Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Wesley Medical Center, LLC, d/b/a Galichia Heart Hospital
Docket No. A-17-62
Decision No. 2820
September 15, 2017

DECISION

Wesley Medical Center, LLC (Wesley), an acute care hospital doing business as Galichia Heart Hospital, appeals the January 17, 2017 decision of an Administrative Law Judge (ALJ) again ruling in favor of the Centers for Medicare & Medicaid Services (CMS) after remand by the Board. *Wesley Medical Center, LLC, d/b/a/Galichia Heart Hospital,* DAB CR4772 (2017) (ALJ Decision II), on remand from DAB No. 2580 (2014) (Board Remand Decision). The Board Remand Decision overturned a prior ALJ grant of summary judgment to CMS and instructed the ALJ to further develop the record and issue a new decision consistent with the Board's analysis. Board Remand Decision, overturning *Wesley Medical Center, LLC, d/b/a/Galichia Heart Hospital,* DAB CR3033 (2013) (ALJ Decision I). The ALJ sustained CMS's determination that the effective date of Wesley's Medicare participation is April 20, 2012, based on the recommendation of its accrediting organization (AO) after a survey conducted on April 17-19, 2012. The AO had earlier completed a survey and recommended an effective date of February 17, 2012, but decided to do another survey after CMS objected that the first survey did not constitute a full standard survey of a new provider. CMS considered Wesley a new provider because it did not accept assignment of the existing provider agreement when it acquired Galichia Heart Hospital. Wesley seeks to reinstate the February 17, 2012 effective date.

For the reasons discussed below, we reject Wesley's arguments and conclude the April 20, 2012 effective date is correct.

I. Legal Background

The applicable law is set out fully in the Board Remand Decision. For the convenience of the reader, we set out the relevant provisions briefly here. To participate as a provider in Medicare, a hospital must enter into a provider agreement with CMS. Social Security

Act (Act)[1] § 1866; 42 C.F.R. § 489.3.[2] Before CMS will accept the provider agreement, the hospital must meet requirements specified in the Act and regulations. Act §§ 1861(e), 1861(k), 1866; 42 C.F.R. Parts 482, 489. The Secretary 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. Act § 1866(b)(2).

Hospitals must either be certified as in compliance by a state survey agency, Act § 1864; 42 C.F.R. Part 488, or accredited by an AO under a CMS-approved accreditation program that all applicable conditions have been met or exceeded, after which CMS deems the hospital to be compliance. Act § 1865(a); 42 C.F.R. §§ 488.4-488.9. State agency surveyors follow protocols in the CMS State Operations Manual (SOM). CMS Pub. 100-07, App. A, *Survey Protocol, Regulations and Interpretive Guidelines for Hospitals*.[3]

Section 1865(a) of the Act (with emphasis added) provides:

> (1) If the Secretary finds that accreditation of a provider entity . . . [by a] national accreditation body demonstrates that all of the applicable conditions or requirements of this title (other than the requirements of section 1834(j) or the conditions and requirements under section 1881(b)) are met or exceeded—
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> > (A) in the case of a provider entity not described in paragraph (3)(B), the Secretary **shall** treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding; or
> >
> > (B) in the case of a provider entity described in paragraph (3)(B), the Secretary **may** treat such entity as meeting those conditions or requirements with respect to which the Secretary made such finding.

[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.

[2] This decision cites to the regulations in effect in 2012, when the surveys at issue were conducted and CMS issued its determination of the effective date of Wesley's Medicare participation.

[3] The SOM is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

> (2) In making such a finding, the Secretary shall consider, among other factors with respect to a national accreditation body, its requirements for accreditation, **its survey procedures**, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

As explained in our prior decision, subsection (a)(1)(B) above applies to skilled nursing facilities; while subsection (a)(1)(A) applies to all other provider entities including hospitals. Board Remand Decision at 6.

Section 489.13 provides that when a hospital is surveyed by an AO "whose program has CMS approval in accordance with section 1865 of the Act," and the hospital is found to meet all conditions of participation but has lower-level deficiencies (and no other federal requirements remain to be satisfied), the effective date is the date "a CMS-approved [AO] program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies" (absent a waiver request). 42 C.F.R. §§ 489.13(a)(1)(ii), 489.13(c)(2)(ii). When a provider changes ownership, "the existing Provider Agreement is automatically assigned to the new owner, effective on the date of transfer, unless the new owner rejects that assignment" by notifying CMS, in which case the existing provider agreement terminates. *Eagle Healthcare, Inc. v. Sebelius*, 969 F.Supp.2d 38, 40 (D.D.C. 2013) (citing 42 C.F.R. § 489.18(c)); 42 C.F.R. § 489.52.

