Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Ridgeview Hospital
Docket No. A-14-78
Decision No. 2593
September 24, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Ridgeview Hospital (Ridgeview), a psychiatric hospital, appeals the March 31, 2014 Administrative Law Judge (ALJ) decision granting summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS). *Ridgeview Hospital*, DAB CR3183 (2014) (ALJ Decision). The ALJ sustained CMS's determination that the effective date of Ridgeview's Medicare participation under 42 C.F.R. § 489.13(c)(2) is September 21, 2012. Ridgeview argues that it is entitled to an effective date of July 19, 2012 based on the same regulation. Alternatively, Ridgeview asks the Board to remand this case for further development to address what it alleges to be a dispute of material fact.

For the reasons discussed below, we sustain the September 21, 2012 effective date of Ridgeview's Medicare participation. We conclude that the undisputed facts support a September 21, 2012 effective date based on section 489.13(c)(2). We further conclude that Ridgeview's proposed interpretation of the regulation is unreasonable. In contrast, we explain, CMS's interpretation is reasonable and consistent with its longstanding construction of the regulation. Lastly, we conclude that there is no genuine dispute of material fact and that Ridgeview's request for remand to pursue discovery has no merit.

I. Legal Background

The Social Security Act (Act) defines "psychiatric hospital" to mean an institution that is "primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons . . ."[1] Act § 1861(f). In order to participate as a provider in Medicare, a psychiatric hospital must meet

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

requirements specified in the Act and Medicare regulations and enter into a provider agreement with CMS on behalf of the Secretary of the Department of Health and Human Services. Act §§ 1861(e)(3)-(9), 1861(f), 1866; 42 C.F.R Parts 482, 489.[2]

The health and safety requirements for hospitals, called conditions of participation, are codified in 42 C.F.R. Part 482. Each condition of participation represents a general health or safety requirement described in a single regulation, which is composed of subpart "standards." A provider is not in compliance with a condition of participation "where the deficiencies are of such character as to substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients[.]" 42 C.F.R. § 488.24(b). Whether an entity is in compliance with a particular condition of participation "depends upon the manner and degree to which the provider . . . satisfies the various standards within each condition." 42 C.F.R. § 488.26(b). CMS may "refuse to enter into an agreement" with a provider that "fails to comply substantially" with the provisions of the provider agreement, the Act, or applicable regulations, including Medicare's health and safety requirements. Act § 1866(b)(2).

A psychiatric hospital seeking to participate in Medicare may choose to show its compliance with the health and safety requirements in one of two ways. First, it may undergo a survey by a state survey agency or CMS surveyors to assess whether it is in compliance with the requirements. Act § 1864; 42 C.F.R. Part 488. Based on the survey findings and recommendations, CMS determines whether the psychiatric hospital qualifies to participate in Medicare and to enter into a provider agreement. 42 C.F.R. §§ 488.12, 489.11-12.

Alternatively, the hospital may apply for accreditation by a national accreditation organization (AO) under a CMS-approved accreditation program. Act § 1865(a); 42 C.F.R. §§ 488.4-488.9, 488.12. In this case, CMS will "deem" the prospective provider to have met the applicable Medicare health and safety requirements if it has been accredited by the approved AO program. In 2011, CMS approved the Joint Commission (TJC) for recognition as a national accreditation program for psychiatric hospitals seeking to participate in Medicare and Medicaid effective February 25, 2011, through February 25, 2015. 76 Fed. Reg. 10,598 (Feb. 25, 2011).

Section 489.13 of the regulations governs the effective date of a Medicare provider agreement with a health care facility that is subject to survey and certification based on either a state agency or CMS survey, or in lieu of such a survey and certification, accreditation by a CMS-approved AO program. 42 C.F.R. § 489.13(a). A CMS determination of the effective date of a Medicare provider agreement is an initial determination subject to appeal. 42 C.F.R. § 498.3(b)(15).

[2] All regulatory citations in this decision are to the 2012 regulations in effect during the period at issue unless otherwise specified.

II. Case Background

The following facts are drawn from the record and are not disputed.

On March 21, 2012, CGS, a Medicare contractor, told Ridgeview that it had completed processing Ridgeview's Medicare enrollment form and that the next step in the enrollment process would involve a "site visit or survey conducted by the State Survey Agency or accrediting organization to ensure compliance with the conditions of participation . . . ." P. Ex. 6.

