Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Waianae Coast Comprehensive Health Center (CCN: 12-1831, 12-1832, 12-1833),	Date: March 20, 2009
Petitioner,	Docket No. 08-378
v.	Decision No. CR1929
Centers for Medicare & Medicaid Services.	

DECISION

The effective date of participation in the Medicare program as Federally Qualified Health Centers (FQHC) of Petitioner's permanent units, Kapolei Health Care Center (CCN: 121831), Waipahu Family Health Center (CCN: 121832), and Waiola Clinic (CCN: 121833), is May 2, 2007.

I. Background

Petitioner, Waianae Coast Comprehensive Health Center, requested a hearing by an administrative law judge (ALJ), by letter dated April 3, 2008. Petitioner requested review of the January 25, 2008 reconsideration decision of the Centers for Medicare & Medicaid Services (CMS) denying Petitioner's request for an earlier effective date of participation in Medicare as FQHCs for three of its units. The case was docketed, assigned to me for hearing and decision on April 22, 2008, and a Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction.

On June 25, 2008, the parties filed a joint settlement status report and a joint request for stay to permit settlement negotiations. On July 9, 2008, I granted the request for stay by amending the date of the Prehearing Order to May 22, 2008, and I directed that the parties file a joint settlement status report that complied with the requirements of the prehearing order not later than July 21, 2008. The parties filed a second joint status report on July 21, 2008, by which they advised me that their attempt to settle this case was futile and that they were not able to agree upon the facts. The parties further advised me that Petitioner desired a hearing and that CMS wished to file a motion for summary judgment. The parties proposed a schedule for CMS to file its motion for summary judgment, for Petitioner to file an opposition and/or cross-motion, and for CMS to respond. On August 1, 2008, I stayed further proceedings and adopted the schedule the parties proposed for the filing of pleadings related to summary judgment.

On August 15, 2008, CMS filed a motion for summary judgment, supporting memorandum (CMS Motion), and exhibits (CMS Exs.) 1 through 7. On September 15, 2008, Petitioner filed its opposition to the CMS motion for summary judgment (P. Opp.) with P. Exs. 33 through 37, and its cross-motion for summary judgment with supporting memorandum (P. Motion and P. Memo., respectively), and P. Exs. 2, 9, and 33 through 37 (copies of the same exhibits filed with its opposition). On September 29, 2008, CMS filed its reply to Petitioner's opposition (CMS Reply) and a motion to strike Petitioner's cross-motion including a request for an additional 20 days to respond to Petitioner's cross-motion if the motion to strike was denied. On October 10, 2008, Petitioner filed its opposition to the CMS motion to strike, and P. Ex. 38. The CMS motion to strike is denied as a cross-motion for summary judgment is an appropriate response to a motion for summary judgment, and the parties clearly agreed in their second joint status report that Petitioner could file an opposition and/or cross motion.[1] The motion to strike verges on being frivolous in light of the parties' agreement regarding briefing in their second joint status report. Further, the CMS request for additional time to file a reply could be construed to be an attempt to unnecessarily delay proceedings. The CMS request for additional time to respond to Petitioner's cross-motion for summary judgment is denied; however, I deny it not to impose a sanction, but rather, because my decision obviates the need for further briefing. No objection has been made to my consideration of the offered exhibits, and they are admitted.

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[1] My Order dated August 1, 2008, required that Petitioner file a "response" to the CMS motion for summary judgment with supporting evidence not later than September 15, 2008. The Order did not limit Petitioner to filing an "opposition" or preclude the filing of a cross-motion.

II. Discussion

A. Applicable Law

A FQHC is an entity that:

> 1. receives a grant under section 330 of the Public Health Service Act (PHSA) (42 U.S.C. § 254b); or
>
> 2. meets the requirements to receive a grant under section 330 of the PHSA but receives the funds under a contract with the recipient of such a grant;
>
> 3. is determined by the Secretary (the Secretary) of Health and Human Services (HHS) to meet the requirements for receiving a grant under section 330 of the PHSA, including requirements that an entity may not be owned, controlled, or operated by another entity, based on the recommendation of the Health Resources and Services Administration (HRSA) of the Public Health Service (PHS), HHS; or
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> 4. was treated by the Secretary as a "comprehensive Federally funded health center as of January 1, 1990."

Act §§ 1861(aa)(4) (42 U.S.C. § 1395x(aa)(4)); 1905(l)(2)(B) (42 U.S.C. § 1396d(l)(2)(B)).