II. Case Background

The full background is set out in the Board Remand Decision and only summarized here. On February 1, 2012, Wesley acquired Galichia Heart Hospital, an acute care hospital in Wichita, Kansas, and notified CMS it rejected assignment of the provider agreement. CMS Ex. 1. Wesley contracted with Det Norske Veritas Healthcare, Inc. (DNV) to conduct an accreditation survey. DNV is an AO approved by CMS for recognition as a "national accreditation program for hospitals seeking to participate" in Medicare for the period September 26, 2008 through September 26, 2012. 73 Fed. Reg. 56,588 (Sept. 29, 2008). DNV conducted a single-day survey on February 1, 2012, and found several lower-level deficiencies for which Wesley submitted a corrective action plan. CMS Ex. 2; P. Ex. 2.

DMV sent a letter dated March 28, 2012 to Wesley granting "full accreditation" to the hospital effective February 1, 2012, and recommending the hospital for "deemed status in the Medicare Program." CMS Ex. 2, at 1. The letter continued, "Please note that CMS makes the final determination regarding your Medicare certification and the effective date of Medicare participation in accordance with the regulations at 42 CFR 489.13." *Id.*

By letter dated April 4, 2012, DNV notified Wesley that, after consulting CMS, the effective date of accreditation was changed to February 17, 2012, the date of receipt of the plan of correction, as provided by 42 CFR § 489.13(c)(2)(ii)(A). P. Ex. 3, at 2; P. Ex. 5.

On April 16, 2012, CMS told DNV that the February survey was not a "full, standard survey," which CMS said was required because Wesley had chosen to reject assignment of the previous owner's provider agreement. CMS Ex. 8, ¶ 6; P. Pre-hearing Br. and Cross-motion for Summary Judgment at 4. On April 17-19, 2012, DNV conducted a second survey of Wesley and again found deficiencies for which Wesley submitted another plan of correction. P. Ex. 6. By letter dated May 2, 2012, DNV advised Wesley that its date of accreditation was April 20, 2012 when the plan of correction was received. Docket No. A-14-44, Transcript of May 22, 2014 Oral Argument (Tr.) at 4.

By letter dated May 11, 2012, CMS notified Wesley that CMS had determined that the effective date of Wesley's Medicare participation is April 20, 2012. P. Ex. 7. CMS issued a reconsideration determination upholding that effective date. CMS Ex. 10; P. Ex. 8. CMS determined that DNV was obligated to follow "survey protocols commensurate with those of state survey agencies" and to conduct a full, "initial" hospital survey because Wesley chose not to accept assignment of the seller's Medicare provider agreement. *Id.* CMS concluded that DNV's February 1, 2012 survey was insufficient under the State agency survey protocols. *Id.*, citing SOM, App. A.

Wesley requested a hearing to challenge the effective date determination on the grounds that CMS was obligated to accept the results of the February 2012 survey by DNV. The ALJ granted summary judgment in favor of CMS finding she had no jurisdiction over CMS's review of an AO survey. ALJ Decision I. On appeal of that decision, the Board determined that only a survey conducted by the AO under its CMS-approved program could form the basis of an effective date determination and remanded to the ALJ to determine whether such a survey underlay the effective date determination here. Board Remand Decision. The ALJ concluded that only the April 2012 survey constituted such a survey and therefore upheld CMS's effective date determination. ALJ Decision II. This appeal ensued.

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 the following: 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; 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*, https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html.

IV. Analysis

1. The record as developed now provides a sufficient basis for a final decision.

   A. *The basis of the Board Remand Decision and instructions on remand to the ALJ*

The Board's analysis rejected Wesley's contention that section 1865(a)(1) compelled CMS to always deem a hospital to be in compliance with the conditions of participation after an AO so recommends, regardless of the nature of the survey underlying the AO's accreditation decision. Board Remand Decision at 6. The Board recognized Congress' use of "shall" in section 1865(a)(1)(A) relating to deeming hospitals (as opposed to "may" in relation to skilled nursing facilities), but also concluded that, "[r]ead as a whole and consistent with the regulations, section 1865 provides for CMS to treat a provider as meeting the conditions of participation **where an AO survey follows the standards and procedures established under a CMS-approved accreditation program**." *Id*. (emphasis added).