On July 19, 2012, TJC completed an initial accreditation survey of Ridgeview to assess its compliance with the Medicare health and safety requirements for psychiatric hospitals. P. Ex. 7, at 1. TJC concluded that Ridgeview had seven standard-level deficiencies. *Id.* TJC did not find that any of the deficiencies rose to condition-level noncompliance. *Id.*

On September 21, 2012, Ridgeview submitted to TJC "evidence of standards of compliance" addressing the deficiencies. *Id.* Based on Ridgeview's submission, TJC concluded that the deficiencies had been resolved and issued a letter to Ridgeview stating that TJC was "granting [Ridgeview] an accreditation decision of Accredited with an effective date of September 21, 2012." *Id.* TJC also stated that it was "recommending [Ridgeview] for Medicare certification effective September 21, 2012," but that the CMS regional office would make the final determination of Medicare participation and Ridgeview's effective date based on section 489.13 of the regulations. *Id.*

In October 2012, CMS notified Ridgeview that CMS had accepted Ridgeview's "request for participation . . . based on accreditation by [TJC]." P. Ex. 8, at 1; CMS Ex. 2, at 1. CMS determined that Ridgeview's effective date of participation was September 21, 2012. Ridgeview requested reconsideration of the effective date of its Medicare participation, seeking an effective date of July 19, 2012, the date TJC completed the accreditation survey of Ridgeview.

On October 25, 2012, CMS issued a reconsideration determination sustaining the September 21, 2012 effective date of Ridgeview's Medicare participation. CMS Ex. 1. CMS stated:

> For the purposes of assigning the effective date for Medicare approval of accredited providers and suppliers, the regulation at 42 [C.F.R.] 489.13(c)(2)(ii)(A) states that the Medicare effective date is based on when a "*CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies.*"

Id. (emphasis in original). Here, CMS stated, TJC recommended initial Medicare certification for Ridgeview effective September 21, 2012 based on Ridgeview's submission of an acceptable plan of correction for its seven lower-level deficiencies; TJC received that plan of correction on September 21, 2012. *Id.* Therefore, CMS explained, it could not approve Ridgeview for Medicare participation any earlier than September 21, 2012. *Id.*

III. Standard of Review

Our standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. The bases for modifying, reversing or remanding an ALJ decision include: a finding of material fact necessary to the outcome of the decision is not supported by substantial evidence; a legal conclusion necessary to the outcome of the decision is erroneous; the decision is contrary to law or applicable regulations; or a prejudicial error of procedure (including an abuse of discretion under the law or applicable regulations) was committed. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/guidelines/prov.html.

Summary judgment is appropriate when there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012), *aff'd, Mission Hosp. Reg'l Med. Ctr. v. Sebelius*, No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. May 31, 2013); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). Whether summary judgment is appropriate is a legal issue that we address de novo, viewing the proffered evidence in the light most favorable to the non-moving party. *Cmty Hosp. of Long Beach*, DAB No. 1938 (2004).

IV. Analysis

Below, we first explain that the ALJ properly sustained Ridgeview's September 21, 2012 effective date of participation based on 42 C.F.R. § 489.13(c)(2) and the undisputed material facts. We next address Ridgeview's arguments that it is entitled to a July 19, 2012 effective date. We describe why we conclude that Ridgeview's interpretations of the first clause of section 489.13(c)(2)(i) and section 489.13(c)(2)(ii)(A) are unreasonable. We further explain that CMS's construction and application of the regulation in this case are consistent with the agency's prior statements and the regulation's history and purpose. In the last section of our analysis, we discuss why we find no merit in Ridgeview's argument that there remains a disputed issue of material fact requiring remand, and we conclude that the ALJ properly denied Ridgeview's related discovery requests.

A. The ALJ properly sustained Ridgeview's effective date of participation based on 42 C.F.R. § 489.13(c)(2) and the undisputed material facts.

As noted, section 489.13 governs the effective date of a Medicare provider agreement with a health care facility that is subject to survey and certification by a state agency or CMS, or in lieu of such a survey and certification, accreditation by a CMS-approved AO program. Section 489.13(b) addresses the effective date for a provider that meets all health and safety standards on the date of its initial survey. When a hospital that seeks to participate based on a state agency or CMS survey meets all health and safety standards on the date of its initial survey, the agreement is effective on the date the survey is completed; when a hospital that seeks to participate through accreditation by an AO meets all health and safety standards on the date of its initial survey, the agreement date is "the effective date of the accreditation decision." *Id.*

Section 489.13(c) governs the effective date where a provider does not meet all health and safety standards on the date of its initial survey. It provides in relevant part:

> (2) For an agreement with, or an approval of, any other provider [other than a skilled nursing facility or provider specified in section 489.13(a)(2)] . . ., the effective date is the earlier of the following:
> (i) [clause 1] The date on which the provider . . . meets all applicable conditions of participation, . . . ; [clause 2] or, if applicable, the date of a CMS-approved accreditation organization program's positive accreditation decision, issued after the accreditation organization has determined that the provider . . . meets all applicable conditions.
> (ii) The date on which a provider . . . is found to meet all conditions of participation . . . , but has lower-level deficiencies, and—
> (A) [clause 1] CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies (the date of receipt is the effective date regardless of when the plan of correction is approved); [clause 2] or, if applicable, a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; . . .

The language of section 489.13(c)(2) thus recognizes that if a hospital does not meet all applicable health and safety standards on the date of its initial survey, various scenarios may follow. The hospital's effective date is thus established by determining: 1) whether the provider thereafter meets all applicable conditions of participation, or meets them but has lower-level deficiencies; and 2) whether there was a CMS or state agency survey, or an AO survey.