A FQHC provides physician, nurse practitioner, physician assistant, clinical psychologist, or clinical social worker services and supplies incident to such services, on an outpatient basis to patients of the FQHC. Act §§ 1861(aa)(3) (42 U.S.C. § 1395x(aa)(3)); 1905(l)(2)(A).

The Secretary has implemented regulations for the enrollment in Medicare of FQHCs. According to 42 C.F.R. § 405.2401(b), a FQHC is:

> [A]n entity that has entered into an agreement with CMS to meet Medicare program requirements under §§ [sic] 405.2434 and–
>
> (1) Is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 329, 330 or 340 of the Public Health Service Act;

> (2) Based on the recommendation of the PHS, is determined by CMS to meet the requirements for receiving such a grant;
> (3) Was treated by CMS, for purposes of part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or
> (4) Is an outpatient health program or facility operated by a tribe or tribal organizations under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

In order to participate in Medicare as a FQHC, an entity must enter an agreement with CMS, and the content and terms of the agreement are specified in 42 C.F.R. § 405.2434. The effective date of the agreement with CMS "is the date CMS accepts the signed agreement, which assures that all Federal requirements are met." 42 C.F.R. § 405.2434(b). Part 491 of 42 C.F.R. establishes the conditions for certification for rural health clinics and the conditions for coverage for FQHCs, i.e. the conditions that must be met for Medicare reimbursement for services or supplies provided to eligible beneficiaries.

The procedures for filing to participate in Medicare as a FQHC are established by 42 C.F.R. § 405.2430(a). An entity that wishes to participate in Medicare as a FQHC makes a request to CMS to enter into an agreement. CMS sends the entity a written notice of its disposition of the entity's request. CMS sends the entity two copies of the agreement when the following requirements are met: the PHS recommends that the entity qualifies as a FQHC; the FQHC assures CMS that it meets the requirements of 42 C.F.R. Part 405, subpart X and Part 491; and the FQHC terminates other provider agreements except as specified in the regulation. The entity must sign and return both copies of the agreement to CMS. If CMS accepts the agreement, it returns to the entity one copy of the agreement with a notice of acceptance that specifies the effective date of participation as an FQHC, determined in accordance with 42 C.F.R. § 405.2434. If CMS fails to enter into an agreement with an entity, the entity is entitled to a hearing in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 405.2430(d).

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). The Departmental Appeals Board (the Board) has previously addressed an appropriate allocation of the burden of persuasion and the burden of going forward with the evidence in cases subject to 42 C.F.R. Part 498. The Board has held that CMS must make a prima facie showing of the basis for its action and CMS has the initial burden of going forward

with the evidence. "Prima facie" means 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); s*ee also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dep't of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). To prevail, a petitioner has the burden of persuasion and must overcome the CMS prima facie case by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004)*, aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611.

B. Issues

Whether summary judgment is appropriate; and

Whether May 2, 2007 is the correct effective date of participation in Medicare as FQHCs for Petitioner's units.

C. Analysis

1. Facts

This statement of facts is based upon the evidence and the undisputed allegation of facts from the pleadings of the parties. Pursuant to paragraph A.5.b of the Prehearing Order, any fact alleged in the parties' pleadings not specifically denied may be accepted as true for purposes of summary judgment. All favorable inferences are drawn in favor of Petitioner for purposes of deciding this case by summary judgment.

Petitioner, Waianae Coast Comprehensive Health Center, and the three facilities, Kapolei Health Care Center (CCN: 121831), Waipahu Family Health Center (CCN: 121832), and Waiola Clinic (CCN: 121833), are operated by the Waianae District Comprehensive Health and Hospital Board, Inc. P. Memo. at 1. The Waiola Family Health Center is located in Waianae, Hawaii (CMS Ex. 1, at 8), the Waipahu Family Health Center is located in Waipahu, Hawaii (CMS Ex. 2, at 7), and the Kapolei Health Care Center is located in Kapolei, Hawaii (CMS Ex. 3, at 6). Petitioner was approved to participate in Medicare as a FQHC effective October 1, 1991. P. Ex. 9, at 72. HRSA approved for purposes of receiving a grant, the Waiola Clinic effective February 1994, the Waipahu Family Health Center effective July 1996, and the Kapolei Health Care Center effective September 2000. CMS Ex. 7; P. Memo. at 7. Petitioner operated the three clinics