Citing the statute, the applicable regulations, and the terms of CMS's approval of DNV as AO, the Board described the basis on which an AO survey may be considered to follow the standards and procedures of its CMS-approved program. *Id*. at 6-9. The AO must show the "comparability of survey procedures to those of State survey agencies[.]" 42 C.F.R. § 488.8(a)(2)(ii). CMS thus reviewed DNV's representation about "the composition of the survey team, [and] surveyor qualifications," comparing its "processes to those of State survey agencies," as well as its survey process, forms, and instructions to surveyors, as well as making "a detailed comparison of the organization's accreditation requirements and standards with the applicable Medicare requirements[.]" 42 C.F.R. §§ 488.4(a)(2)-(3), 488.6; 73 Fed. Reg. at 56,589 (DNV's notice of approval). Following the requirements in the regulations, CMS explained that DNV's approved "accreditation **program** meets or exceeds Medicare's requirements." 73 Fed. Reg. at 56,590 (emphasis added).

The Board concluded, however, that approval of an AO is limited to the accreditation program as reviewed and approved by CMS, although AOs often offer other accreditation programs to clients. Board Remand Decision at 7, citing Survey and certification memorandum, S&C-09-08, Att. A, I-8 (2008). "For Medicare participation purposes," to be eligible for deeming, a "facility must be accredited under the AO's CMS-recognized deemed status accreditation program." *Id.* "Thus," CMS stated in S&C-09-08, "it is not sufficient for a health care facility seeking Medicare participation to document that it is accredited; it must document that a CMS-recognized AO has accredited it **under its recognized deemed status program** and that the AO has recommended that CMS grant the facility certification via deemed status." *Id.* (emphasis added); *see also Oak Lawn Endoscopy,* DAB No. 1952 (2004) (concluding CMS reasonably interpreted similar language in section 498.13(d)(1) (2003) as limiting the applicability of deemed status determinations to approved programs).

Ultimately, the Board concluded that, "while subsection (a)(1)(A) of section 1865 uses the compulsory term 'shall' to direct the Secretary to treat a hospital accredited by an AO as meeting the conditions of participation, the language of section 1865 as a whole, consistent with the regulations, limits the applicability of deemed status treatment to providers whose accreditations are supported by surveys conducted in accordance with CMS-approved programs," and does not preclude CMS from "questioning or verifying whether a survey was conducted under an AO's approved program." Board Remand Decision at 8-9. Moreover, an AO may, and the Board noted apparently did in this case, conclude "that its survey did not follow the approved standards and procedures" and do another survey. *Id*. at 9. The Board also held that a full initial provider survey was indeed required when a hospital purchaser has not accepted assignment of the seller's provider agreement. *Id*. at 12.

The Board concluded, however, that the question of what effective date applied could not be resolved without determining when DNV completed the initial survey required under its CMS-approved program. The Board spelled out the questions to be resolved as follows: "1) What were DNV's approved accreditation program standards and procedures for an initial hospital survey during the period at issue? 2) When did DNV first conduct an initial accreditation survey of Wesley conforming to DNV's approved program? 3) When did DNV receive an acceptable plan of correction for the lower-level deficiencies found during that survey? 4) When did DNV issue a positive accreditation decision after receiving that acceptable plan of correction?" *Id.* The Board remanded the case with instructions to the ALJ to do the following:

- "[D]evelop the record to include evidence of DNV's CMS-approved accreditation program standards and survey procedures for the applicable period, including the protocols for an initial hospital survey[;]"

- "[E]valuate the evidence relating to the February 1, 2012 survey to determine whether that survey was conducted in accordance with DNV's approved survey standards and procedures for an initial hospital survey[;]"

- If it was not, "review the evidence of the April 2012 survey to determine whether the later survey was conducted in accordance with DNV's approved standards and procedures for an initial hospital survey[;]" and

- Obtain for the record a copy of the reported "letter from DNV dated April 20, 2012 stating that Wesley's accreditation date is April 20, 2012."

Id. at 14-15. The Board also explained that the survey, to be conducted in accordance with the applicable CMS-approved program, needed to be a full initial survey for new hospital applicants. *Id.* at 9-12.

B. *The development of the record on remand and ALJ Decision II*

The ALJ on remand received supplemental briefing and additional exhibits from both parties. ALJ Decision II, at 1 n.1. We conclude that the ALJ's findings regarding DNV's survey in February 2012, combined with our own review of the expanded record, are sufficient to allow us to now resolve the questions which we were not able to resolve before.