As noted, the parties do not dispute that on July 19, 2012, a CMS-approved AO program (TJC) completed an initial survey of Ridgeview that found multiple standard, lower-level deficiencies. Consequently, the parties agree, section 489.13(c)(2) controls the effective date of Ridgeview's Medicare participation. The parties also do not dispute that on September 21, 2012, TJC received from Ridgeview "evidence of standards [of] compliance," which TJC determined "effective[ly] resol[ved]" the standard-level deficiencies identified during the survey. P. Ex. 7. TJC notified Ridgeview that it "grant[ed]" Ridgeview accreditation effective September 21, 2012. *Id.*

In light of these undisputed facts, we find no error in CMS's determination and the ALJ's conclusion that section 489.13(c)(2)(ii)(A) applied under the circumstances presented and established the September 21, 2012 effective date of Ridgeview's provider agreement because: 1) Ridgeview "[met] all conditions of participation . . . but ha[d] lower-level deficiencies" on the date TJC completed the initial survey; and 2) TJC "issue[d] a positive accreditation decision after it receive[d] an acceptable plan of correction for the lower-level deficiencies" on September 21, 2012. Accordingly, CMS and the ALJ reasonably construed 42 C.F.R. § 489.13(c)(2) to preclude Ridgeview from participating in and billing Medicare any earlier than September 21, 2012.

B. Ridgeview's interpretation of 42 C.F.R. § 489.13(c)(2) is unreasonable.

1. Ridgeview's interpretation of the first clause of section 489.13(c)(2)(i) is unreasonable.

Ridgeview argues that because TJC did not cite condition-level deficiencies in its July 2012 survey, the hospital is entitled to a July 19, 2012 effective date of Medicare participation based on the first clause of section 489.13(c)(2)(i) ("The date on which the provider . . . meets all applicable conditions of participation, . . ."). Noting that the introductory language of section 489.13(c)(2) establishes that the effective date of a hospital's participation in Medicare will be the "earlier" of the applicable dates that follow, Ridgeview says that the relevant dates here are: (a) July 19, 2012, the last day of its initial survey, which, according to Ridgeview, "is the date that TJC determined that all Medicare [conditions of participation] were met;" and "(b) September 21, 2012, the effective date of TJC's accreditation determination." P. Br. at 16. Ridgeview contends that under the plain meaning of the first clause of 489.13(c)(2)(i), its "initial Medicare enrollment effective date is obviously July 19, 2012, the earlier of the two possible enrollment dates." *Id.*

CMS challenges this reading of the regulation, arguing that the first clause in section 489.13(c)(2)(i) "pertain[s] to prospective providers that [unlike Ridgeview] pursue CMS or state survey certification, while the second clause . . . pertain[s] to the special case of accredited entities." CMS Br. at 19. In essence, CMS interprets the language of the

second clause ("or, *if applicable*, the date of a CMS-approved [AO] program's positive accreditation decision . . .") as limiting the applicability of the first clause to providers that are *not* surveyed by an AO. 42 C.F.R. § 489.13(c)(2)(i) (emphasis added).

Ridgeview argues, however, that the first clause of section 489.13(c)(2)(i) "is unequivocal and does not include any language stating, or that could be interpreted as stating, that it is subject to, or limited by, the second clause." P. Br. at 17. According to Ridgeview, while "the second clause applies by its own terms to an accredited provider," its "applicability is apparently limited to where the [AO] initially determined that the provider did not meet 'all applicable conditions' and subsequently determines that it does – and only then issues a 'positive accreditation decision.'" *Id.*

We reject Ridgeview's interpretation of section 489.13(c)(2)(i). It is a fundamental principle of statutory construction, equally applicable to regulatory construction, that every word and every phrase of the text must be given effect so that no word or phrase is rendered superfluous or to have no consequence. 2A Norman J. Singer and J.D. Shambie Singer, Sutherland Statutes and Statutory Construction § 46:6 (7th ed.); *Texas Office of the Att. Gen.*, DAB No. 2124, at 10 (2007); *North Ridge Care Ctr.*, DAB No. 1857 (2002) (noting that the Board generally strives to apply or interpret statutory or regulatory language in a way that does not render some provisions superfluous). Ridgeview's argument that the first clause of section 489.13(c)(2)(i) applies to accredited providers (as well as providers surveyed by CMS or a state agency) violates this basic principle because it would render the second clause of section 489.13(c)(2)(i) superfluous. As reflected in the plain language of the second clause, "a CMS-approved [AO] program's positive accreditation decision" is "issued **after** the [AO] has determined that the provider . . . meets all applicable conditions." (Emphasis added.) Thus, if the scenario described in the first clause of subsection (i) (the provider meets all applicable conditions of participation) were applicable to accredited providers, as Ridgeview argues, the second clause of section 489.13(c)(2)(i) would be superfluous because the date identified under the second clause, by the very terms of that clause, would always occur after or on the same date identified under the first clause. Consequently, the second clause would have no practical effect.

