medicare coverage could not have begun the day it opened its doors, because of the roughly 20 days (or more) required for a new provider to demonstrate that it meets Medicare participation requirements. See Discussion at V.

regulations for beginning its Medicare program participation are summarized as follows:

> Petitioner is required by the regulations to make application to participate in Medicare. 42 C.F.R. § 489.10. Petitioner applied to become a Medicare provider of skilled nursing facility services on September 6, 1995. HCFA Ex. 6; HCFA Ex. 32 at 3.
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> Petitioner is required by the regulations to sign copies of the Medicare provider agreement. 42 C.F.R. § 489.11. Petitioner's Administrator signed the agreement on September 8, 1995. P. Ex. 19.
>
> Petitioner is required by the regulations to undergo an on-site survey to determine whether Petitioner is in substantial compliance with Medicare participation requirements. 42 C.F.R. §§ 488.10, 488.11. Medicare regulations require direct observations of patient care prior to certification. 42 C.F.R. § 488.26. Pre-occupancy license surveys do not assess actual patient care. HCFA Ex. 37. The effective date of the Medicare provider agreement is the date the on-site survey is completed, if all Medicare participation requirements are met on that date. 42 C.F.R. § 489.13(a). Petitioner's on-site survey occurred on September 5-8 and September 11, 1995. HCFA Exs. 7, 8, 12, 15.
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> Petitioner is required by the regulations to be in substantial compliance[7] with Medicare participation requirements, or at least to submit a plan of correction[8] acceptable to HCFA. 42 C.F.R. § 489.13(b)(3). Petitioner was found not to be in substantial compliance with Medicare participation requirements, specifically Quality of Care and Resident Assessment. HCFA Exs. 12, 15. On September 18, 1995, Petitioner submitted a plan of correction acceptable to

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[7] 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. See also 59 Fed. Reg. 56,183 (1994).

[8] Plan of correction means a plan developed by the facility and approved by HCFA or the survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected. 42 C.F.R. § 488.401.

HCFA for the deficiencies found during the on-site survey.

Petitioner's Medicare provider agreement was approved effective September 18, 1995. HCFA Exs. 19, 20.

V. Petitioner's approval as a Medicare provider was delayed for more than two months.

The on-site survey to determine whether Petitioner was in substantial compliance with Medicare participation requirements would likely have been done promptly after Petitioner opened, had the process for a new provider, the "Richmond Beach" process, been implemented. Consequently, the direct observations of actual patient care, which are required for a new provider to obtain a Medicare agreement and provider number, would likely have occurred promptly after Petitioner opened. Petitioner would likely have addressed promptly in a plan of correction any deficiencies found. HCFA would likely have communicated promptly whether Petitioner's plan of correction was acceptable.

My expectation that these actions would all have occurred promptly, had the process for a new provider been initiated, is based on actual events once Petitioner "got on the right track" for a new provider, during September 1995, and based also on the Richmond Beach experience, when the process from the facility's opening to Medicare certification took about 20 days. P. Exs. 32, 33. Had Petitioner's certification as a new Medicare provider taken roughly the same amount of time after opening as demonstrated by those two events, Petitioner would likely have been approved for a Medicare agreement by mid-July 1995.[9] Since the effective date of Petitioner's Medicare agreement is September 18, 1995, I conclude that Petitioner's approval as a Medicare provider was delayed for more than two months.[10]

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[9] Whether Petitioner could have opened earlier than June 23, 1995, had Petitioner known it would be undergoing the "Richmond Beach" process, is not clear. Whether any of the beds under Petitioner's Certificate of Need from the State [P. Ex. 14], was available to it earlier than June 23, 1995, such as any of the 31 beds it was acquiring from Aurora-Edmonds Nursing Homes, Edmonds, is not clear.

[10] During the more than two month-delay, Petitioner provided care to Medicare beneficiaries. Medicare reimbursement would have amounted to nearly one-half million dollars. HCFA Ex. 42; P. Ex. 32 at 9.

There were two sources of delay in Petitioner's obtaining approval as a Medicare provider: Petitioner and the State.

