Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: September 3, 2009
Family Health Services of Darke County, Inc.,	
Petitioner,	Civil Remedies CR1862 App. Div. Docket No. A-09-45
	Decision No. 2269
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Family Health Services of Darke County (Family Health), a Federally Qualified Health Center (FQHC), appealed the November 14, 2008 decision of Administrative Law Judge (ALJ) Steven T. Kessel in Family Health Services of Darke County, Inc., DAB CR1862 (2008) (ALJ Remand Decision), and his February 10, 2009 Revised Decision (ALJ Revised Decision).[1] The Centers for Medicare & Medicaid Services (CMS) appealed the ALJ Revised Decision.

Section 491.5(a)(3)(iii) of 42 C.F.R. requires that, if FQHC Medicare "services are furnished at permanent units in more than one location, each unit is independently considered for . . . approval as an FQHC." Prior to 2002, Family Health operated a

[1] The ALJ issued both decisions under Docket No. C-08-366.

CMS-approved FQHC in one location.[2] In 2002, Family Health added a second permanent unit in an additional location; in 2004, it added a third permanent unit in a third location. At issue here are the effective dates for FQHC Medicare participation for the second and third locations. In the ALJ Remand Decision, the ALJ upheld CMS's determination adopting an effective date of September 8, 2005 for both additional locations. In the Revised Decision, the ALJ modified the effective dates to June 30, 2005 (second location) and August 29, 2005 (third location).

Family Health argues that the ALJ should have adopted earlier effective dates, specifically December 19, 2002 and April 1, 2004 for the second and third locations respectively. Petitioner Request for Review (P. RR) at 2. CMS argues that the ALJ was correct in originally upholding September 8, 2005 as the effective date and should not have modified that date. CMS RR at 2.

Family Health previously appealed this dispute to the Board. See DAB No. CR1518 (ALJ's initial decision) and DAB No. 2092 (Board's remand decision). In DAB No. 2092, the Board remanded the case because the initial record before the ALJ was insufficient to support the ALJ's summary judgment upholding an effective date of September 8, 2005. The Board directed the ALJ to develop the record, and he did so.

Based on the developed record, we conclude that the ALJ has now correctly determined that Family Health's arguments in support of earlier effective dates are without merit and that CMS did not abuse its discretion in adopting September 8, 2005 as the effective date for the two locations. We base this conclusion on the following considerations.

- The governing regulations provide that the effective date of approval for an FQHC is the date on which CMS accepts a

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[2] Family Health qualifies as an FQHC under section 1861(aa)(4) of the Social Security Act because it receives a grant under section 330 of the Public Health Service (PHS) Act (42 U.S.C. § 254b). See also 42 C.F.R. § 405.2401(b) (definition of FQHC). Section 330 grants are administered by the Health Resources and Services Administration (HRSA), a component of the Department of Health and Human Services.

signed agreement which assures that the FQHC meets all Federal requirements.

- Prior to 2005, Family Health did not request CMS approval for these two permanent units as FQHC Medicare locations or provide the regulatory assurances of compliance with FQHC Medicare requirements.

- On receipt of these requests and assurances in 2005, CMS followed its established process for approving FQHC locations. The effective date of participation resulting from this process was September 8, 2005.

- In light of Family Health's failure to request CMS approval or make assurances of FQHC compliance prior to 2005, Family Health's pre-2005 dealings with CMS about the locations are not, as Family Health alleged, grounds for concluding that CMS abused its discretion by declining to approve earlier effective dates of participation.

We therefore conclude that the effective date is September 8, 2005, as the ALJ originally determined (in the ALJ Remand Decision), and reverse his determination (in the ALJ Revised Decision) of effective dates of June 30, 2005 and August 29, 2005.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address *de novo*. Lebanon Nursing and Rehabilitation Center, DAB No. 1918 (2004). Summary judgment is appropriate if there are no genuine disputes of fact material to the result. Everett Rehabilitation and Medical Center, DAB No. 1628, at 3 (1997). Family Health identifies no disputed material facts on appeal before the ALJ or the Board. See ALJ Remand Decision at 2, n.2. The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous.

Background

FQHC Medicare reimbursement is paid on a per-visit basis by a Medicare fiscal intermediary. CMS Ex. 1, at 3, citing 42 C.F.R.

§ 405.2460 et seq.[3] The fiscal intermediary calculates an FQHC's per-visit reimbursement rate from costs reported on the FQHC's annual cost report.[4] CMS Ex. 1, at 4; 42 C.F.R. § 405.2462 et seq. During the period at issue, CMS's national FQHC fiscal intermediary was United Government Services (UGS).

