Department of Health and Human Services

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

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| In the Case of: | ) | |
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| Family Health Services of Darke County, Inc., | ) | Date: November 14, 2008 |
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| Petitioner, | ) | |
| | ) | |
| - v. - | ) | Docket No. C-08-366 |
| | ) | Decision No. CR1862 |
| Centers for Medicare & Medicaid Services. | ) | |
| | ) | |

## DECISION GRANTING SUMMARY JUDGMENT TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES

I grant summary judgment to the Centers for Medicare & Medicaid Services (CMS). I sustain its determination to certify for Medicare participation as Federally Qualified Health Centers (FQHC) two locations belonging to Petitioner, Family Health Services of Darke County, effective September 8, 2005.[1] I deny Petitioner's motion for summary judgment in which it contends that these two locations ought to be certified to receive earlier effective participation dates.

### I. Background

This is the second time that I have heard this case. On October 12, 2006, I issued a decision granting summary judgment to CMS and affirming CMS's determination to certify the two locations as FQHCs effective September 8, 2005. *Family Health Services*

[1] The two locations are at 828 Central Avenue, Greenville, Ohio, and 702 North Main Street, Arcanum, Ohio. I refer to them in this decision collectively as "the two locations" or individually as the "Central Avenue location" and the "North Main Street location."

*of Darke County, Inc.,* DAB CR1518 (2006). Petitioner appealed my decision to the Departmental Appeals Board and on June 12, 2007, a Board appellate panel issued a decision which affirmed in part and reversed in part my original decision. *Family Health Services of Darke County, Inc.,* DAB No. 2092 (2007). In its order of remand the Board gave me the option of remanding the case back to CMS so that CMS might make a new determination consistent with the Board's decision. I issued a remand order on June 15, 2007. On January 17, 2008, CMS issued a reconsideration determination in which it affirmed its initial finding that the effective certification date for the two locations is September 8, 2005. Petitioner appealed, and the case was assigned to me for a hearing and a decision.

Neither party has requested that I hear testimony in person.[2] Rather, each party moved for summary judgment. CMS filed 30 proposed exhibits which it designated as CMS Ex. 1 - CMS Ex. 30. Petitioner filed 35 proposed exhibits which it designated as FH Ex. 1 - FH Ex. 35. I am receiving all of these exhibits into the record of this case. For purpose of deciding the parties' motions, I assume to be true all of the facts stated in their respective exhibits including the written direct testimony of the parties' witnesses.

## II. Issue, findings of fact and conclusions of law

### A. Issue

The issue in this case is whether Petitioner established that CMS ought to have certified the two locations as Medicare-participating FQHCs on dates that are earlier than September 8, 2005.

I addressed this same issue in my original decision. In its first hearing request, Petitioner contended that the two locations should not be obligated to seek certification from CMS as FQHCs because they were not free-standing entities but, rather, were satellites of Petitioner's certified facility. Thus, according to Petitioner, Medicare items or services provided by the two locations should be treated by CMS as fungible with those provided by Petitioner at its central location. I rejected this argument, holding that each of the two

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[2] Each side filed the written direct testimony of witnesses but neither has expressed a desire to conduct cross-examination of the other party's witnesses. In its motion for summary judgment Petitioner asks that I set this case for an in-person hearing "in the alternative" to granting its motion. Petitioner's motion at 27. However, it has not stated what it would offer at an in-person hearing in addition to that which is contained in its proposed exhibits, including the written declarations of its witnesses. Nor has Petitioner contended that there are any disputed issues of material fact in this case.

locations was a free-standing entity which necessitated separate FQHC certification in order to be eligible for Medicare reimbursement. The Board affirmed my holding as to this issue. I do not revisit it here.

What remains to be decided is the question of whether each of the two locations qualified individually for participation on a date that is earlier than September 8, 2005. In my original decision I held that the effective date of a facility's participation as an FQHC is the date when CMS determines to accept a signed agreement which assures that the facility meets all federal participation requirements. I premised this holding on the plain language of 42 C.F.R. § 489.13(a)(2)(i), which states that the effective date of certification of an FQHC is the date when CMS "accepts a signed agreement." I held that the regulation's language vested non-reviewable discretion in CMS to decide on which date to accept an agreement. I held that CMS's determination to accept the two locations' agreements effective September 8, 2005 was non-reviewable. I declined to look behind CMS's determination so as to make an independent decision whether the two locations may have qualified at an earlier date than September 8.