A. Examples of Petitioner's contribution to the delay:

1. When Petitioner's representatives -- i.e., Richard Marcotte, Russell Kubik -- met with Kamla Mehta of the State on the morning of May 22, 1995, they failed to tell her specifically that Petitioner's representatives had chosen not to obtain the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor. P. Exs. 32, 33; HCFA Ex. 38.

2. It is not clear when Petitioner's representatives got a copy of the Medicare and Medicaid Certification by the State. The remarks therein, "[e]ffective June 23, 1995 Colby Manor has moved to a new location, increased their total number of beds and changed its name to Everett Rehabilitation Medical Center" were a red flag -- Petitioner's representatives knew that Colby Manor didn't move and didn't change its name. P. Ex. 17. Yet Petitioner's representatives failed to correct the record.

3. As early as July 5, 1995, Petitioner's representatives expected to follow up with HCFA, but failed to do so, regarding the Medicare and Medicaid Certification by the State. HCFA Ex. 46; HCFA Comments on HCFA Exhibits 44-47 at 7.

4. On or about July 26, 1996, in response to HCFA's inquiry about whether Petitioner "should be treated as a relocation or as a new facility for purposes of the Medicare program," Petitioner's representative Russell Kubik advised Petitioner's paralegal, Kim Hagen, "that the matter was already taken care of and was a moot issue." P. Ex. 37. Consequently, Kim Hagen responded to Kirk Pagett's inquiry, that Russ Kubik had said everything was taken care of, so why was he even working on this. HCFA Ex. 45.

B. Examples of the State's contribution to the delay:

1. When Kamla Mehta, Manager, District 3, of the State, met with Petitioner's representatives on the morning of May 22, 1995, she failed to inquire specifically whether Petitioner was acquiring the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor. HCFA Ex. 38; P. Exs. 32, 33.

2. Kamla Mehta failed to make adequate inquiry upon her receipt of a letter from Tom Brown on the afternoon of May 22, 1995. HCFA Ex. 38. On May 19, 1995, Tom Brown, as President of Colby Manor, anticipating completion and licensure for occupancy of the new Everett Medical and Rehabilitation Center, had written to Kamla Mehta, to give notice of the termination of the Medicare and Medicaid contracts of Consumer Homes, Inc., doing business as Colby Manor. P. Ex. 12; HCFA Ex. 38.

Kamla Mehta apparently did not want to believe Tom Brown's letter. She wrote, on or about September 15, 1995:

> May 22 . . . Received Letter from Tom Brown re: Colby Manor Terminating Medicare/Medicaide [sic] contract. He also mailed similar letter to residents.
>
> May 22 . . . I called and told him that he has to withdraw that letter. Everett Rehab Center is a replacement facility, residents have right to move to new building.

P. Ex. 11.

3. Kamla Mehta assumed that Tom Brown would "withdraw that letter," as she had instructed. P. Ex. 11. Kamla Mehta consequently failed thereafter to determine the status of the Medicare provider agreement and Medicare provider number of Consumer Homes, Inc., doing business as Colby Manor.

4. Kamla Mehta failed to grasp the significance of the SUN HEALTHCARE GROUP, INC. and SUNRISE HEALTHCARE CORPORATION letterhead of the letters she received from Petitioner's representatives prior to Petitioner's opening. P. Exs. 4, 9, 15, 16.

5. The State failed to note Petitioner's identity as specified in Petitioner's Application for License to Operate a Nursing Home: "Nursing Home, Inc. is 100% owned by Sunrise Healthcare Corporation and Sunrise Healthcare Corporation . . . [is] 100% owned by Sun Healthcare Group, Inc." P. Ex. 1 at 6.

6. The State may have failed until about July 19, 1995,[11] to forward to HCFA the State's Medicare and Medicaid Certification for Petitioner, which contained the remarks: "[e]ffective June 23, 1995 Colby Manor has moved to a new location, increased their total number of beds and changed its name to Everett Rehabilitation Medical Center." HCFA Ex. 4; P. Ex. 11.

7. In August 1995, the State failed to act promptly upon information from Hannah Hirabayashi of HCFA that Sun Health Care Group was the new corporation and was a CHOW -- "CHOW" means change of ownership. Kamla Mehta's response was that the State was not considering [the transaction] as a CHOW. P. Ex. 11 at 2.

