Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Cedar Park Regional Medical Center, (CCN: 67-0043),	)	Date: March 9, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-682
	)	Decision No. CR1919
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

This matter is before me on the Motions for Summary Judgment filed by the Centers for Medicare & Medicaid Services (CMS) and by Petitioner Cedar Park Regional Medical Center (CPRMC). CMS and CPRMC have filed briefs and exhibits in support of their positions. All proffered exhibits have been admitted. Having reviewed these pleadings and exhibits, I find that no material facts remain in dispute and conclude that CMS's position is correct as a matter of well-recognized and long-established law. I therefore grant CMS's Motion and thus summarily affirm CMS's determination to approve CPRMC's provider agreement as a hospital under the Medicare program effective February 1, 2008, but not earlier. CPRMC's Motion is in all respects denied.

I. Procedural Background

CPRMC is an acute care hospital located in Cedar Park, Texas. On or about October 31, 2007, CPRMC began the process of applying for certification to participate in the Medicare program by submitting a CMS Form 855A to the Medicare Part A fiscal intermediary for Texas, TrailBlazer Health Enterprises (TrailBlazer). TrailBlazer received the Form 855A on or about November 2, 2007, and thereafter treated that date as the date of CPRMC's application. This latter date will be the subject of some brief discussion below.

CPRMC's Form 855A showed that it was seeking accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an alternative to inspection of its facility by state health department authorities. 42 C.F.R. § 488.5. JCAHO conducted a survey of CPRMC's facility from December 19, 2007 through December 21, 2007, and notified CPRMC on December 27, 2007, that it had received JCAHO's accreditation effective that day.

During early stages of this litigation, CPRMC's discussion of the record as it then existed might have conveyed the impression that the Form 855A TrailBlazer received from CPRMC on November 2, 2007, was not amended or supplemented in any fashion before it was approved by TrailBlazer on February 1, 2008. If that impression was conveyed deliberately, it was deliberately misleading: CPRMC submitted several changes to its Form 855A while it was before TrailBlazer, and the latest of them were dated January 31, 2008, and received by TrailBlazer on February 1, 2008. CMS Ex. 1, at 28, 29, 31, 32, 34, 36, 38, 41-46. I note these facts by way of acknowledging them and by observing that TrailBlazer's final approval of the Form 855A appears to have been given immediately upon CPRMC's final submission of documents amending its application. Nevertheless, I must point out that any unresolved disputes about these facts require no further examination here because they are, under the established and widely-understood rules of this forum, immaterial to the resolution of the legal issues before me.

What is material is the undisputed fact that, at the time of the JCAHO survey, TrailBlazer had not yet approved CPRMC's Form 855A. That review and approval of the Form 855A was not complete until February 1, 2008, when TrailBlazer wrote to the Texas Department of Health, CMS, and CPRMC, and announced its approval of the Form 855A.

CMS determined to make CPRMC's provider agreement effective on February 1, 2008. This determination was announced to CPRMC by CMS on April 1, 2008. CPRMC objected to February 1, 2008 as the effective date of its agreement, and in its May 28, 2008 letter to CMS, asked that its provider agreement be made effective as of December 27, 2007, the day its JCAHO accreditation became effective. CMS declined to alter the date, and affirmed the February 1, 2008, date in a letter to CPRMC on June 16, 2008.

On August 15, 2008, CPRMC timely filed a request for hearing contesting CMS's determination to approve CPRMC's provider agreement to participate in the Medicare program effective February 1, 2008. As it has below, CPRMC asserts here that the approval date should be December 27, 2007.

II. Issue

The issue before me is simply whether CPRMC is entitled to approval of its provider agreement and certification as a Medicare provider effective as of any date prior to February 1, 2008.

This issue has been addressed in a variety of factual settings by several other Administrative Law Judges (ALJs), by appellate panels of the Departmental Appeals Board (Board), and by me most recently in *Dublin Methodist Hospital*, DAB CR1894 (2009); *University Behavioral Health of El Paso, LLC*, DAB CR1880 (2009); *Physicians Medical Center of Santa Fé, LLC*, DAB CR1790 (2008); and *Oklahoma Heart Hospital*, DAB CR1719 (2008), *aff'd*, DAB No. 2183 (2008). Some of those cases differ slightly from the present one in certain factual details, but all invoke rules well-settled in this forum, and all rest on principles that require the conclusion that CPRMC is not entitled to approval or certification as a Medicare provider on any date prior to February 1, 2008.

III. Controlling Statutes and Regulations

In order to participate in the Medicare program, a prospective provider such as a hospital must apply for and be granted an approved provider agreement with CMS. The general framework of the application process is set out at section 1866 of the Social Security Act (Act), 42 U.S.C. § 1395cc. Before CMS will approve a provider agreement and certify that a prospective provider is eligible, the provider must meet all of the requirements of participation relevant to that provider. 42 C.F.R. §§ 488.3(a)(2), 489.10(a).

One requirement hospitals wishing to participate in Medicare must meet addresses the identity, qualifications, and character of the hospital's *operating entity*. The eligibility of the *operating entity* must be assessed according to the criteria established at 42 C.F.R. §§ 489.10 and 489.12 for transparency of ownership, reliability, financial soundness, and compliance with important civil rights standards. CMS may decline to approve a provider agreement if the hospital's *operating entity* does not meet the criteria listed at 42 C.F.R. §§ 489.10 and 489.12.