providing FQHC-type services, treating them as satellite sites of Petitioner and billed Medicare for services provided. P. Memo. at 1; CMS Ex. 7, at 1. Petitioner intended to continue to operate the three units as FQHCs. Petitioner was advised by a consultant assisting with the preparation of its "2006 cost report" that CMS had adopted new enrollment procedures and Petitioner took steps to comply. P. Memo. at 8. Petitioner obtained separate provider identification numbers for each of the three facilities in February 2007. P. Memo. at 8; CMS Ex. 1, at 36; CMS Ex. 2, at 36; CMS Ex. 3, at 33. Petitioner also submitted Medicare enrollment applications (Form CMS-855A) for each of the three facilities on February 12, 2007, that were received by CMS on February 13, 2007.[2] CMS Ex. 1, at 1; CMS Ex. 2, at 1; CMS Ex. 3, at 1; CMS Ex. 7. The applications reflect that the last of the certification statements for the applications were received by CMS on April 26, 2007. CMS Ex. 1, at 28; CMS Ex. 2, at 28; CMS Ex. 3, at 25. CMS notified Petitioner's operator by letters dated July 12, 2007, that each of the three clinics was accepted for participation in Medicare as a FQHC effective May 2, 2007. CMS Exs. 4, 5, 6. Petitioner requested reconsideration of the effective date of participation by letter dated September 19, 2007, arguing that the three facilities were not new, the February 2007 enrollment applications were not for new enrollments, and that the effective date of participation for each facility as a FQHC should be: Waiola Clinic – effective February 1994, the Waipahu Family Health Center – effective July 1996, and the Kapolei Health Care Center – effective September 2000, the dates the units were approved for grants by the HSRA. CMS Ex. 7; P. Memo. at 21. On January 25, 2008, Petitioner's request for reconsideration was denied. P. Ex. 2.

My conclusions of law are set forth in bold followed by my analysis.

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

An ALJ may decide a case by summary judgment, without an oral evidentiary hearing, if the case presents no genuine issues of material fact. *Crestview Parke Care Center v. Thompson,* 373 F.3d 743, 750 (6th Cir. 2004); *Livingston Care Center v. U.S. Dep't of Health and Human Services,* 388 F.3d 168 (6th Cir. 2004). The Board has previously

[2] Each application bears a stamp indicating that the application was received at "Provider Enrollment" on February 16, 2007 and a handwritten entry "2/13/07." The inference favorable to Petitioner, for purposes of summary judgment, is that receipt of the applications was February 13, 2007.

approved the use of a summary judgment procedure "akin to the summary judgment standard contained in Federal Rule of Civil Procedure 56" in cases subject to 42 C.F.R. Part 498. *Crestview Parke Care Center*, 373 F.3d 743, 750. Under that rule, 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,* 388 F.3d at 173*, quoting 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); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). A mere scintilla of supporting evidence is not sufficient. "If the evidence is merely colorable or is not significantly probative summary judgment may be granted." *Livingston Care Center*, 388 F.3d at 173, *quoting Anderson v. Liberty Lobby,* 477 U.S. 242*,* at 249-50 (1986). 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 nonmovant, with all favorable inferences drawn from the evidence in that party's favor. *Innsbruck HealthCare Center,* DAB No. 1948 (2004); *Madison Health Care, Inc.,* DAB No. 1927 (2004).

The Prehearing Order advised the parties that the Federal Rules of Civil Procedure and the Federal Rules of Evidence do not apply to proceedings before ALJs assigned to the Departmental Appeals Board, Civil Remedies Division. However, the Prehearing Order also advised the parties that both the Federal Rules of Evidence and the Federal Rules of Civil Procedure (Fed. R. Civ. P.) may be consulted as guides for resolution of issues due to the fact that further review in this case may be by the federal courts. Based upon the language of the Prehearing Order, prior decisions of the Board and ALJs that relied upon summary judgment procedures akin to those of Fed. R. Civ. P. 56 and related cases, I conclude that the parties were on notice of the summary judgment procedures and standards applicable to this case. *Wade Pediatrics*, DAB No. 2153, at 16-18 (2008).

This case is appropriate for summary judgment. There is no genuine dispute as to any material fact, and I have drawn all favorable inferences in favor of Petitioner, the nonmovant, for purposes of summary judgment. This decision turns upon the interpretation of regulatory provisions, which are issues of law, and their application to the undisputed material facts.

3. Petitioner's facilities, Kapolei Health Care Center (CCN: 121831), Waipahu Family Health Center (CCN: 121832), and Waiola Clinic (CCN: 121833), are permanent units in different locations and must be separately approved as FQHCs pursuant to 42 C.F.R. § 491.5(a)(3)(iii).