The Board reversed this part of my decision and held, effectively, that I (and it) had authority to review for reasonableness CMS's determination that the two locations first qualified for certification on September 8, 2005. It directed CMS to determine whether documents that Petitioner had filed on behalf of the two locations prior to September 8, 2005, and communications between Petitioner and CMS or its representatives prior to that date, might substitute for the documentation that CMS had found to be an acceptable signed agreement from Petitioner. The Board ordered that CMS and I look at the totality of the relationship between Petitioner and CMS in order to decide whether the parties' interactions might substitute constructively for the documentation that CMS determined to constitute an acceptable agreement.[3]

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[3] In its decision the Board found that I should consider whether the following actions suffice to serve as proof that the two locations qualified for FQHC certification prior to September 8, 2005:

> obtaining a change of scope for . . . [Petitioner's] PHS Act grant to include . . . [the two locations]; consulting with CMS and its intermediaries about how to qualify additional locations for Medicare FQHC reimbursement; pursuant to that consultation, filing of CMS-855B applications ("Medicare Enrollment Application - Clinics/Group Practices and Certain Other Suppliers") and CMS-855Rs (Medicare Federal Health Care Benefits Enrollment Application - the Reassignment of Medicare Benefits") for the doctors practicing at the location[s]; and CMS's subsequent payment of

### B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

***1. In order to qualify as an FQHC an entity must satisfy all federal enrollment requirements including those which specifically apply to FQHCs and it must provide CMS with assurance, in the form of an attestation, that it is complying with these requirements.***

The prerequisites for qualification as an FQHC are that an entity must: satisfy all federal enrollment requirements; and, provide CMS with proof that it has done so. 42 C.F.R. § 405.2430(a). There is nothing in the regulations governing FQHCs that suggests that an entity may qualify for FQHC status without first having satisfied these two essential prerequisites. Nor do the regulations allow for a waiver of these prerequisites.

There are participation requirements that apply specifically to FQHCs as distinguished from Medicare providers and suppliers in general. An entity applying for FQHC status must complete an application form (known as "form 855A") which addresses those specific participation requirements. In addition, it must complete an attestation statement in which it certifies that: it has reviewed each federal requirement for FQHCs at section 1861(aa)(4) of the Social Security Act (Act) and all regulatory requirements that are specified in 42 C.F.R. Part 405 Subpart X, and Part 491; and that it is currently in compliance with all of these requirements and regulations. CMS Ex. 3; CMS Ex. 7. The attestation, which is made subject to both civil and criminal penalties for false statements, is a certification by the applicant that it will comply with the *specific requirements* governing FQHCs in the Act and implementing regulations.[4]

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reimbursement to . . . [Petitioner] for FQHC services at these locations.

DAB No. 2092 at 14.

[4] An applicant for FQHC participation must attest as follows:

> I certify that I have reviewed each Federal requirement in § 1861(aa)(4) of the Social Security Act and the federally qualified health center requirements specified in 42 CFR Part 405 Subpart X, and Part 491, as described in § 405.2434(a) and that _____(name of facility) is currently in compliance with these requirements and regulations. I agree to inform CMS of any changes that result in noncompliance.

There is nothing in the Act or in the regulations that provides that an FQHC may satisfy the attestation requirement by providing something to CMS that is less specific than that which is demanded from it by CMS. The requirement of a specific attestation of compliance with FQHC requirements is premised on the fact that FQHCs comprise Medicare suppliers, which provide services, and which are subject to participation requirements, that differ from those that apply to providers and suppliers generally.

CMS's requirement of a specific attestation from an applicant for FQHC participation is not a mere technicality that can be overlooked. CMS insists on an attestation specifically related to FQHC participation requirements precisely because FQHCs have attributes and functions that are different from those of other providers and suppliers. Therefore, it is entirely consistent with the Act's very specific requirements for FQHC participation and CMS's role to assure that participating FQHCs comply with those requirements that CMS demand from an applicant a specific attestation of compliance. And, for that reason, a more generalized assurance of compliance with Medicare laws, regulations, and policies will not suffice as an acceptable substitute for the specific attestation that is demanded by CMS.

***2. Petitioner did not provide CMS, prior to September 8, 2005, with an attestation that it was complying with all FQHC requirements. CMS therefore correctly determined to certify the two locations effective September 8, 2005.***

Each of the two locations filed a statement attesting compliance with FQHC requirements on September 8, 2005. CMS Ex. 3; CMS Ex. 7. Petitioner has not asserted that either of the two locations filed this document prior to September 8.

One reasonably could conclude that Petitioner's failure to file attestation statements for the two locations prior to September 8, 2005 is, as a matter of law, enough to support a finding that the two locations did not qualify for certification as FQHCs at any time prior to that date. In *Schweiker v. Hansen*, 450 U.S. 785 (1981), the United States Supreme Court found that an agency of this Department's requirement that an application be in writing had the force of law and that estoppel did not lie against the Department for the failure of one of its employees to inform an applicant of the requirement that she complete an application in writing.[5] The clear meaning of *Schweiker v. Hansen* is that

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CMS Ex. 3; CMS Ex. 7.