An entity is eligible for Medicare reimbursement for FQHC services as of "the date on which CMS accepts a signed agreement which assures that the . . . FQHC meets all Federal Requirements." 42 C.F.R. § 489.13(a)(2)(i); see also 42 C.F.R. § 405.2434(b). CMS originally approved Family Health as an FQHC in the Medicare program effective October 1, 1991. CMS Ex. 1, at 4. At that time, Family Health was located at 5735 Meeker Street, Greenville, Ohio. Id. In 2002 and 2004, Family Health added two additional locations to its operation, first at Central Avenue, Greenville, Ohio, and then at North Main Street, Arcanum, Ohio. Petitioner (P.) Ex. 1, at 2-4. Thereafter, Family Health included the costs from these locations in its FQHC cost reports submitted to UGS, claimed FQHC Medicare reimbursement for patient visits at the two locations, and was reimbursed for those visits. CMS Ex. 1, at 4.

In a UGS audit of Family Health's cost report for the fiscal year ending (FYE) March 31, 2003, the auditor discovered that "Family Health had included site visits from non-FQHC certified sites on its cost report for the 5725 Meeker Road location." CMS Ex.29, at 2. UGS subsequently determined that Family Health had included visits from the two unapproved sites at issue in its cost reports for FYE March 31, 2004, 2005, and 2006. Id. In January 2005, "a UGS auditor notified Family Health that while it

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[3] Citations of exhibits are to the record in C-08-366.

[4] Fiscal intermediaries are CMS contractors that process Medicare Part A claims; carriers are CMS contractors that process Part B claims. CMS Ex. 18, at 6. Generally, Part A "provides basis protection against the costs of hospital, related post-hospital, home health services, and hospice care . . . ." 42 U.S.C. § 1395c. FCQH services are funded under Medicare Part B. 42 U.S.C. § 1395k(a)(2)(D). However, "[s]ince payment for services covered under the FHQC benefits is made on a cost-related basis, [FQHC] claims are processed by a fiscal intermediary." 61 Fed. Reg. 14,640, 14,656 (April 3, 1996).

was permissible to file one cost report for multiple FQHC locations, it was necessary to file a CMS 855A application (855A) for the Central Avenue and Main Street locations." P. Ex. 2, at 1.

In May 2005 and successive months, Family Health filed form 855A and other documents requested by UGS needed to complete the applications for the two locations. CMS Exs. 2, 6. On September 19, 2005, CMS notified Family Health that it had "accepted [Family Health's] request for approval as a [FQHC] in the Medicare program" for the Central Avenue and North Main locations and that the "effective date of participation is September 8, 2005." CMS Exs. 4, 8.

Family Health requested a hearing before an ALJ, arguing that the effective dates should be at least as early as the dates CMS began reimbursing it for FQHC services at these locations.

CMS moved for summary disposition, which Family Health opposed. The ALJ granted CMS's motion, upholding CMS's determination of September 8, 2005 as the effective date for Medicare participation for the two locations. DAB No. CR1518, at 1.

Family Health appealed the ALJ's decision to the Board. The Board remanded the case to the ALJ because he erred in failing to consider whether undisputed material facts alleged by Family Health could support earlier effective dates and because he erred in concluding that the regulations at issue vested non-reviewable discretion in CMS to set effective dates for FQHC approval for Medicare FQHC reimbursement. DAB No. 2092, at 2. We also noted that --

> [t]he ALJ's review in this case was materially hampered by the fact that CMS, in its initial filing and prior to moving for summary disposition, did not respond to the factual assertions and arguments made by Family Health in its Request for Hearing. After Family Health repeated these arguments in its brief in opposition to CMS's motion for summary disposition, the ALJ specifically requested CMS to file a reply brief to address "arguments raised by Petitioner which were not addressed by CMS in its initial brief" (letter transmitted August 17, 2006). CMS did not do so.

Id. at 5. Moreover, on appeal before the Board, CMS did not file a brief. Id. at n.5. Therefore, prior to the Board's remand of this case, CMS never disputed the facts alleged by Family Health and filed no response to Family Health's arguments concerning the significance of those facts. In addition, relevant documents were not then in the record.

In response to the Board's remand, the ALJ remanded the case to CMS pursuant to 42 C.F.R. § 498.78(b). Order dated June 15, 2007. On January 17, 2008, CMS issued a "Reconsidered Decision for Initial Medicare FQHC Certification Effective Dates Following Remand from ALJ" in which it "determined that the effective date of participation of [the two locations] is September 8, 2005." CMS Ex. 1, at 2.

Family Health appealed CMS's reconsideration decision to the ALJ. The ALJ initially upheld CMS's determination of September 8, 2005. ALJ Remand Decision at 1. Thereafter, he issued a Revised Decision adopting effective dates of June 30, 2005 and August 29, 2006, the respective dates Family Health filed CMS Attestation Statements for the two locations. ALJ Revised Decision at 1. Family Health appeals both of these decisions; CMS appeals the ALJ Revised Decision.

Analysis

For the following reasons, we determine that the effective date for FQHC Medicare participation for both locations is September 8, 2005.[5]

1. CMS approved the two locations as Medicare-eligible FQHC sites pursuant to applicable regulations and its published FQHC approval process. The effective date resulting from this process was September 8, 2005.