Even under Ridgeview's construction of the second clause's "limited" applicability, the second clause of section 489.13(c)(2)(i) would be superfluous if the first clause were applicable to accredited providers. That is, even if the second clause of the section applied only "where the AO initially determined that the provider did not meet all applicable conditions and subsequently determines that it does – and only then issues a 'positive accreditation decision,'" the AO still would be issuing its positive accreditation decision after it had determined that the provider ultimately met all applicable conditions.

Consequently, the date identified under the second clause still would occur after or on the same date as the date identified under the first clause. Thus, the second clause of section 489.13(c)(2)(i) would remain surplusage even if it applied only in the limited circumstance described by Ridgeview.

In addition, Ridgeview's interpretation of the first clause of 42 C.F.R. § 489.13(c)(2)(i), to apply where a prospective accredited provider meets all conditions of participation but has standard, lower-level deficiencies, violates the basic principle of statutory construction that the text must always be interpreted as a whole. That is, the meaning of a word or phrase should be determined not in isolation, but in the context of the act in its entirety. 2A Norman J. Singer and J.D. Shambie Singer, Sutherland Statutes and Statutory Construction § 46:5 (7th ed.). As set forth above, section 489.13(c)(2) has two subsections, 489.13(c)(2)(i) and 489.13(c)(2)(ii), which are organized in parallel: The first clause of subsection (c)(2)(i) and the first clause of subsection (c)(2)(ii)(A) relate to providers surveyed by a state survey agency or CMS; whereas the second clause of each subsection relates to providers seeking to participate based on accreditation by an approved AO program.[3] While the introductory language of section 489.13(c)(2)(i) states that it applies where "a provider . . . meets all applicable conditions of participation," the introductory language of the subsequent section, 489.13(c)(2)(ii), specifies that it applies where a provider "is found to meet all conditions of participation, . . . *but has lower-level deficiencies.*" (Emphasis added.)

Taking into account the structure and language of the regulation as a whole, it logically follows that section 489.13(c)(2)(i) must be read to apply where a provider is found to meet all conditions of participation *and* to have no lower-level deficiencies. To accept Ridgeview's interpretation of the regulation, we agree with CMS, "would make clause (c)(2)(ii)(A) a mere subset of (c)(2)(i)" and make no sense given the structure of the regulation. CMS Br. at 19. *Cf. Oak Lawn Endoscopy*, DAB No. 1952 (2004) (stating that the language of section 489.13(c)(2)(i) (2003) "must be read to mean the absence of any deficiencies (even 'lower-level' deficiencies)" because the language of section 489.13(c)(2)(ii) (2003) "includes facilities that meet the conditions (but still have deficiencies and thus are not in full compliance with all Medicare standards)").

Moreover, if section 489.13(c)(2)(i) were applicable to providers with standard, lower-level deficiencies, as Ridgeview argues, section 489.13(c)(2)(ii)(A) would have no practical effect. Under the first clause of section 489.13(c)(2)(ii)(A), the operative date for a provider surveyed by CMS or a state survey agency and found to have lower-level deficiencies is the date on which CMS or the state survey agency receives the provider's acceptable plan of correction for the lower-level deficiencies. Under the second clause, the operative date is the date on which the CMS-approved AO program issues a positive

[3] Section 489.13(c)(2)(ii) is divided into subsections (A) and (B), the latter of which relates to approvable waiver requests. Neither party argues that subsection (B) is applicable here.

accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies. In the briefs before the ALJ and on appeal, neither CMS nor Ridgeview has identified any scenario in which CMS, a state agency, or an approved AO program would receive an acceptable plan of correction for lower-level deficiencies before completing a survey concluding that the provider met all conditions of participation but had lower-level deficiencies. Thus, if the first clause of 489.13(c)(2)(i) were construed to apply to a provider that meets the conditions of participation but has lower-level deficiencies, as Ridgeview argues, section 489.13(c)(2)(ii)(A) would be reduced to surplusage because the operative dates under that provision would never occur before the date identified under section 489.13(c)(2)(i).

Accordingly, we reject Ridgeview's argument that it is entitled to a July 19, 2012 effective date based on the first clause of section 489.13(c)(2)(i) because Ridgeview's interpretation of that provision fails to take into account the regulation as a whole and would render the second clause of section 489.12(c)(2)(i) and section 489.13(c)(2)(ii)(A) superfluous.

2. Ridgeview's interpretation of section 489.13(c)(2)(ii)(A) is unreasonable.

As explained above, the ALJ sustained the September 21, 2012 effective date of Ridgeview's Medicare participation based on section 489.13(c)(2)(ii)(A) because that was the date on which Ridgeview "me[]t all conditions of participation, . . . but had lower-level deficiencies, and . . . a CMS-approved [AO] program issue[d] a positive accreditation decision after it receive[d] an acceptable plan of correction for the lower-level deficiencies; . . . ." Arguing in support of the ALJ Decision, CMS reiterates in its brief on appeal that Ridgeview is not entitled to an earlier effective date because section 489.13 does not entitle prospective providers that choose to participate in Medicare through accreditation "to enroll before they are actually accredited." CMS Br. at 23.