[5] The agency involved in *Schweiker* was the Social Security Administration which, at the time, was a part of this Department. The application was for Supplemental

agencies of this Department have the right under the law to insist that applicants for benefits – or for participation in Medicare – comply precisely with specific agency requirements as a prerequisite for approval. Under *Schweiker v. Hansen* an agency is not required to accept a functional equivalent of an application which is not of the precise form and conduct that the agency requires.

And, for good reason. Each year CMS processes many thousands of applications for certification of providers and suppliers to participate in the Medicare program. Its requirement that an applicant fill out a precise form or series of forms as a prerequisite for certification is necessitated, in part, by efficiency considerations. If CMS were required to accept functional equivalents for applications that have not been perfected, that would open the door to numerous claims that certifications should have been made based on the supply of equivalent information. That, conceivably, could bog CMS down in endless debates as to whether applicants for participation should have been certified at dates earlier than the dates when they completed their applications for participation.

However, the Board has ordered that I decide whether Petitioner, in effect, constructively completed an attestation of compliance prior to September 8, 2005 and has directed that I consider other documents that Petitioner filed with CMS or with its intermediary or with a Medicare carrier prior to that date. I have done so and I find nothing in the record of this case, whether considered individually or in combination with other documents, that is the functional equivalent of the attestation statements that Petitioner filed on September 8.

The undisputed material facts establish that Petitioner was incorporated in 1973 for the purpose of providing comprehensive health care services to poor, underprivileged and indigent persons. It was certified as an FQHC effective October 1, 1991. It currently serves patients from its principal offices at 5735 Meeker Road, Greenville, Ohio. In applying for certification Petitioner executed the attestation statement that I describe at Finding 1 of this decision. FH Ex. 5, at 6.

Subsequent to its being certified as an FQHC, Petitioner determined to open the Central Avenue location and the North Main Street location in order to incorporate the practices of several local family practice physicians who wished to affiliate with Petitioner. On

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Security Income (SSI). The respondent in *Schweiker* had been misled by a field representative of the Social Security Administration into believing that she was not eligible for SSI benefits. As a consequence, she failed to file an application for SSI even though she was eligible. The Social Security Administration subsequently denied the respondent's claim to retroactive SSI on the ground that she had failed to comply with the agency's requirement that she complete a written application.

October 9, 2002, Petitioner submitted a change of scope request with the Health Resources and Services Administration of the United States Department of Health and Human Services (HRSA) in order to include the Central Avenue location within Petitioner's Public Health Services Act (PHS) grant. FH Ex. 7.[6] On March 1, 2004, Petitioner filed with HRSA a change of scope request to include the North Main Street location within Petitioner's PHS grant. FH Ex. 14.

Each of the two change of scope requests states unambiguously Petitioner's intent to conduct operations at the location described in the request in addition to Petitioner's main office. FH Ex. 7, at 13; FH Ex. 14, at 2. Neither of the documents, however, contains an attestation as is required by CMS for FQHC certification. Indeed, neither of the change of scope requests refer directly or indirectly to FQHC participation requirements. Rather, these documents are created for an altogether different purpose, that being to justify the inclusion of each of the two locations within a PHS grant.

Subsequently, Petitioner filed forms known as "855R" and "855B" applications relating to the two locations. An 855R form is an application for reassignment of Medicare benefits. FH Ex. 8. Its purpose is to document the reassignment of Medicare benefits from an individual practitioner (physicians in this case) to a supplier receiving the individual practitioner's reassigned benefits. *Id.* at 1. It is not an application for participation of an FQHC and makes no reference to laws or regulations governing FQHC participation. The form contains an attestation statement. This statement requires the provider who completes the form to attest that the contents of the form are true, accurate, and complete, and subjects the provider to civil and criminal penalties for deliberate false statements. But, it does not refer to specific Medicare requirements governing FQHCs.[7]

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[6] HRSA has authority to administer PHS grants. It does not certify providers, including FQHCs, to participate in Medicare.

[7] The attestation statement is:

> I certify that I have examined the above information [the information in the 855R form] and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws. I certify that the provider/supplier requesting to receive payments is legally eligible to receive reassigned benefits per CMS regulations.

FH Ex. 8, at 3.