C. *Analysis of correct effective date*

The answers to the questions for which the case was remanded are:

1) DNV's approved accreditation program standards and procedures for an initial hospital survey during the period at issue are set out in CMS Supplemental Exhibit 1, and incorporate by reference policies and procedures from CMS's State Operations Manual. CMS Supp. Ex. 1, at 3; *see also* CMS Supp. Ex. 4.

2) DNV first conducted an initial accreditation survey of Wesley conforming to DNV's approved program in April 2012. The discussion of the February 2012 survey in ALJ Decision II clearly sets out the numerous discrepancies that demonstrate that it was not conducted as an initial survey under DNV's CMS-approved program whereas the April 2012 survey by DNV was so conducted. ALJ Decision II, at 4-6, and record citations therein.

3) DNV received an acceptable plan of correction for the lower-level deficiencies found during that survey on April 20, 2012. P. Ex. 6.

4) DNV issued a positive accreditation decision after receiving that acceptable plan of correction on May 2, 2012. P. Supp. Ex. 1.

As the ALJ correctly concluded, these facts support CMS's assignment of April 20, 2012 as the effective date for Wesley's participation in Medicare.

2. Wesley's arguments for seeking reversal of ALJ Decision II are unpersuasive.

We address first Wesley's attempt to relitigate issues that we resolved in our prior decisions. We then address why CMS reasonably concluded that the February 2012 survey was not conducted pursuant to DNV's CMS-approved program. Finally, we conclude that only the April 2012 survey and accreditation provide a basis for Wesley's effective date.

A. *CMS is not required to deem a hospital as meeting Medicare requirements where the AO survey was not conducted under its CMS-approved program*.

Wesley replays its argument, which we rejected in the Board Remand Decision, that the statute compels CMS to accept every recommendation of an AO to deem a hospital compliant and set the Medicare effective date.[4] RR at 8-19. In most of its contentions, Wesley focuses on rebutting its characterization of the ALJ Decision as holding that CMS has discretion without regard for the statutory language to reject AO recommendations for any reason and to require "unlimited" numbers of surveys. Whether that characterization properly describes the ALJ's holding, or not, it does not reflect the conclusion set out in the Board Remand Decision.

Contrary to Wesley's contentions and regardless of what the ALJ may have commented, the Board did not treat Wesley as if it were a skilled nursing facility rather than a hospital. *Contra* RR at 10. As the Board explained, the language in section 1865(a)(1)(B) applies to skilled nursing facilities certified by an AO, while hospitals certified by an AO are governed by section 1865(a)(1)(A). Board Remand Decision at 6. However, the Board held that Congress' use of the term "shall" as compared to "may" in

[4] Wesley also argues that the ALJ erred in reiterating her prior conclusion that she lacked jurisdiction to determine the correct effective date because she could not review whether CMS properly rejected the February 2012 AO survey. RR at 6-8. We need not reach that issue because, as we have concluded, the correct issues and necessary record were ultimately fully developed in the ALJ Decision, obviating any prejudice from the error.

the former must be viewed in the context of the language of the statutory section and implementing regulations as a whole. *Id*. at 8. So viewed, the Board concluded,

> Accordingly, while subsection (a)(1)(A) of section 1865 uses the compulsory term "shall" to direct the Secretary to treat a hospital accredited by an AO as meeting the conditions of participation, the language of section 1865 as a whole, consistent with the regulations, limits the applicability of deemed status treatment to providers whose accreditations are supported by surveys conducted in accordance with CMS-approved programs. Moreover, neither section 1865 nor any other section of the Act or regulations precludes CMS from questioning or verifying whether a survey was conducted under an AO's approved program. Nor does section 1865 preclude the AO itself from concluding that its survey did not follow the approved standards and procedures, undertaking a subsequent survey conforming to its approved program, or revising an accreditation determination to meet the requirements of the Act and regulations.

Id. at 8-9 (emphasis added). Thus, the Board recognized the distinction in language, and rejected Wesley's position that that distinction compels the Secretary to accept all recommendations regarding hospital surveys by any AO that has been through the approval process, holding instead that, "[r]ead as a whole and consistent with the regulations, section 1865 provides for CMS to treat a provider as meeting the conditions of participation where an AO survey follows the standards and procedures established under a CMS-approved accreditation program." *Id*. at 6 (emphasis added). CMS is therefore required to accept an AO recommendation only when that recommendation arises from a survey conducted in accordance with the provisions of the AO's CMS-approved program, which was not the case here. This is logical because only a survey using the approved program's procedures and standards can have been the subject of the finding by the Secretary that the AO program suffices to ensure Medicare requirements are satisfied.