Ridgeview accepts that the second clause of section 489.13(c)(2)(ii)(A) "could plausibly be read to apply here." P. Br. at 20. Ridgeview argues, however, that even if its effective date of Medicare participation must be determined solely under that clause, its effective date is July 19, 2012. Specifically, Ridgeview contends that the second clause of section 489.13(c)(2)(ii)(A) "does not state that the date of the 'positive accreditation decision' is the only date that can be used as the effective date of the Hospital's Medicare enrollment." *Id*. at 20 (emphasis in original). Rather, Ridgeview says, "the requirement for TJC acceptance of the Hospital's plan of correction under § 489.13(c)(2)(ii)(A) is for purposes of establishing the condition for enrollment, not the timing thereof." *Id.* at 21 (emphasis in original). "The plain reading" of the regulatory language, Ridgeview asserts, is that the effective date for an accredited provider that meets all conditions of

participation but has lower-level deficiencies is the date that the provider has been found to meet all conditions of participation, (in this case, July 19, 2012), "provided that the Hospital has submitted a plan of correction for the lower-level deficiencies that is found to be acceptable by [the AO]." *Id.* (emphasis in original).

In support of its interpretation of the regulation, Ridgeview argues that the first clause of section 489.13(c)(2)(ii)(A), which addresses providers surveyed by CMS or a state agency, includes a parenthetical statement that the effective date of Medicare enrollment is the date of receipt of the plan of correction, regardless of when the plan of correction is approved. P. Br. at 20-21. Ridgeview points out that the parenthetical statement is not repeated in the second clause of the section, which addresses accredited providers. Consequently, Ridgeview argues, it would be "improper for CMS to interpret the two provisions the same way where the timing parenthetical appears only in one provision." *Id.* at 22.

We disagree with Ridgeview that a "plain reading" of section 489.13(c)(2)(ii)(A) shows that the requirement in the second clause, for the AO to issue a positive accreditation decision after accepting the provider's plan of correction, establishes merely a condition for enrollment, not an operative date. The plain language of the regulation does not say that the effective date is the date that the provider meets all conditions of participation but not all standards, *provided that* the AO *later* accepts the provider's plan of correction for the lower-level deficiencies, as Ridgeview asserts. Rather, the exact wording of the provision is that the operative date is "(ii) The date on which a provider . . . is found to meet all conditions of participation . . . but has lower level deficiencies, *and* -- (A) . . . if applicable, a CMS-approved accreditation organization program *issues* a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies." (Emphasis added.) The use of the conjunction "and" in section 489.13(c)(2)(ii) signals that the operative date is the date when *all* of the grammatically connected sequential events described in the applicable subsection have occurred: In the case of a prospective accredited provider, the provider is in compliance with all applicable conditions of participation but has lower-level deficiencies; the AO has received an acceptable plan of correction; *and* the AO has issued a positive accreditation decision. Here, that date was September 21, 2012.

Furthermore, Ridgeview's assertion that the second clause of 489.13(c)(2)(ii)(A) establishes merely a condition for enrollment and not a date again ignores the structure of section 489.13(c)(2). Under section 489.13(c)(2), Ridgeview recognizes, the effective date of a provider's participation in Medicare is determined based on the earliest of the relevant dates described in the various scenarios that follow. As CMS observes, however, Ridgeview has failed to offer any rational explanation why the second clause of section 489.13(c)(2)(ii)(A), of all of the clauses under section 489.13(c)(2), is the only one that does not establish an operative enrollment date. CMS Br. at 29.

In addition, we are not persuaded by Ridgeview's argument that the second clause of section 489.13(c)(2)(ii)(A) should be construed as establishing a condition for enrollment but not an effective date because the parenthetical statement in the first clause (that the "date of receipt is the effective date regardless of when the plan of correction is approved") is not repeated in the second clause. The placement of the parenthetical statement in the first clause, after the phrase "CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies," shows that the parenthetical is meant to clarify that the effective date under that particular scenario is the date of receipt of the plan, not the date of approval of the plan. This clarifying parenthetical statement is not needed in the second clause of section 489.13(c)(2)(ii)(A), however, because the effective date for an accredited provider cannot occur before the AO has issued a positive accreditation decision, which, the wording of the regulation recognizes, always occurs "*after*" the AO has both received and approved the plan.