In 2005, Family Health requested CMS approval of these two locations as FQHC Medicare sites by filing 855As and Attestation

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[5] We have fully considered all arguments raised by Family Health on appeal and reviewed the full record, regardless of whether we have specifically addressed particular assertions or documents in this decision.

Statements for each location.[6] On receipt of Family Health's 2005 requests, CMS followed its established process for approving FQHC locations and the effective date resulting from this process was September 8, 2005. Below we discuss the relevant regulations and CMS policies, and their application to the facts of this case.

Subpart A of Part 491 of 42 C.F.R. establishes "FQHCs Conditions for Coverage" for FQHC Medicare reimbursement. Section 491.5(a)(3)(iii) states:

> *Permanent unit in more than one location.* If . . . services are furnished at permanent units in more than one location, each unit is independently considered for . . . approval as an FQHC.

Family Health does not dispute that the Central Avenue and North Main locations are permanent units that required separate approval by CMS. See P. RR at 5.

Sections 405.2430 and 405.2434 address the FQHC approval requirements and process. For approval, an entity is required to "assure[] CMS that it meets the Federally qualified health center requirements specified in this subpart and part 491, as described in 405.2434(a)." 42 C.F.R. § 405.2430(a)(1)(ii). When this and other section 405.2430(a)(1) requirements are met, "CMS sends the entity two copies of the agreement. The entity must sign and return both copies of the agreement to CMS." 42 C.F.R. § 405.2430(a)(3). "If CMS accepts the agreement filed by the [FQHC], CMS returns to the center one copy of the agreement with the notice of acceptance specifying the effective date (see § 489.11), as determined under § 405.2434." 42 C.F.R. § 405.2430(a)(4).

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[6] As discussed in subsequent sections of the decision, Family Health took other actions in reference to these locations prior to 2005 and represents that it believed that these actions were attestations and requests for CMS approval of the locations as FQHC sites. However, CMS has now articulated reasonable grounds for treating the pre-2005 actions as inadequate to constitute requests and attestations for FQHC approval.

Section 405.2434(b) provides that the effective date of this agreement (with one irrelevant exception) is "the date CMS accepts the signed agreement, which assures that all Federal requirements are met." Similarly, section 489.13(a)(2)(i) provides that, for an agreement with an FQHC, the effective date "is the date CMS accepts the signed agreement which assures that the . . . FQHC meets all Federal requirements."

Section 405.2434 sets forth standards for the "content and terms of the agreement." CMS treats a document titled "Attestation Statement for Federally Qualified Health Centers" (Attestation Statement) (set forth in Exhibit 177 of CMS's State Operations Manual (SOM)) as the agreement required by section 405.2430. CMS Ex. 22, at 2-3 (section 2826B of SOM as of May 21, 2004); CMS Ex. 21, at 2 (section 2826 of SOM as of March 14, 2002); CMS Ex. 7 (Attestation Statement).

As the national FQHC Medicare fiscal intermediary, UGS was responsible for initially processing documents for FQHC-approval requests.[7] CMS Ex. 1, at 2. In 2005, Family Health requested CMS's approval of the additional locations as FQHCs by filing with UGS 855As, Attestation Statements, and other supporting documents that UGS requested. CMS Exs. 2 and 6. The last requested documents were submitted September 6, 2005. CSM Exs. 2, at 3; and 6, at 3. UGS reviewed and verified Family Health's documentation and, on September 8, 2005, informed CMS that it had "found no evidence to indicate the application should be denied."[8] CMS Exs. 2, at 1, and 6, at 1. CMS stated that it

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[7] Family Health argues that CMS has improperly "delegated" the FQHC approval process to the fiscal intermediary. P. RR at 14. This argument is without merit. The record shows that, while the fiscal intermediary processes the documents and verifies facts required for the FQHC determination, CMS makes the determination. See CMS Exs. 4, 8.

[8] UGS stated in its September 8, 2005 letters to CMS that it had enclosed copies of the completed 855A applications and "supporting documentation" and that it had verified the data elements on the application; checked individuals and organizations on the application to verify that none were currently sanctioned, excluded, or the subject of a pending fraud review; and verified the location of the applicant and officers and ownership. CMS Exs. 2, at 1 and 6, at 1. CMS also

(Continued. . .)

"routinely uses the date of [UGS's] recommendation letter as the effective date so that any delay by CMS in reviewing the application will not delay the FQHC's admission into the Medicare program." CMS Ex. 1, at 2; see also CMS Ex. 22, at 5 (CMS State Operations Manual stating: "If the application is complete and all requirements have been met when the [Regional Office] reviews the application, the [Regional Office] will use the date of the intermediary's recommendation letter as the effective date.") CMS, therefore, used the September 8, 2005 date of UGS's recommendation as the effective date for Family Health's two additional locations. Id.