4. Pursuant to 42 C.F.R. §§ 405.2434(b)(1) and 489.13(a)(2)(i), the effective date of participation of Petitioner's facilities as FQHCs is May 2, 2007.

It is not disputed that Petitioner's facilities, Kapolei Health Care Center (CCN: 121831), Waipahu Family Health Center (CCN: 121832), and Waiola Clinic (CCN: 121833), have different locations, that Petitioner intended to provide FQHC services within the meaning of section 1861(aa)(3) of the Act at those locations, and that Petitioner intended to obtain payment from Medicare for FQHC services provided at those locations. Petitioner does not dispute that the three facilities are "permanent units" of Petitioner within the meaning of 42 C.F.R. § 491.5(a)(3)(i), i.e., "[t]he objects, equipment, and supplies necessary for the provision of the services furnished directly by the clinic or center are housed in a permanent structure." Section 491.5(a)(3)(iii) of 42 C.F.R. provides that "[i]f clinic or center services are furnished at permanent units in more than one location, each unit is independently considered for approval as a rural health clinic or for approval as an (sic) FQHC." *See Family Health Services of Darke County*, DAB No. 2092, at 6-7 (2007) (citing with approval an ALJ's conclusion that the regulation requires that a FQHC "obtain separate [Medicare] certification for each permanent unit that is part of the FQHC's overall operation.") The new regulations establishing a new category of facility known as a FQHC were first published as a final rule with comment period at 57 Fed. Reg. 24,961, 24,982-83 (June 12, 1992) with an effective date of June 12, 1992. The preamble to the final rule discussed that section 4161(a) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508 (OBRA '90) amended section 1861(aa) of the Act and established a new Medicare benefit, outpatient services furnished by provider-based and independent FQHCs. Title 42 C.F.R. § 491.5(a)(2) (1992) of the new regulations provided that if "clinic services are furnished at permanent units in more than one location, each unit will be independently considered for certification as a rural health clinic or for coverage as a Federally qualified health center." Section 491.5(a) of 42 C.F.R. was amended to its current form by a final rule effective May 3, 1996, and published at 61 Fed. Reg. 14,640, 14,658 (April 3, 1996), and the requirement for independent consideration of separate units was moved to 42 C.F.R. § 491.5(a)(3)(iii).

The regulations provide that the effective date of a FQHC's participation agreement is the date on which CMS accepts the signed agreement. 42 C.F.R. §§ 405.2434(b)(1) and 489.13(a)(2)(i). It is not disputed in this case that CMS accepted the participation agreements of Petitioner's three units effective May 2, 2007.

Petitioner argues in opposition to the CMS motion for summary judgment, that there are material facts in dispute that prevent entry of summary judgment for CMS. Petitioner asserts that from September 1991 to September 1993, it operated two facilities under a single participation agreement and a single Medicare number. P. Opp. at 2; P. Memo. at 3-4, 6-7, 18. I accept for purposes of summary judgment Petitioner's assertion of fact. Thus, no there is no issue of material fact in dispute for purposes of summary judgment.

Petitioner requests in its cross-motion for summary judgment that I conclude that 42 C.F.R. § 491.5(a)(3)(iii), the regulation that CMS cites in support of its position that independent approval of separate permanent units is required, is invalid because it conflicts with and contradicts section 1861(aa)(4) of the Act. P. Motion at 1-2. Petitioner also argues that because the predecessor to CMS, the Health Care Financing Administration (HCFA), permitted Petitioner to operate two facilities without requiring separate certification for each as a FQHC, HCFA's "practice at that time was **not** to require separate" FQHC participation agreements. P. Opp. at 2 (emphasis in original). Petitioner argues that "alterations in an agency's long standing practice constitute regulatory changes that are invalid unless they are first subject to the notice and comment requirements of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553." P. Opp. at 3; P. Memo. at 18 n.6.

Petitioner's arguments are without merit. The promulgation of 42 C.F.R. § 495.1 in 1992 and its amendment in 1996, appears to have been accomplished by notice and comment procedures consistent with those required by the APA and Petitioner alleges no defect in the rule-making procedure. Thus, even if, as Petitioner asserts, HCFA followed a practice of not requiring independent approval of separate sites when the FQHC benefit was first established, that practice was changed by the promulgation of 42 C.F.R. § 491.5 effective June 12, 1992.[3] The fact that Petitioner operated two separate FQHC units under a single Medicare number for two years, particularly where nearly half of the two-year-period occurred before promulgation of 42 C.F.R. § 491.5, which was effective June 12, 1992, does not constitute a long-standing agency practice of permitting a FQHC to operate separate units without independent approval of each unit. Assuming that HCFA failed to