Ridgeview's interpretation of section 489.13(c)(2)(ii)(A) also fails to take into account 42 C.F.R. § 489.13 as a whole. Under section 489.13(b), when "[a]ll health and safety standards are met on the date of survey," the provider agreement "is effective . . . on the *effective date of the accreditation decision*, as applicable, if on that date the provider . . . meets all applicable Federal requirements. . . ." (Emphasis added.) Thus, to construe 489.13(c)(2)(ii)(A) to permit a provider surveyed by an AO and found to have lower-level deficiencies to participate in Medicare as of the last date of its initial survey and prior to submitting a plan of correction would, paradoxically, allow the provider to participate *sooner* than if it had met *all* applicable requirements during the initial survey. Ridgeview fails to explain why section 489.13 should be read to irrationally entitle prospective accredited providers with lower-level deficiencies to participate in Medicare before wholly compliant accredited providers.

Moreover, CMS clarified in the preamble to the 2010 revision of section 489.13, applicable here, that an accredited provider should not be given "preferential treatment in its provider agreement . . . effective date determination compared to a nonaccredited facility that chooses to be surveyed by the State agency or CMS." 75 Fed. Reg. 50,042, 50,404 (Aug. 16, 2010). To read the second clause of section 489.13(c)(2)(ii)(A) to permit a prospective accredited provider with lower-level deficiencies to participate in Medicare prior to submitting an approvable plan of correction would plainly give preferential treatment to the accredited provider since under the first clause of section 489.13(c)(2)(ii)(A), a provider with lower-level deficiencies surveyed by CMS or a state survey agency may participate no sooner than the date its acceptable plan of correction has been received.

Accordingly, we reject Ridgeview's interpretation of section 489.13(c)(2)(ii)(A) to achieve a July 19, 2012 effective date of Medicare participation.

C. CMS's interpretation and application of section 489.13(c)(2) here are consistent with CMS's prior statements and the regulation's history.

Ridgeview further contends that CMS's interpretation and application of 42 C.F.R. 489.13 in this case, as precluding Ridgeview from obtaining an effective date prior to its TJC accreditation, is merely a litigation position consisting of "post hoc arguments by CMS counsel." P. Br. at 18, n. 6; P. Reply at 7, 12, 15. According to Ridgeview, CMS's interpretation of the regulation here contradicts CMS's statement in the "final rule adopting the 2010 changes to 42 C.F.R. §489.13(c)" that CMS intended the regulation "to assure that accredited and nonaccredited facilities are treated in the same manner." P. Br. at 18, citing 75 Fed. Reg. 50,402. Ridgeview argues that CMS's "attempt . . . to deprive accredited providers of the benefit of the first clause of §489.13(c)(2)(i) is improper under the agency's own Federal Register pronouncements." P. Br. at 18-19. Ridgeview also argues that notwithstanding its lower-level deficiencies, it should be permitted to participate in Medicare effective on the last date of its survey because section 488.28 of the regulations permits existing providers to continue to participate in Medicare unless survey deficiencies are of a type that "jeopardize the health and safety of patients [or] are of such character as to seriously limit the provider's capacity to render adequate care." P. Br. at 25-26, citing 42 C.F.R. § 488.28(b).

For the reasons explained in detail above, Ridgeview's argument that it is entitled to "the benefit of the first clause of section 489.13(c)(2)(i)" and its suggestion that nonaccredited providers with lower-level deficiencies do have the "benefit" of that clause are meritless. In addition, we agree with CMS that the regulations rationally treat existing and new providers differently because "only the existing provider has demonstrated the *capacity* to meet all of Medicare's health and safety standards at least once," whereas a prospective provider has "no prior enrollment track record to fall back upon." CMS Br. at 17-18 (emphasis in original).

Furthermore, contrary to Ridgeview's assertion, CMS's arguments here are consistent with the regulatory history and CMS's prior statements about the meaning and intent of the effective date regulation. Before CMS enacted the current version of the regulation in August 2010, paragraph (c) of section 489.13 applied to prospective providers who did not meet all federal requirements on the date of the initial survey; a separate paragraph (d) of section 489.13 governed the effective date of "currently accredited" providers and suppliers. Under section 489.13(d)(2), CMS was permitted to establish a retroactive enrollment date for some "currently accredited" providers "for up to one year to encompass dates on which the provider . . . furnished, to a Medicare beneficiary, covered services for which it has not been paid." 62 Fed. Reg. 43,936 (Aug. 18, 1997); 42 C.F.R. § 489.13 (2009).

Notably, when CMS promulgated that earlier version of the regulation, it made clear that even where retroactive enrollment would be permitted, an accredited provider could not be enrolled in and bill Medicare prior to the date of its accreditation. 62 Fed. Reg. 43,933. Similarly, CMS stated in the preamble to the 2006 final rule establishing the requirements for providers and suppliers to establish and maintain Medicare enrollment that for "those providers and suppliers seeking accreditation from a CMS-approved accreditation organization, the *effective date for reimbursement is the later of the date accreditation was received* or the final approval of the CMS 855" (Medicare enrollment application). 71 Fed. Reg. 20,754, 20,758 (Apr. 21, 2006) (emphasis added).