An 855B form is an application for enrollment in the Medicare program for a health care supplier that will bill a Medicare carrier. FH Ex. 6. As with the 855R form, it is a generic form which does not specifically identify the applicant as an applicant for FQHC participation. Although it might be possible to infer from the 855B forms and related documents that Petitioner filed on behalf of the two locations that Petitioner envisioned these locations as functioning as FQHCs, there is nothing in the forms themselves that specifically states that intent. The 855B form contains a certification statement in which the applicant attests that it:

> agree[s] to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions . . ., and on the supplier's compliance with all applicable conditions of participation in Medicare.

FH Ex. 6, at 5.

This certification, although clearly obligating a supplier to comply with governing laws, regulations, and program instructions, is a general attestation of compliance. It does not provide CMS with the assurance that is contained in the FQHC attestation of knowledge of, and compliance with, the very specific laws, regulations, and policies that govern FQHCs.

Thus, there is nothing in the record of this case which suffices to provide CMS with all of the information that was required of Petitioner as a pre-condition for participation as an FQHC. The earliest date – as determined by CMS – that Petitioner provided such information was September 8, 2005.

As per the Board's decision I have also considered the fact that CMS evidently made some payments to Petitioner for items or services that were provided by the two locations prior to September 8, 2005. That CMS did so does not change my analysis or my decision. The fact that CMS may have made payments in error to Petitioner does not vest rights in Petitioner to a participation date for the two locations that is earlier than the date when these locations met all of CMS's requirements for FQHC certification. I do not find that such payments signify that CMS had, in fact, reviewed the qualifications of the two locations and found that they met participation requirements prior to September 8, 2005.

Petitioner's principal argument is that there was a course of conduct between it and CMS prior to September 8, 2005 that constituted a constructive acceptance by CMS of the two locations as participating FQHCs. In support of this argument, Petitioner points to the following communications:

> • Notices of grant approvals from HRSA approving Petitioner's requests to add the two locations to its PHS grant.
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> • Letters from CMS to Petitioner, dated September 23, 2003 and November 3, 2002 which: accepted a cost report from Petitioner that included the Central Avenue location; and giving a $13,000 settlement to Petitioner covering claims for costs that included the Central Avenue location.

But, these facts do not document a de facto acceptance by CMS of the two locations as FQHCs. The PHS grant approval process is not certification. The fact that PHS approved grants or expanded grants to Petitioner may have been a prerequisite to approval to operate the two locations as FQHCs. But, it does not in any respect substitute for the review and approval process that CMS engages in to determine whether an FQHC applicant satisfies all federal requirements. The fact that CMS may have made erroneous or incorrect payments to Petitioner is not, as I have explained, on its face tantamount to certification of the two locations.

Petitioner argues also that, in fact, the two locations satisfied all federal participation requirements on dates prior to September 8, 2005. However, and as I discuss in detail above, Petitioner did not provide CMS with the requisite attestation of compliance with federal laws, regulations, and policies governing FQHCs at any time prior to September 8. I do not question Petitioner's assertion that the two locations may have functioned as FQHCs on dates prior to September 8. But, the federal requirements that are at issue here include not only performance as an FQHC but they include the requirement of an attestation of compliance with governing laws, regulations, and policies.

Petitioner argues that equitable considerations weigh in favor of certification of the two locations at dates earlier than September 8, 2005. But, I have no authority to compel CMS to certify the two locations based on equitable considerations. Principles of equity are inapplicable here. *Schweiker v. Hansen*, *supra*; *Heckler v. Community Health Services*, 467 U.S. 51 (1984).

Finally, Petitioner asserts that CMS's determination to certify the two locations effective September 8, 2005 is an abuse of its discretion and is contrary to governing law. Petitioner's premise for this argument is that applicable regulations governing FQHCs do not specify precisely the form of the application that a facility must complete in order to

qualify for FQHC participation. But, the fact that CMS has chosen to implement the regulations by requiring a particular form (in this case an 855A form plus an attestation statement) as a prerequisite for processing an application is hardly an abuse of discretion. CMS clearly has the obligation to implement regulatory mandates in a logical and efficient way and developing and implementing an appropriate application form is entirely consistent with this duty.

Moreover, it is not correct to infer that CMS failed to provide applicants for FQHC participation with notice of the forms it required that they complete. The preamble to regulations governing FQHCs states explicitly that "each site [applying for certification] must indepenently attest to meeting the conditions in Part 491 Subpart A." 61 Fed. Reg. 14640, 14641 (April 3, 1996). CMS's State Operations Manual in effect on relevant dates states that, as a prerequisite to FQHC participation, the applicant is required to submit a signed and dated attestation statement to CMS. CMS Ex. 21, at 2.

/s/
Steven T. Kessel
Administrative Law Judge