Wesley's own assertions offer further support for the Board's analysis. As Wesley itself recognized, determining the "plain and unambiguous meaning of a statute" depends "not only on 'the language itself,' but also 'the specific context in which the language is used, and the broader context of the statute as a whole.' *Robinson v. Shell Oil Co*., 519 U.S. 337, 341 (1997). After all, '[a]mbiguity is a creature not of definitional possibilities but of statutory context.' *Brown v. Gardner*, 513 U.S. 115, 118 (1994)." RR at 9. Wesley emphasizes that "[t]he statute remains substantially the same today and means exactly what the Secretary said that it means when CMS renewed DNV's deeming authority in August 2012:

> If an accrediting organization is recognized by the Secretary of the Department of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, *any provider entity accredited by the national accrediting body's approved program would be deemed to have met the Medicare conditions*.

RR at 12, quoting 77 Fed. Reg. 51,537, 51,538 (Aug. 24, 2012) (emphasis added in RR). But the quoted language is precisely the same as the Board's conclusion – a hospital would be deemed to have met Medicare conditions and requirements whenever (but only when) it has been accredited by the AO's *approved* program, which includes the approved survey procedures.[5]

Wesley also contends that CMS initially complained only that DNV's first survey was not a "full" survey and that the position that the survey was not conducted under DNV's approved program is an impermissible post hoc rationalization. RR at 19, citing CMS Ex. 8 (Melanson Decl.). We disagree with this characterization of the record. The cited declaration spells out some of the characteristics of the first DNV survey that indicated to CMS that no full standard survey could have been conducted. CMS Ex. 8. These characteristics are mostly identical to those which established to CMS (and the ALJ) that the first DNV survey could not have been conducted under the CMS-approved program. *Compare* CMS Ex. 8 *with* ALJ Decision II at 4-5 and CMS Response to RR at 2-5. Moreover, prior Board decisions have permitted CMS to revise the basis for its actions during the appeal process so long as the affected party is provided with sufficient notice of the revised basis and an adequate opportunity to respond. *See, e.g.*, *Fady Fayad, M.D.*, DAB No. 2266, at 10-11 (2009*), aff'd, Fayad v. Sebelius*, 803 F.Supp.2d 699 (E.D. Mich. 2011); *Green Hills Enter., LLC*, DAB No. 2199, at 8 (2008). Here we do not believe that the basis for CMS's rejection of the first DNV survey significantly changed,

[5] Wesley points out that the overall Secretarial finding that an AO has a program capable of meeting Medicare requirements is made after a public notice process and argues that the statute therefore could not have intended that CMS review whether a particular survey was conducted in accordance with the approved program, since such an individualized decision would not involve public notice. RR at 14-16. Thus, says Wesley, the "Secretary is only permitted to evaluate the 'survey procedures' employed by an AO during the agency's initial review of the AO" with public participation. *Id*. at 15. The public notice process is provided for the initial review of whether an approvable program exists at the AO, but nothing in the statute implies that CMS is precluded from determining whether an accreditation action taken by the AO comported with its approved program. The requirement for a public notice process to be conducted by CMS before approving any AO program does not imply that CMS must undertake such a public notice process when determining whether a particular survey was conducted under the approved program.

given that the factual underpinnings remained effectively the same whether the inadequacies were framed in terms of not using the CMS-approved program for surveys or falling short of a full survey. But in any event, there can be no question but that Wesley had ample notice and opportunity to respond when the matter was remanded to the ALJ for full record development.[6]

We therefore next consider the results of that record development.

B. *The February 2012 DNV survey was not conducted in accordance with DNV's CMS-approved program and therefore could not form the basis to deem Wesley in compliance with Medicare requirements*.

The ALJ on remand took evidence as to whether the DNV surveys were conducted in accordance with the DNV accreditation program approved by CMS, and concluded that the February 2012 survey was not so conducted. ALJ Decision II at 4-5. As the ALJ pointed out, the DNV accreditation program for Medicare deeming explicitly states that CMS's SOM provides the "policies and procedures" for its "survey activities." CMS Supp. Ex. 1, at 3. Therefore, the ALJ compared the specific policies and procedures for the conduct of initial hospital surveys in the SOM with the procedures DNV conducted in its February 2012 survey to determine if that survey was conducted as part of DNV's CMS-approved program. We need not repeat the ALJ's analysis in detail, but merely highlight some of the discrepancies that make it evident that the CMS-approved program for initial hospital surveys (as opposed to annual re-accreditation) was not implemented during that survey. An initial hospital survey would be expected to involve two to four inspectors spending three or more days and would include a review of at least 30 records requiring three to six hours in itself. ALJ Decision II at 4-5. The February 2012 survey involved three inspectors spending just one day and reviewing at most fourteen records (possibly as few as four) over about one hour. *Id*. An initial hospital survey must cover "all departments, services, and locations," but DNV explicitly told its survey team to limit itself to review only a "sampling of the organization" and that it need not "visit all areas of the hospital." *Id*.[7]