Family Health has not shown any error in CMS's processing of its 2005 applications for approval but argues that CMS abused its discretion by not treating earlier events as sufficient to constitute applications for approval of the additional sites as FQHC permanent units. We explain next why we reject that argument.

2. The ALJ correctly found that CMS did not abuse its discretion by refusing to recognize Family Health's or CMS's actions prior to 2005 as bases for approving earlier effective dates.

Family Health makes a number of arguments in support of its position that CMS abused its discretion when it refused to approve earlier effective dates. These arguments are based on events occurring before 2005. In the ALJ's and the Board's prior reviews of this case (DAB No. CR1518 and DAB No. 2092), CMS did not dispute facts relied by Family Health or address their significance. As discussed below, the subsequent development of the record shows why these facts provide no grounds for altering CMS's effective date determination of September 8, 2005.

Family Health relies on the following undisputed facts. Family Health added the locations at issue to its operation after local

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(Continued. . .)

represents that UGS "obtained information from [HRSA] indicating that" the two locations "were given FQHC status by HRSA in November 2002 and March 2004 respectively." CMS Ex. 1, at 2.

doctors, in 2002 and 2004, asked to join Family Health. Family Health did not have room at its Meeker Road facility for the doctors, so the doctors remained in their respective practice locations on Central Avenue and Main Street. For each location, Family Health obtained a change of scope to its PHS grant. After consulting with its Medicare Part B carrier, Palmetto GBA (Palmetto), regarding the first additional location, Family Health filed 855Bs and 855Rs with Palmetto for the doctors practicing at the locations; included the costs of the locations in its annual FQHC cost reports filed with UGS; sought FQHC Medicare reimbursement for visits of Medicare beneficiaries to the locations; and was reimbursed for FQHC services at these locations on a per-visit basis.

As explained below, these facts do not support Family Health's position. Instead, these facts and the evidence developed on remand show that, prior to 2005: (1) Family Health did not request CMS's approval of these locations as FQHC sites; (2) Family Health did not submit the required assurances to secure approval of the sites; (3) CMS did not approve these locations as FQHC sites; and (4) Family Health did not reasonably rely on advice from CMS about securing such approvals.

a. Failure to request approval

Family Health asserts that it "request[ed] approval of the Central Avenue and Main Street locations as FQHCs" in 2002 and 2004 by submitting 855Bs and 855Rs to Palmetto, its Medicare carrier, and that CMS abused its discretion in declining to treat Family Health's submissions as requests for approval and a basis for accepting, prior to 2005, an FQHC agreement with it for these locations. P. RR at 9, 11; P. Reply at 5. Citing 42 C.F.R. § 424.510(a), Family Health stresses that, prior to 2006, CMS regulations did not require entities to use any particular CMS form in requesting approval of FHQCs or FHQC locations.[9] P.

[9] Section 424.510(a), which was not effective until 2006, provides that "providers and suppliers must submit enrollment information on the applicable enrollment application."

RR at 1, 3 at n.1, and 8. The ALJ rejected similar arguments, concluding that filing of an 855A was required.[10] ALJ Remand Decision at 4.

A review of the content and purpose of the 855B and 855R and Family Health's use of the forms shows that the ALJ correctly rejected Family Health's position.

- Both forms relate to Part B reimbursement paid by Medicare carriers; they are unrelated to FQHC Medicare reimbursement paid by fiscal intermediaries. CMS Ex. 1, at 3-4; see also 61 Fed. Reg. at 14,655.

- The 855B is titled "Application for Health Care Suppliers that will Bill Medicare Carriers." CMS Ex. 20, at 1. FQHCs use the 855B to enroll for Part B reimbursement paid by carriers for non-FQHC services.[11] CMS Ex. 1, at 3; 61 Fed. Reg. 14,640, at 14,655 (April 3, 1996). Form 855B instructs FQHCs to apply for such carrier-paid

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[10] We do not review the ALJ's conclusion, since, as discussed herein, we find that Family Health, prior to 2005, never requested FQHC approval for these locations by any means, much less by filing an 855A. We note, however, that the ALJ's conclusion seems to have been based in part on his assertion that the 855A itself "addressed . . . specific [FQHC] participation requirements." ALJ Remand Decision at 4. The ALJ cites no support in the record for this assertion. See CMS Ex. 18 (blank CMS 855a).

[11] In the preamble to the federal regulation adopting the FQHC rules, CMS discussed "the billing mechanism for non-FQHC services" provided by FQHCs. 61 Fed. Reg. 14,640, at 14,655. (Examples of such services include physician visits of hospitalized FQHC patients or the technical component of x-ray services. Id. at 14,646.) CMS stated that --

> [i]n order to bill for non-FQHC services a clinic must have a separate Part B billing number. The FQHC must obtain the billing number from the Medicare Part B carrier.

Id. at 14,655.

reimbursement as a "Multi-Specialty Clinic." CMS Ex. 20, at 10.