[3] Petitioner ceased operation of one of its two units in September 1993, due to termination of its lease on September 23, 1993. P. Ex. 35; P. Memo. at 3-4.

enforce the regulatory requirement that separate units be considered independently for FQHC status for approximately 14 to 15 months in Petitioner's case, I do not conclude that fact shows it was a long-standing agency practice to ignore the regulatory requirement for independent approval of separate units promulgated in 1992. Furthermore, I will not find CMS bound or stopped by the prior agency action as that action would have been based on an erroneous interpretation or application of the regulation. The United States Supreme Court has previously indicated that estoppel will generally not lie against the government in cases involving benefits to be paid from the Treasury, particularly in the administration of complicated benefit programs such as the Social Security Act. *See Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51 (1984); *Schweiker v. Hansen*, 450 U.S. 785 (1981).[4]

The requirement that each permanent unit of a FQHC in a separate location be independently considered for approval as a FQHC was promulgated in 1992, when the regulations were amended to recognize the newly created FQHC under OBRA '90. The regulation has been amended and the requirement for approval of each permanent unit has not been changed since 1992. Thus, there has been no change in the Secretary's requirement that permanent units of a FQHC in separate locations be considered separately for approval as a FQHC. The fact that Petitioner may have avoided the requirement of the regulation in the past does not warrant ignoring the requirement and its applicability to the three permanent units before me.

Petitioner's argument that 42 C.F.R. § 491.5(a)(3)(iii) is inconsistent with the "plain language" of section 1861(aa) of the Act and, therefore, is unenforceable, is also without merit. Petitioner engages in an exercise in statutory interpretation arguing that the regulation, 42 C.F.R. § 491.5(a)(3)(iii), is inconsistent with the language of the Act. Petitioner argues that section 1861(aa)(4) defines a FQHC as an "entity" that, inter alia, receives a grant under section 330 of the PHSA. Petitioner reasons that a subpart or "unit" of an entity cannot itself be qualified as a FQHC under the Act. The gist of

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[4] 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 HealthCare Resources, Inc.*, DAB CR446 (1996); *T.L.C. Mental Health Center*, DAB CR636 (1999); *Therapeutic Rehabilitation Centers, Inc.*, DAB CR531 (1998). However, I find no similar limit to my jurisdiction where Petitioner asserts estoppel as a defense in an enforcement action. *Accord Stacy Ann Battle, D.D.S.,* DAB No. 1843 (2002).

Petitioner's argument is that Petitioner or its operator is the "entity" within the meaning of the Act and that CMS cannot apply 42 C.F.R. § 491.5(a)(3)(iii) to require that its three units apply separately for enrollment as FQHCs or that they have dates of participation separate from that of Petitioner, except to the extent they received their grant at a later date, as Petitioner concedes they did.

The Secretary promulgated regulations pursuant to authority granted by Congress in sections 1102 and 1871 of the Act. The Act does not specify procedures for the enrollment of FQHCs and the Secretary promulgated the regulations at 42 C.F.R. Part 405, subpart X, and Part 491, establishing the procedure for enrollment and the conditions for coverage of services provided by a FQHC. Because the Act does not specify enrollment procedures, there is no conflict between the regulatory language that establishes such procedures and the Act. Petitioner recognizes that "entity" is not defined by the Act. P. Memo. at 11. The fact that the term "entity" is not defined is also inconsistent with Petitioner's argument that the Secretary's regulations provide a conflicting definition or interpretation of the term. Rather, the absence of the definition of "entity" is consistent with the conclusion that Congress left to the Secretary's discretion the appropriate definition, if definition was determined by the Secretary to be necessary.

Furthermore, 42 C.F.R. § 491.5 does not purport to change the definition of a FQHC or to provide a definition for the term "entity" as used in section 1861(aa)(4) of the Act or 42 C.F.R. § 405.2401(b). Rather, 42 C.F.R. § 491.5(a) establishes the requirements for location of rural health clinics and FQHCs, recognizes that both may have permanent or mobile units to service their populations, and establishes the requirement that permanent units in more than one location be independently considered for approval as FQHCs or as rural health clinics. The Act contains no provisions similar to 42 C.F.R. § 491.5(a), and there is no conflict between the Act and the regulation in this regard.

V. Conclusion

For the foregoing reasons, summary judgment is granted for CMS, and the effective date of participation as FQHCs in Medicare for Petitioner's permanent units is May 2, 2007.

/s/
Keith W. Sickendick
Administrative Law Judge