8. Through September 7, 1995, Kamla Mehta failed to alert Petitioner's representatives to the potential consequences of Petitioner failing to have a Medicare provider agreement and Medicare provider number. P. Exs. 12, 32.

I find specifically that HCFA did not contribute to the delay.

In May 1995, Kamla Mehta described the transaction for Hannah Hirabayashi at HCFA by telling her that Colby Manor was moving. Based on the information Kamla Mehta gave her, Hannah Hirabayashi concluded that the transaction was a relocation. HCFA Exs. 39, 38. Thus, Kamla Mehta wrote on May 26, 1995: "I have discussed with Hanna [sic] at ROX [Hannah Hirabayashi at HCFA Regional Office, Region X], as all Colby Manor residents will be moving, she says they do not have to get new [M]edicare/Medicaid certification. WE should only notify ROX date of move, name and address change and change of ownership if any." P. Ex. 10.

About July 24, 1995, HCFA became aware that further investigation was necessary: "[q]uestions from Kirk Pagett [Petitioner's representative, Sunrise Senior Reimbursement Analyst] cast doubt on the state's recommendation, and we began to collect information to determine the facts after his phone call **July 24, 1995** [emphasis added]." HCFA Ex. 43 at 4-5; HCFA Ex. 4.

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[11] The Certification had been signed on June 27, 1995. The State indicated they sent it to HCFA on June 28, 1995. HCFA Ex. 46.

HCFA may not have received the State's Medicare and Medicaid Certification for Petitioner until about July 19, 1995. P. Ex. 11; HCFA Ex. 4. The State indicated they sent it to HCFA on June 28, 1995. HCFA Ex. 46.

As early as July 26, 1995, Petitioner knew that HCFA was trying to determine whether Colby Manor had relocated or whether Petitioner was a new provider that needed a survey and a new provider number. This is confirmed in the notes of Petitioner's paralegal, Kim Hagen. HCFA Ex. 44 at 10; HCFA Comments on HCFA Exhibits 44-47 at 3-4; HCFA Memorandum in Opposition to Subpoena at 8. HCFA never did assign Colby Manor's provider number to Petitioner. HCFA Ex. 43 at 4-5; HCFA Ex. 51.

On August 22 or 23, 1995, Hannah Hirabayashi of HCFA called Kamla Mehta of the State to let her know that it was HCFA's opinion that Petitioner was a new facility and that an initial survey should be conducted as soon as possible. HCFA Ex. 33 at 4. On August 23, 1995, Hannah Hirabayashi of HCFA advised Kirk Pagett that "after talking to their in-house attorney that it appears Everett is a brand new facility which needed to be surveyed and given their own Medicare #." HCFA Ex. 45 at 2. On August 25, 1995, Hannah Hirabayashi of HCFA advised Kirk Pagett that she hoped the patients would be paid for that were in the facility, but there was no guarantee. She also explained the survey process for a new facility. HCFA Ex. 45 at 4; P. Ex. 31.

On September 6, 1995, Hannah Hirabayashi of HCFA advised Kirk Pagett that Petitioner should not admit any more Medicare and Medicaid patients until Petitioner was certified. HCFA Ex. 48. On September 7, 1995, HCFA's message that HCFA would not pay for Medicare residents until a survey is done was relayed by Kamla Mehta to Petitioner. P. Exs. 11, 32.

VI. <u>HCFA is not bound by the mistakes that were made in determining the effective date of Petitioner's Medicare provider agreement</u>.

Petitioner argues that HCFA is bound by the State's erroneous determinations, because the State is HCFA's agent:

> Of course, the agency relationship does not preclude HCFA, as principal, from later deciding an initial survey is required. The relationship, however, prevents HCFA from avoiding the authorized actions of its agent, DSHS [the State]. Because HCFA cannot avoid its agent's decision that a relocation occurred, [Petitioner] is

> entitled to the full benefit of that decision and the June 23 1995 effective date.

P. Reply Memorandum on Agency at 10.

The State has no decision-making authority regarding a provider's Medicare agreement. The State merely recommends; HCFA decides. HCFA Ex. 48; Mountain View; Charter Hospital.