- The 855R is titled "Medicare Federal Health Care Benefits Enrollment Application - Reassignment of Medicare Benefits." CMS Ex. 1, at 3. The 855R is used to reassign Medicare reimbursement. Here, the doctors joining Family Health used 855Rs to reassign their rights to Part B payments to Family Health. Id.

Based on these considerations, the ALJ correctly concluded that Family Health's filing of 855Bs and 855Rs did not constitute requests for approval of these locations as FQHCs and that CMS did not abuse its discretion in declining to treat them as such. ALJ Remand Decision at 5, 7-10. The 855Bs and 855Rs are unrelated to any aspect of CMS's process for approving FQHC locations. Moreover, Family Health filed the forms with its Medicare carrier, Palmetto, which it knew or should have known had no role in processing requests for approval of FQHC locations. Finally, Family Health points to nothing on these forms that would have given Palmetto any reason to believe that Family Health was requesting anything beyond approval to bill Palmetto for non-FQHC Part B services.

Family Health relies on the case of Harriett Cohn Center, DAB No. 1817 (2002), which considered 42 C.F.R. § 489.13(a)(2)(i) in the context of certification of a community mental health center. Family Health argues that, under Cohn, CMS should have approved these locations as of the dates Family Health filed the 855Bs and 855Rs. P. RR. at 11-12. We disagree and find the facts in Cohn were materially different. Family Health's reliance on Cohn is based on its assertion that Family Health actually had "supplied CMS with provider agreements, including attestations . . . effective 12/19/02 and 4/01/04." Id. at 11, citing the 855Bs and 855Rs filed for these locations. As discussed above, these 855Bs and 855Rs were not agreements or attestations relevant to qualifying for FQHC reimbursement.

Family Health also argues that, by relying on Family Health's failure to file 855As, CMS violated the Administrative Procedure Act, 5 U.S.C. §§ 551 et seq. P. RR at 11-13. Family Health represents, that prior to 2006, CMS "established a practice of accepting FQHC requests without requiring submissions of a CMS

855A . . . ." and that CMS cannot change that practice without engaging in notice and comment rulemaking.[12] Id. at 12. This argument has no merit. First, Family Health cites no support in the record for its representation about CMS's practice prior to 2006, and CMS denies it. See CMS Response at 29, citing CMS Ex. 21, at 7. Second, as discussed above, nothing in the record on remand suggests that, at the time it filed the 855Bs and 855Rs, Family Health was requesting CMS's approval for these locations as FQHC units. Thus, this is not a matter of CMS's arbitrarily refusing to accommodate Family Health's inadvertent use of a "wrong form." Rather, in filing 855Bs and 855Rs Family Health used the right forms and filed them with the right Medicare contractor for completely different purposes (i.e., qualifying for non-FQHC Part B reimbursement and reassigning physician payments). Moreover, Family Health has never explained why, if it considered these forms to be requests for FQHC approval of its additional locations, it did not submit them to UGS, its fiscal intermediary, to which Family Health submitted its FQHC cost reports. Nor does Family Health represent that it ever asked CMS or UGS about how to obtain FQHC approval for these locations. Given these circumstances, CMS can hardly be said to have abused its discretion in declining to treat these filings as requests for FHQC approval.

b. Failure to provide assurances

Section 405.2430(a)(1)(ii) of 42 C.F.R. requires an entity applying for FQHC approval to "assure[] CMS that it meets the Federally qualified health center requirements specified in this subpart and part 491, as described in 405.2434(a)." Family Health argues that it gave such assurances prior to 2005. P. RR at 5-6, 9. It relies on the general assurances of compliance with Medicare requirements in the 855Bs and 855Rs and the FQHC Attestation Statement that it executed in 1992 when it first applied for FQHC Medicare reimbursement. P. RR at 5-6, 9. Family Health asserts that its 1992 Attestation Statement should be sufficient because none of the Attestation Statements were

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[12] Family Health incorrectly cites DAB No. 2092 in support of this assertion. P. RR at 12, citing DAB No. 2092 at 12, n.10. The Board stated only that the FQHC approval process included "a request by the FQHC 'to participate in the Medicare program.'" DAB No. 2092, citing 42 C.F.R. § 405.2430(a).

"site specific," i.e., identified the address of the location on the Statement. P. RR at 6.