[6] As mentioned in our first decision, the Board provided guidance even prior to oral argument in the first appeal to the Board that the parties needed to address the question of "whether DNV's February 1, 2012 survey was consistent with the survey procedures in its CMS-approved program." Board Remand Decision at 13 n.5, citing May 13, 2014 Guidance for Oral Argument in A-14-44.

[7] Wesley argues that the survey team is not required "to put its eye on every nook and cranny of a hospital during the physical tour [but only to] survey the locations where the hospital provides services." RR at 25. No one suggested that surveyors had to physically observe "every nook and cranny," but the language of the approved program clearly requires scrutiny of all the various departments and services for which the hospital bills, not merely a tour of the single location of the hospital facility. We cannot see how this expectation is compatible with instructing the surveyors that they need not look at all the departments and services but may merely review a sampling.

Wesley argues that the ALJ mistakenly referred to practices from the SOM because she thought that "DNV's reference to the non-binding CMS [SOM] transforms it into a mandate, even when its provisions are not specifically referenced—and indeed—inconsistent with those approved by CMS." RR at 20, citing ALJ Decision II, at 4-5. We disagree, for several reasons. First, DNV does not merely "reference" the SOM but rather, as quoted above, adopts the SOM's policies and procedures for DNV's own survey activities in the program it presented to CMS for approval. Second, the ALJ did not (and we do not) treat the SOM as a binding mandate, much less enforce any provisions inconsistent with what CMS approved. It is DNV which adopted the SOM for the limited purposes of shaping its survey activities. Furthermore, we did not remand for consideration of the nature of DNV's approved program in order to independently evaluate the quality of the surveys it conducted – as we have made repeatedly clear that is not within our jurisdiction. We remanded to determine if CMS could reasonably conclude that the February survey, whatever its merits, was not conducted under the approved program for Medicare deeming. For this purpose, we are not looking at whether DNV fell short in some respects of compliance with its program, but rather at whether the overall conduct of the survey was sufficiently discrepant from the initial hospital survey process set out in the approved program to support CMS reasonably reaching the conclusion that it did not support deeming Wesley in compliance.

Moreover, many of the characteristics of the February survey relied on by the ALJ, including those we highlighted above, depart not only from the SOM but also from the express provisions of the DNV program. In discussing survey teams in its application, DNV states that it decides the size and composition of a particular team, but notes that "[i]n general, a suggested survey team for a full survey of a mid-size (200 bed) hospital would include 3-4 surveyors who will be at the facility for three or more days." CMS Supp. Ex. 1, at 6. This is consistent with the expectations set out in the SOM. DNV goes on to state that every hospital survey team will include a nurse or physician with hospital experience, a life safety specialist, "as well as other surveyors who have the training and expertise needed to determine whether the facility is in compliance." *Id.* Wesley argues that the size of the team and length of the survey are merely suggested rather than required and that it was smaller than 200 beds (i.e., 99) [RR at 20], but we conclude that CMS could reasonably expect that a full hospital survey under the approved program would at least generally resemble the scale suggested by both the SOM and the application – not a one-day stop by three surveyors. While the program does describe small hospital surveys permitting inpatient records to be sampled for 10% (or a minimum of 10) patients in the average daily census, it also makes clear that these are to be mostly open records, are to include examples for each nursing unit, and are in addition to

samples of outpatient records. CMS Supp. Ex. 1, at 8. The surveyors are to conduct a "comprehensive review of care and services received by patients in the sample," to include observing a range of treatments and talking to patients and staff about their care as well as reviewing their records. *Id*. at 9. CMS could reasonably conclude that the scale of the survey DNV conducted in February 2012 could not have been designed to meet these expectations.