HCFA has a contractual relationship with the State, which is further defined and clarified by statutes and regulations. Certain responsibilities are assigned to the State, including the certification-related duties of "explaining the requirements and conditions for qualifying as a provider or supplier of services," and "surveying for the purpose of certifying to the Secretary compliance or non-compliance of providers and suppliers. . . ." P. Ex. 35 at 8-9.

"Certification" is defined as "a recommendation made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements (for SNFs and NFs), and conditions of coverage." 42 C.F.R. § 488.1.

Certifications by the State survey agency represent only recommendations to HCFA. On the basis of those recommendations, HCFA will determine whether a provider is eligible to participate in or be covered under the Medicare program. Mountain View.

As provided by Mountain View:

> 42 CFR 488.10 and 488.11 provide that State agencies that have agreements under Section 1864(a) of the Social Security Act (42 U.S.C. 1395aa) may survey and make recommendations whether prospective providers meet the Medicare conditions of participation. 42 CFR 488.12 provides that certifications by the State survey agency represent recommendations to HCFA and that on the basis of those recommendations, HCFA will determine whether a provider is eligible to participate in or be covered under the Medicare program. 42 CFR 489.10(b) provides that the State survey agency will ascertain whether the provider meets the conditions of participation or requirements (for skilled nursing facilities) and make its recommendations to HCFA.
>
> Based on these regulations, it is clear that the State agency is responsible for making recommendations regarding Medicare participation, and that HCFA is solely responsible for entering into Medicare agreements with providers. The survey recommendations which

> resulted after the surveys done in February, March and April 1988 did not have any greater significance. They formed the basis upon which HCFA would execute an agreement for Medicare participation. The survey results could not, under the regulations, amount to the agreement itself.
>
> The last concern to be addressed is whether Respondent should be estopped from establishing the effective date of the Medicare agreement later than February 5, 1988, based on the erroneous advice petitioner received from the State survey agency and upon which Petitioner relied to its detriment. However, there is no authority which allows the petitioner to prevail on this argument. While the result in this case is unfortunate it is mandated by the controlling authority of the Social Security Act and implementing regulations.

Mountain View, at 2-3.

HCFA cannot delegate its decision-making powers. Charter Hospital. Regarding the effective date of the Medicare provider agreement, Charter Hospital concludes:

> Sections 1861, 1864 and 1866 [of the Social Security Act[12]] specifically delegate authority to HCFA to contract with State agencies to perform virtually any form of facility survey needed and make recommended findings to HCFA. The regulations set forth the State agencies' responsibility and role with clarity and repeat the caveat that their decisions are only recommendations. See 42 CFR 488.11(a), (c) and 488.12(a).

Charter Hospital, at 5-6.

> The Act grants HCFA the authority to delegate its investigative powers, but it does not allow HCFA to delegate its decision-making powers. Since only HCFA may decide who participates in Medicare, any comments or assertions made by the surveyors must be treated as dicta. HCFA cannot delegate the decision-making power exclusively conferred upon it by statute.
>
> Furthermore, inasmuch as the regulations make it clear that the surveyors are only empowered to recommend, the provider or prospective provider must be deemed to

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[12] 42 U.S.C. § 1395x, 42 U.S.C. § 1395aa, and 42 U.S.C. § 1395cc.

> proceed at its own risk if it anticipates what action HCFA will take.

Charter Hospital, at 6.

VII. Petitioner claims estoppel.

Petitioner claims that HCFA is estopped from denying Petitioner a June 23, 1995 effective date of its Medicare provider agreement. Estoppel is an equitable principle which, if applied here, would conflict with the regulations. My authority is limited. I do not have the authority to relieve Petitioner of the requirements under the regulations for beginning its Medicare participation.

Further, an estoppel theory presents an uneasy fit in these circumstances, where the State has no decision-making authority regarding a provider's Medicare agreement. The State merely recommends; HCFA decides. HCFA Ex. 48. HCFA decided, correctly under the regulations, to approve Petitioner's Medicare provider agreement with an effective date of September 18, 1995. HCFA Exs. 19, 20, 43 at 4-5; HCFA Ex. 51.

CONCLUSION

The effective date of Petitioner's Medicare provider agreement is September 18, 1995, and no earlier.

/s/

Jill S. Clifton

Administrative Law Judge