The ALJ correctly rejected Family Health's position. ALJ Remand Decision at 7-10. FQHCs are subject to specific unique requirements set out in 42 C.F.R. Part 405, subpart X, and Part 491.[13] Unlike most other entities that are reimbursed on the basis of cost reports, an FQHC is approved by CMS on the basis of the FQHC's self-attestation to CMS that it meets the applicable requirements, not on the basis of surveys to confirm compliance. 61 Fed. Reg. at 14,641; CMS Ex. 21, at 2 (SOM § 2825 stating, "The [State Agency] survey and certification process does not apply to FQHCs."). CMS's regulations reflect the critical role of FQHC assurances by both requiring them and adopting standards for them. 42 C.F.R. §§ 405.2430(a)(1)(ii) and 405.2434(a). In the SOM, CMS provided FQHCs with specific assurance language and required the assurances to be made under penalty of perjury. CMS Ex. 19, at 6. The Attestation Statement set out in the SOM provides:

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

This language is clearly designed to ensure that the person giving the assurances is knowledgeable about FQHC requirements and has considered whether the location at issue meets those requirements. CMS therefore reasonably informed Family Health

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[13] Requirements in 42 C.F.R. 405, subpart X address the FQHC agreement, charges and refunds to beneficiaries, treatment of beneficiaries, termination of the agreement, reinstatement, public notice, change in ownership, scope of services, and preventive primary services. Part 491 of 42 C.F.R. addresses physical plant and environment requirements, organizational structure, staffing, provision of services, patient health records, and program evaluation.

in its reconsideration letter that CMS does not "consider [the 855B assurance] specific enough to assure CMS that an FQHC meets, and will continue to comply with, the FQHC requirements specified in 405 Subpart X and Part 491, as described in 42 C.F.R. § 405.2434(a)." CMS Ex. 1, at 4.

Similarly, CMS reasonably declined to rely on the Attestation Statement Family Health executed in 1992 for its Meeker Street location. As CMS asserts, "[a] supplier cannot attest that a site location that is not yet in existence is in compliance with FQHC requirements." CMS Response at 21. Moreover, the fact that none of the Attestation Statements identified a particular site is irrelevant since each was filed in conjunction with a request for the approval of a specific location.

Family Health argues that the 1992 Attestation Statement should be sufficient because it includes an assurance that Family Health will report "any change that results in noncompliance." P. Response at 9, citing P. Ex. 5, at 2. Family Health reasons that the 1992 assurance would have required it, as the entity operating all of the locations, to report noncompliance at any of its sites. This point is not persuasive. CMS is responsible for seeing that all FQHC sites are in compliance with Medicare requirements. The preamble to the FQHC rules states that section 491.5(a)(3)(iii) requires separate assurances for each location and explains CMS's reasons for requiring site-specific approvals. 61 Fed. Reg. at 14,641 (stating "each site must independently attest to meeting the [Medicare] conditions.") Moreover, in the 1992 letter explaining how to apply to qualify as an FQHC, CMS (then the Health Care Financing Administration) explained to potential FQHCs that the entity would have to file specific forms including the enclosed "attestation statement." P. Ex. 5, at 8. It went on to explain that -

> [o]ne of each of these forms must be completed for each entity (site) that wishes to be approved as an FQHC. This is true regardless of whether the entity is operated as part of . . . a group of entities (i.e., multiple clinic sites).

Id. Family Health does not deny that it received this letter (which it submitted for the record) prior to the time at issue here.

c. Lack of approval by CMS

Citing numerous documents, Family Health asserts that the ALJ erred in concluding that CMS had not approved the locations as FQHCs prior to 2005. P. RR at 4, 10. The ALJ explained why those documents did not constitute acceptance by CMS of an FQHC agreement with Family Health. ALJ Remand Decision at 7-9. Briefly, those documents and reasons include the following.

- Family Health relies on documents showing that HRSA modified the scope of its PHS grant to include these locations. See, e.g., P. Exs. 7, 10, 14, 16; CMS Exs. 2, at 32; 6, at 31. As the ALJ stated, these Changes in Scope were requested by Family Health for the purpose of "justif[ing] the inclusion of each of the two locations within the PHS grant." ALJ Remand Decision at 7. He also pointed out that the change requests were filed with and made by HRSA, not CMS. Id. The changes were a precondition to the locations' FQHC Medicare eligibility but not part of the CMS approval process itself.[14]

- Family Health relies on documents associated with its filing of 855Bs and 855Rs with Palmetto, including Palmetto's notices that Family Health had been given a "Medicare group provider identification number (PIN)" as a "Multi-Specialty Group" for the two locations. P. Exs. 13, 15. As discussed above, Palmetto approved only Family Health's receipt of Part B reimbursements for non-FQHC

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[14] The HRSA Change in Scope checklist, which FQHCs use to obtain such changes, specifically states:

> If the health center receives cost-based reimbursement from Medicare by virtue of being a FQHC, the health center will notify the CMS Regional Office regarding any approved site changes.

P. Exs. 7, at 11; 14, at 12. For both sites, Family Health asserted that it would do so. Id.; see also CMS Ex. 23. Yet Family Health offered no evidence that it did so. See, e.g., P. Ex. 1, at ¶¶ 6-10 (stating that Family Health assured HRSA that it would notify the CMS Regional Office of the changes but describing only its filing of 855Bs and 855Rs with Palmetto.)

services. Palmetto had no authority to process FQHC approvals and no reason to think that Family Health was requesting FQHC approval. Family Health should have known that UGS, the national FQHC fiscal intermediary, was the contractor with authority to process FQHC approvals.