In 2010, CMS revised section 489.13 to clarify the effective date requirements and remove the provision permitting retroactive enrollment for some currently accredited providers. Discussing the earlier version of the regulation, CMS noted that under both paragraphs (b) and (d), the effective date of a provider agreement was "the date on which *all* Federal requirements have been met." 75 Fed. Reg. 50,400 (emphasis added). CMS further stated that it "believed it was appropriate to remove § 489.13(d), and to instead make appropriate reference to the situation of accredited facilities in §§ 489.13(b) and (c)." *Id.* at 50,403. CMS gave no indication, however, that it intended the revisions to change its policy precluding accredited providers from participating in and billing Medicare prior to obtaining accreditation by a CMS-approved AO program. To the contrary, CMS referenced section 1866(b)(2) of the Act, which gives the Secretary discretion to refuse to enter into a provider agreement for various reasons, including failure to meet any of the applicable "health and safety standards." *Id.* at 50,400. CMS also noted that "in accordance with section 1865 of the Act, CMS may 'deem' an entity to have satisfied these requirements if it *has been accredited* by a national accreditation program approved by CMS." *Id.* (emphasis added). Thus, CMS's position in this case, that "[s]ection 489.13 does not entitle prospective providers that opt to pursue accreditation to enroll before they are actually accredited," is entirely consistent with CMS's prior statements about the meaning and intent of the effective date regulation. CMS Br. at 23.

Both parties point out that the preamble to the 2010 revision of the regulation stated that the proposed revisions to paragraphs (b) and (c) of section 489.13 were intended "to assure that accredited and nonaccredited facilities are treated in the same manner." 75 Fed. Reg. at 50,402; P. Br. at 18; CMS Br. at 25. As reflected in the August 2010 final revisions and the preamble discussion, however, treating the two types of facilities "in the same manner" does not mean that an accreditation survey and a state agency survey are equivalent for purposes of establishing a provider's effective date of participation. Rather, as section 489.13(b) and CMS's statements in the August 2010 preamble make clear, CMS treats "*accreditation itself*, not the accreditation survey findings, as the equivalent to passing a state survey" for purposes of determining a provider's effective date of Medicare participation. CMS Br. at 15 (emphasis in original), citing, inter alia, 75 Fed. Reg. 50,401 ("passed a State survey or been accredited"); *id.* at 50,402 ("CMS

makes the determination on whether a provider . . . is eligible to participate . . ., based on the State survey agency's recommendation or on the facility's accreditation"); *see also* 42 C.F.R. 489.13(b) (When "[a]ll health and safety standards are met on the date of survey," the provider agreement "is effective on the date the State agency, [or] CMS . . . survey is completed, or on the effective date of the accreditation decision, as applicable . . . .").

We also note that while not binding on the ALJ or the Board, CMS's 2008 Survey and Certification letter S&C-09-08, which CMS referenced in the August 2010 *Federal Register* preamble, evidences that CMS has historically treated prospective accredited providers found to have deficiencies below the condition level consistent with its treatment of Ridgeview. As explained in the letter, CMS "requires AOs to employ the same approach when recommending" a provider "to CMS for initial Medicare program participation as is used by CMS, in accordance with 42 CFR §489.13, when a [state agency] conducts the initial Medicare survey." CMS Ex. 6, at 7 (S&C-09-08, Att. A, II-5). Accordingly, CMS stated, "before the AO can issue accreditation and a recommendation to CMS that a provider" be deemed to meet the Medicare standards, "the AO must conduct a survey and determine that the applicant meets all applicable Medicare" conditions of participation. *Id.* If the applicant-provider "has deficiencies below the condition level," the AO "must receive an acceptable" plan of correction "for such deficiencies and may not make the effective date of its deemed status accreditation prior to the date of receipt of a" plan of correction "that the AO finds acceptable." *Id.*

It is well-settled that where the language of a statute or regulation is ambiguous, a reasonable interpretation of the text by the agency responsible for administering the provision is entitled to deference. *The Orthotic Ctr.* DAB No. 2531, at 18-19 (2013); *Dist. Mem'l Hosp. of Southwestern N.C., Inc. v. Thompson*, 364 F.3d 513, 518 (4th Cir. 2004); *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994). In light of our conclusion that CMS reasonably construed section 489.13(c)(2)(ii)(A) to determine Ridgeview's September 21, 2012 effective date of Medicare participation, and in view of the regulatory history showing that CMS's construction of section 489.13 in this case is consistent with CMS's prior statements about the intent of the regulation, we defer to CMS's interpretation of section 489.13(c)(2) as precluding Ridgeview from obtaining an effective date of Medicare participation prior to obtaining TJC accreditation.