Apart from the specific discrepancies identified in ALJ Decision II (and others that can be discerned in a careful comparison of the February 2012 survey with the approved program), we find another compelling reason to conclude that the February 2012 survey was not conducted under DNV's approved program for certification subject to Medicare deeming. DNV's apparent response to CMS pointing out that Wesley was a new applicant for certification because it had not taken assignment of the provider agreement of the prior hospital operator and that therefore a full initial survey was required is revealing. CMS reported that, on receiving this information, DNV "responded by indicating its intention to conduct a full, standard survey of the hospital promptly." CMS Ex. 8, at 4 (Melanson Decl.). This response suggests that DNV did not dispute that it had misunderstood the situation and had not applied its approved program to survey new hospital applicants during the February survey. Moreover, Wesley presented no evidence, even on remand after the issue was plainly joined, that its AO disagreed with CMS's assessment or asserted that its first survey of Wesley did comply with its approved program for surveying new hospital applicants. We can reasonably infer from this failure on Wesley's part (given that Wesley selected and employed DNV as its AO) that the discrepancies noted by CMS and the ALJ did not reflect some exercise of discretion by AO under its approved program but rather DNV's misunderstanding about what the applicable program was in light of Wesley's refusal to accept assignment of the seller's Medicare provider agreement.

This inference is further bolstered by the striking fact, pointed out by the ALJ, that the entire February survey was conducted on Wesley's first day of operation of the facility. ALJ Decision II at 5, citing CMS Ex. 2 (DNV's noncomformity notes from the February survey, noting DNV's multiple observations about policies and processes that Wesley had only begun reviewing, updating or implementing which limited DNV's analysis). Wesley argues that no authority holds that a survey conducted on the first day of a new owner's operation is "improper." RR at 24. That argument again misses the point. We are not evaluating whether DNV's February survey was improper but whether DNV conducted the survey under its approved program for an initial hospital survey. We find that a single-day survey is even less likely to have been conducted as a full initial survey under DNV's CMS-approved program when that day is the first one on which the applicant provider operated any services in the facility.

In short, we agree with the ALJ that the February 2012 survey was not conducted under the CMS-approved program and therefore was not a basis for CMS to deem Wesley in compliance with Medicare for effective date purposes.

C. *Only the April 2012 full survey complied with DNV's CMS-approved program and therefore was a basis to set the effective date.*

In essence, what occurred in this case is that Wesley sought to avoid accepting the liabilities and responsibilities that attached to accepting assignment of the previous operator's provider agreement with CMS but to nevertheless compel CMS to treat its operation as continuous with that of the previous operator. Wesley reframes in this appeal the contention rejected in our prior decision that it was not required to undergo a new provider survey after refusing to accept assignment. Wesley Reply Br. at 8. According to Wesley's current account, CMS insisted on a full initial survey (rejecting an effective date based on the truncated February 2012 survey) as "brazen retaliation" for Wesley having exercised its "statutory right to seek a new provider number." *Id*. Wesley says that CMS should have no complaint about the survey being conducted on the new owner's first day of operation because a "hospital's operation, staff, and clientele do not automatically change simply because it is purchased by another entity." *Id*. at 7 n.2.

The requirement that a new owner be treated as a new provider is in no way punitive. On the contrary, the provision allowing for seamless Medicare billing after acquisition creates an exception to the normal process of obtaining a provider number and agreement. As we explained fully in the prior decision, the provision at section 489.18(c) of the regulations for automatic assignment of the provider agreement serves to allow "'the new owner to bill Medicare for services provided by the acquired facility as soon as the acquisition takes effect.'" Board Remand Decision at 10, quoting *Mission Hospital*, DAB No. 2459, at 6*; see also Charter Behavioral Health Sys., LLC,* 45 F.App'x. 150, 151 n.1 (3rd Cir. 2002) ("If the new owner elects to take an assignment of the existing Medicare Provider Agreement, it receives an uninterrupted stream of Medicare payments but assumes successor liability for overpayments and civil monetary penalties asserted by the Government against the previous owner" (citing 42 C.F.R. § 489.18(d)); *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1103-05 (8th Cir. 2000); *United States v. Vernon Home Health, Inc.*, 21 F.3d 693, 696 (5th Cir. 1994), *cert. denied*, 115 S.Ct. 575 (1994). By assuming the existing agreement, however, the new owner proffers some assurance to CMS that it will continue compliance with applicable Medicare requirements despite not making the initial demonstration of performance required of new applicants for certification or accreditation. *Id*., citing *Eagle Healthcare*, 969 F.Supp.2d at 39 ("If . . . the new owner rejects the assignment, the prior owner's Provider Agreement terminates and the new owner must seek to enter the Medicare program as a new applicant.") (citing *Vernon*, 21 F.3d at 696).

While a new owner may continue to operate in the same manner, with the same staff and clientele, Wesley identifies nothing that would require or ensure that the new owner must continue to operate as before. A new owner may instead, for example, revise policies and practices, reduce or alter staffing, physical plant, and services, or make any number of other changes that could impact compliance with Medicare requirements. Without assurances that the facility's compliance status is unchanged, CMS could not properly treat the new owner differently than other new applicants for provider enrollment.