- Family Health relies on correspondence with UGS about its cost reports. The first letter, dated September 26, 2003, informs Family Health that UGS has found from its "initial review" that Family Health's FYE03 cost report "meets the minimum standards for acceptability" and that it will contact Family Health if it needs additional information. P. Ex. 17. The second letter, dated November 3, 2003, also concerns UGS's "initial review" of the FYE03 cost report and informs Family Health that the "tentative settlement amount for this period" is $13,000 payable to Family Health. P. Ex. 18. Both of these letters concern "initial reviews" and "tentative settlements." Neither indicates that UGS or CMS has determined that the costs identified in the FYE03 cost report have been finally approved, much less that CMS was approving the addition of the Central Avenue location.[15] CMS subsequently determined that the $13,000 payment and payments in subsequent years were in error. We agree with the ALJ that the tentative settlement payments did "not vest rights in [Family Health] to [an earlier] participation date for the two locations . . . ." ALJ Remand Decision at 8.

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[15] CMS submitted an affidavit from a manager at National Government Services (NGS), which "acquired the Medicare Part A Contract from its affiliate, [UGS], in January 2007." CMS Ex. 29, at ¶ 1. She stated, that upon discovering the "non-FHQC certified site issue" in 2003, further "guidance from CMS had been sought regarding proper handling of the services rendered" and that "[p]ending CMS instruction, the FI decided to include the site visits from the non-FQHC certified sites (in this case, Central Avenue and North Main Street locations) on the cost reports solely for purposes of settling the cost reports and to issue notices of reopening so that the FI could later exclude the non-certified site visits if CMS instructed that the visits should be excluded." Id. at ¶ 3. Family Health offered no evidence to rebut this statement.

Therefore, the ALJ correctly found that CMS's actions prior to 2005 did not constitute approval of the locations as FQHCs.

3. The ALJ did not err by rejecting Family Health's equitable arguments.

Family Health made a number of equitable arguments in support of its proposed effective dates that the ALJ properly rejected.[16] RR at 7. We discuss them below.

Both parties agree that using an effective date of September 8, 2005 instead of the earlier dates for which Family Health argues will have a significant financial impact on Family Health. Family Health alleges that this effective date would create the "risk that Family Health could be shut down, leaving approximately one third of Darke County's population in a medical shortage area without a 'safety net' medical provider." P. Ex. 1, at ¶ 15. Family Health further alleges that the two locations and services provided there always met the federal regulatory standards for FQHC services (id. at ¶ 17) and that it was not trying to circumvent "any overall CMS policy or gain any particular advantage" from its actions (RR at 7).

Neither the Board nor the ALJ have the authority to rely on such factors in deciding the effective dates of participation as an FQHC for these locations. See ALJ Remand Decision at 9, citing

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[16] We do not, however, affirm the ALJ's reliance on Schweiker v Hansen, 450 U.S. 785 (1981) for the proposition that "an agency is not required to accept a functional equivalent of an application which is not the precise form and conduct that the agency requires." ALJ Remand Decision at 6. In Schweiker, a Social Security worker incorrectly advised a woman that she was ineligible for benefits, and, as a result of this advice, she did not file a written application. The Social Security Act provides that benefits are available only to a person who "has filed an application" (42 U.S.C. § 402(g)(1)(D)) and the implementing regulations provided that only written applications satisfy the statutory requirement (20 C.F.R. § 404.601 (1974)). The Court held that it could not grant the woman benefits under an estoppel theory in contravention of these statutory and regulatory requirements. Schweiker, 450 U.S. at 790. Here, the ALJ identified no statutory or regulatory standard requiring the use of the 855A in 2002 or 2004.

Heckler v. Community Health Services of Crawford County, 467 U.S. 51 (1984). As the Board pointed out in DAB No. 2092, CMS could consider these factors in evaluating how to proceed in this matter (DAB No. 2092, at 16). CMS represents that, after the ALJ's remand, it did consider Family Health's assertion that "it would be forced out of business" if it were not given earlier effective dates. CMS Ex. 30, at ¶ 4.

Family Health also asserts that it "researched the issue, contacted CMS, and relied on the CMS NewsFlash to guide its efforts to properly add" the two locations. RR at 8, citing P. Ex. 1 (affidavit of its Executive Director); P. Ex. 3 (affidavit of its Medicare Billing Clerk). To the extent Family Health is raising an estoppel defense, it has no merit since the ALJ and the Board are bound by the effective date provisions of 42 C.F.R. § 489.13 and have no authority to waive them. ALJ Remand Decision at 9, see also Regency on the Lake, DAB No. 2205 (2008).