D. We deny Ridgeview's request for remand and related discovery requests.

As stated above, summary judgment is appropriate whether there is no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. In making this determination, the reviewer must view the evidence in the light most favorable to the nonmoving party, drawing all reasonable inferences in that party's favor. *See, e.g., U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). If the moving party carries its initial burden of demonstrating that there is no genuine dispute of material fact for trial and that it is entitled to judgment as a matter of law, the opposing party "must do more than simply

show that there is some metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574 at 586-587 (1986). "Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no 'genuine issue for trial.'" *Id.* at 587, citing *Cities Service Co.*, 391 U.S. 253, 288-289 (1968).

Ridgeview argues that if we do not reverse the ALJ Decision, we should remand the case so that it may pursue discovery to ascertain whether CMS treated Ridgeview differently from other similarly situated hospitals. P. Br. at 1, 27; P. Reply at 7. According to Ridgeview, there remains a "crucial" disputed fact: "whether (as the Hospital believes) CMS allows the initial Medicare enrollment date of an accredited provider to predate the effective date of the provider's accreditation." P. Br. at 6. Ridgeview says that it has "heard anecdotally that CMS, at least occasionally," has "enrolled other new accredited providers as of the date they met all [conditions of participation] despite [having] standard level deficiencies." P. Br. at 2, 6-7; P. Reply at 4. Ridgeview adds that if its "belief is correct, it could mean that CMS's failure to make" Ridgeview's "initial Medicare enrollment date retroactive to the date that TJC found that it met all Medicare" conditions of participation "was arbitrary, capricious, and otherwise not in accordance with law under the Administrative Procedure Act . . . , 5 U.S.C. §§ 551 *et seq.*" P. Br. at 2 (emphasis in original).

While Ridgeview's appeal was pending before the ALJ, Ridgeview sought evidence through an expedited Freedom of Information Act (FOIA) request and discovery request of CMS seeking documents "to show other instances where CMS had made the initial Medicare enrollment date retroactive to the date the . . . [AO] had found that the provider met all Medicare" conditions of participation. P. Exs. 1, 2; P. Br. at 2. Ridgeview requested that CMS produce "any CMS (not only Region V) document since May 4, 2010 . . . where the initial Medicare enrollment date of an accredited provider was before the effective date of its accreditation." P. Ex. 1, at 2 (emphasis in original). CMS did not agree to produce the documentation voluntarily on the grounds that the documentation sought was irrelevant as a matter of law and that the request was vague, overbroad, and unduly burdensome. P. Ex. 1, at 1.

Ridgeview subsequently asked the ALJ for an order compelling CMS to produce the documents or, "in the alternative, to order CMS to provide a declaration from the Associate Regional Administrators for Survey and Certification for each of the ten Regional Offices stating that the agency has never allowed the initial Medicare enrollment date of an accredited provider to predate the effective date of the provider's accreditation." P. Motion for Summary Judgment at 4, 11. Ridgeview asserted that if the ALJ did not order CMS to provide the documents or declarations, Ridgeview planned to ask the ALJ to subpoena the ten Associate Regional Administrators to testify at the hearing in order to "prove its case." *Id.*; P. Reply at 2; ALJ Decision at 8, citing P. Br. at 4-5, 10-11; P. Ex. 2. The ALJ denied these requests. ALJ Decision at 8.

We conclude that Ridgeview's arguments do not establish that a material fact remains in dispute. We note first that Ridgeview has not come forward with any specific facts or support to substantiate its "belief" that CMS may have "at least occasionally enrolled other new accredited providers" as of the date they were found to have standard-level deficiencies that did not rise to condition-level noncompliance. Moreover, as discussed in detail above, CMS's prior statements about the meaning of the effective date regulation show that, contrary to Ridgeview's unsubstantiated allegations, CMS has consistently interpreted the effective date provisions to preclude accredited providers from participating in and billing Medicare prior to their accreditation.

In any event, whether CMS may have in some instances assigned an accredited provider an effective date of Medicare participation that was prior to its accreditation date is immaterial to the question whether CMS reasonably interpreted and applied section 489.13(c)(2) here. Even if, for purposes of summary judgment, we accepted that there may have been some instances in which CMS assigned an accredited provider an effective date of participation that predated its accreditation, we find no provision in the regulation that would entitle Ridgeview to an effective date prior to September 21, 2012, for the reasons discussed at length above. Moreover, such occasional instances could not reasonably be viewed as showing that CMS had adopted a routine "practice for the initial enrollment of newly-accredited providers," counter to its longstanding interpretation of the effective date regulation, as Ridgeview suggests. P. Br. at 7.

Under section 498.58, the ALJ, at the request of a party, may issue subpoenas to produce documents or witnesses if the subpoenas "are reasonably necessary for the full presentation of the case." In light of our determination that the documentation sought by Ridgeview did not relate to a material disputed issue, we conclude that the ALJ did not err in denying Ridgeview's request for an order to compel CMS to produce the documents Ridgeview requested or to issue subpoenas.

Accordingly, we conclude that Ridgeview has failed to show that there is a material dispute of fact precluding summary judgment in CMS's favor.

V. Conclusion

For the reasons discussed above, we sustain Ridgeview's September 21, 2012 effective date of Medicare participation.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member