As we also explained, Wesley was well aware of these consequences when it declined to accept assignment, both through constructive notice of the legal requirements and through actual communications with CMS prior to the acquisition.[8] *Id*. at 10-11, citing 75 Fed. Reg. at 50,401 ("Medicare will not reimburse the provider . . . for services it provides before the date on which the provider or supplier qualifies as an initial applicant."); 75 Fed. Reg. at 50,404 ("new owners of existing providers . . . who do not accept the seller's existing Medicare provider agreement . . . and who intend to continue Medicare participation are treated as new applicants to the Medicare program and must submit to the same process as any new provider . . . ."); *Delta Health Group Inc., v. Leavitt*, 459 F. Supp. 2d 1207, 1210 (N.D. Fla. 2006) (a new owner that refuses assignment must "go through the initial certification process, enter into a new provider agreement, and, if authorized, obtain a new provider number."); S&C-09-08, Att. A, VII-1 ("[F]or the new owner seeking Medicare participation via accredited deemed status, the AO must conduct a new survey of the entity, issue a new determination as to whether the facility satisfies all requirements for accreditation under the AO's Medicare deeming program, and make a new recommendation to CMS on certification of the facility via deemed status."). Indeed, CMS told Wesley in writing that its AO would have to "conduct [an] initial survey," which could not occur "until the new hospital is licensed by the state, . . . and a sufficient number of patients [had] been treated at the new hospital and [were] present in the hospital to demonstrate the new hospital's compliance with Federal hospital regulations." CMS Ex. 1, at 2 (Jan. 19, 2012 e-mail from D.F., CMS/CQISCO to S.B., HCA Division Director, Reimbursement); *see also* CMS Ex. 1, at 1 (January 23, 2012 e-mail to Wesley: "I want to continue to remind you that the DNV survey cannot take place before the date on which Wesley formally assumes responsibility for [the facility] and the staff at the new hospital has taken care of a sufficient number of patients to demonstrate its ability to meet Federal hospital regulations.").

[8] This fact alone demonstrates how inapposite is Wesley's reliance on a case in which a court found it improper for CMS to require repayment of Medicare claims by a home health provider for reasons that, according to the court, were not contained in the regulations in effect at the time of the services but only in those issued years later. Wesley Reply Br. at 9, citing *Caring Hearts Personal Home Servs., Inc. v. Burwell*, 824 F.3d 968 (10th Cir. 2016). We see no analogy from that case to Wesley's attempt to evade regulatory requirements for new owners declining assignment of existing provider agreements by obtaining a truncated survey which its own AO does not defend as a full initial survey under its CMS-approved program.

We have no evidence in the record as to whether Wesley shared this guidance with its AO prior to the February 2012 survey. The fact that the survey took place on the first day of operation certainly raises questions about whether sufficient patients had been treated under the new management to demonstrate its ability to maintain compliance.[9] In any case, as explained above, CMS could reasonably conclude that the February 2012 survey viewed as a whole did not constitute a full survey of a new hospital applicant under DNV's approved program.

It is undisputed that the second accreditation survey on April 17-19, 2012, was conducted under the CMS-approved program. It is also undisputed that on April 20, 2012, DNV accepted Wesley's plan of correction for lower-level deficiencies found during that survey. As we requested in our prior decision, Board Remand Decision at 14-15, Wesley supplemented the record on remand with a copy of the letter from DNV dated April 20, 2012 stating that Wesley's accreditation date is April 20, 2012 and recommending that CMS deem Wesley in compliance with Medicare requirements as of that date. P. Supp. Ex. 1.

VI. Conclusion

Based on the foregoing analysis, we conclude that the ALJ did not err in upholding CMS's determination that Wesley's effective date of Medicare enrollment is April 20, 2012. ALJ Decision II at 6.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member

[9] Contrary to Wesley's contentions, CMS's concern about the survey occurring on the first day of operation does not represent imposition of some novel "standard" of required survey timing [Wesley Reply Br. at 7 n.2.], but rather reflects a further basis for concluding that DNV likely did not understand the February 2012 survey to be one meant to assess a new applicant's compliance. CMS questioned, for example, whether reviewing patient records on the morning of the first day could disclose the effectiveness of the new owner's processes, a point no different than questioning whether the first handful of patient records created by a new hospital's first morning could give a meaningful sample for compliance review. CMS Br. at 4-5.