In any event, estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct" by the federal government. Office of Personnel Management v. Richmond, 496 U.S. 414, at 421 (1990). Certainly estoppel is unavailable where the party fails to show even the traditional elements of estoppel, such as reasonable reliance. Heckler, 467 U.S. at 60 (fiscal intermediary gave provider incorrect advice but provider failed to show reasonable reliance). Here, as CMS points out, even assuming Family Health relied, as it said it did, on information from a Part B carrier, Palmetto, and a CMS Provider Enrollment NewsFlash, that reliance was not reasonable in light of the governing regulations and other information Family Health had. CMS Response at 24-29.

Family Health's Medicare Billing Clerk (Clerk) represents that, for the Central Avenue location, she contacted Palmetto "and asked about the applications needed to add [two new doctors] to the Family Health Central Avenue location." P. Ex. 3, at ¶ 3. The Clerk does not state that she asked Palmetto how to obtain approval of the location as an FQHC site. The Clerk states that Palmetto instructed her to submit an 855R and that no mention was made of an 855A.[17] Id. As CMS pointed out in its

[17] For the Central Avenue location, Palmetto subsequently also informed Family Health that, before the new doctors could

(Continued. . .)

reconsideration letter, Palmetto gave the correct advice if the question was how to add new physicians to a group. CMS Ex. 1, at 4.

CMS represents (and Family Health does not dispute) that the NewsFlash (P. Ex. 30) was issued by Nationwide Mutual Insurance Company, the Medicare carrier for Ohio prior to Palmetto. CMS Response at 27; see also P. Ex.2, at ¶ 5. CMS asserts that the NewsFlash "was not intended to instruct site locations on how to enroll as FQHCs." Id. Rather, the purpose was to inform suppliers about new CMS forms (855I, 855B, and 855R) that would be used by carriers as of November 2001. Id. Family Health knew or should have known at the time that carriers were not the entities that handled FQHC approval. Family Health has shown no basis for concluding that it reasonably relied on the carrier's NewsFlash for guidance on qualifying the additional locations for FHQC reimbursement through a fiscal intermediary.

Therefore, the ALJ properly rejected Family Health's equitable arguments.

4. The ALJ erred in concluding that the effective dates for these locations were June 30, 2005 and August 29, 2005 rather than September 8, 2005.

The ALJ issued a Revised Decision in which he concluded that the effective dates for the Central Avenue and Main Street locations should be June 30, 2005 and August 29, 2005, respectively. These were the dates that Family Health filed Attestation Statements with UGS for the respective locations.[18] Revised

(Continued. . .)

be "enrolled as a member of a group, a CMS 855B application needs to be completed, so that the group can be added to our system files." CMS Ex. 13, at 14. Family Health did so, and Palmetto approved the Central Avenue location as a "multi-specialty group." P. Ex. 13. This in itself should have put Family Health on notice that the site had not thereby been approved as an FQHC.

[18] In the ALJ Remand Decision, the ALJ erroneously stated that Family Health submitted the Attestation Statements for both locations to UGS on September 8, 2005. ALJ Remand Decision

(Continued. . .)

Decision at 2. The ALJ stated that he was revising the decision based on his reading of DAB No. 2092, which he concluded required him to treat the dates "that UGS had everything it needed to certify the two facilities" as the effective dates. Id.

The ALJ's ruling reflects a misunderstanding of DAB No. 2092. That decision did not hold that CMS could not rely on its interpretation of the regulations and its policies in determining effective dates for FQHCs. Rather, the decision found that, given the absence of relevant documents in the record and CMS's failure to respond to Family Health's arguments, it was inappropriate to conclude on summary judgment that CMS had in fact relied on reasonable interpretations of the regulations or followed its policies. In contrast, the present record shows that Family Health first requested FQHC approval for Medicare for these locations in 2005; that, thereafter, CMS followed its established process for approving FQHC locations; and that the effective date resulting from this process was September 8, 2005.

Rather than dispute this, Family Health's challenge to the ALJ Revised Decision merely reasserts its arguments for setting the effective dates in 2002 and 2004. We have already explained why these arguments are without merit. We do not discuss them further.

Conclusion

We reverse the findings of fact and conclusions of law (FFCLs) in the ALJ Revised Decision.

(Continued. . .)

at 3. After the decision was issued, CMS moved to correct this statement of fact. The ALJ then issued the Revised Decision, changing the effective dates to the dates Family Health filed the Attestation Statements. CMS maintains this correction of fact should not have changed the ALJ's original conclusion that the effective date was September 8, 2005.

We adopt the ALJ's conclusion in the ALJ Remand Decision that September 8, 2005 was the effective date for each location. We modify the FFCLs in the ALJ Remand Decision to read as follows:

1. In order to receive FQHC Medicare reimbursement for FQHC services provided at a permanent unit, an entity must request CMS's approval for the unit and assure CMS that the unit meets applicable FQHC Medicare requirements.

2. CMS correctly determined the effective date for participation as FQHCs in Medicare of the two units at issue to be September 8, 2005.

/s/
Judith A. Ballard

/s/
Stephen M. Godek

/s/
Leslie A. Sussan
Presiding Board Member