Another such requirement is that the hospital's *facility* must be surveyed on-site by an agency authorized by CMS to do so, in order that its compliance with the requirements of the Medicare program can be assessed and certified. 42 C.F.R. §§ 489.2(b)(1) and 489.10(a). JCAHO is authorized to conduct certification surveys. 42 C.F.R. § 488.5. When the surveying agency has completed its on-site survey, it reports the results and its recommendations to CMS. 42 C.F.R. § 488.11(a). On the basis of the agency's report and recommendations, CMS will determine whether the hospital's *facility* is eligible to participate in the Medicare program. 42 C.F.R. § 488.12(a)(1).

Generally, the earliest date on which a hospital may be certified by CMS to participate in Medicare is established by 42 C.F.R. § 489.13. If a hospital's *operating entity* has satisfied all other requirements and the survey of that provider's *facility* is the final step in the review sequence, then 42 C.F.R. § 489.13(b) controls:

> (b) *All federal requirements are met on the date of the survey*. The agreement or approval is effective on the date the survey . . . is completed, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter.

In practice, the survey is usually the last step in the process. But, significantly, 42 C.F.R. § 489.13(c) provides for situations in which the *facility* survey may be completed before the *operating entity* has been approved:

> (c) *All Federal requirements are not met on the date of survey*. If on the date the survey is completed the provider or supplier fails to meet any of the requirements specified in paragraph (b) of this section, the following rules apply:
>
> * * * *
>
> (2) For an agreement with, or an approval of, any other provider . . . the effective date is . . . :
>
> (i) The date on which the provider or supplier meets all requirements.

Until a hospital's *operating entity*'s eligibility has been assessed and verified, and until the hospital *facility* has been surveyed and certified, its agreement cannot be approved. Until its agreement has been approved based on those assessments, its status is that of a *prospective provider*. 42 C.F.R. § 498.2. With limited exceptions, none of which are relevant in the matter presently before me, a *prospective provider*, such as a hospital, may not receive reimbursement for services provided to Medicare beneficiaries prior to the effective date of its provider agreement. Act, section 1814(a) (42 U.S.C. § 1395f(a)).

IV. Findings of Fact and Conclusions of Law

I find and conclude as follows:

1. Because TrailBlazer had not yet approved its Form 855A, Petitioner CPRMC did not meet all applicable federal requirements for participation in the Medicare program when it gained JCAHO accreditation on December 27, 2007.

2. Petitioner CPRMC did not meet all applicable federal requirements for participation in the Medicare program at any time between November 2, 2007, and February 1, 2008.

3. Petitioner CPRMC first met all applicable federal requirements for participation in the Medicare program on February 1, 2008, when TrailBlazer approved its Form 855A.

4. Petitioner CPRMC is entitled to approval or certification as a Medicare provider effective February 1, 2008, but not earlier.

5. There are no disputed issues of material fact and summary disposition is appropriate in this matter. I have viewed the facts and the inferences reasonably to be drawn from the facts in the light most favorable to the nonmoving party. *See Pollock v. American Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd. Cir. 1986); *Brightview Care Center*, DAB No. 2132 (2007); *Madison Health Care, Inc*., DAB No. 1927, at 5-7 (2004).

V. Discussion

Although CPRMC attempts to distinguish them, the decisions of this forum and of the Board that govern its resolution are not in doubt, either as to their meaning or as to their application in this appeal. They are clear and unambiguous, and their holdings may be summarized simply: a hospital's application to be a Medicare provider may not be approved, and CMS may not certify it as a Medicare provider, until the hospital has been determined to meet all applicable federal requirements for participation in the Medicare program, both as to its *facility* and as to its *operating entity*.

There is no dispute as to the material facts surrounding the sequence of steps leading to TrailBlazer's letter of February 1, 2008. CPRMC applied to participate in the Medicare program on October 31, 2007, by submitting its Form 855A to TrailBlazer. TrailBlazer received the Form 855A on or about November 2, 2007. JCAHO accredited CPRMC effective December 27, 2007, based on its survey of CPRMC's *facility*. TrailBlazer completed its assessment of CPRMC's Form 855A on February 1, 2008, and found the facility then in compliance with all *remaining* Medicare requirements, including those related to CPRMC's *operating entity*. This sequence may represent a reversal of the more commonly-seen sequence in which the facility survey is not undertaken until the fiscal intermediary has approved the operating entity. Most of the earlier recorded litigation in this forum seems to have been based on an "*entity*-approval first, *facility*-survey next" model. But that sequence is not the unvarying model, and three significant exceptions to that model apply to these facts and control the disposition of this dispute.

The first significant exception to the usual sequence appears in *SRA, Inc., D/B/A St. Mary Parish Dialysis Center*, DAB CR341 (1994), a case in which an end-stage renal disease treatment center (ESRD) sought certification of its Medicare provider agreement. The ESRD successfully "passed" a state agency survey of its facility, but certain aspects of the ESRD's management, and of its supervisory and professional arrangements, were not then in compliance with Medicare requirements. Eventually those operating arrangements were corrected and approved by CMS's predecessor agency, the Health Care Financing Administration (HCFA). The ESRD claimed that it was entitled to certification as of the date of the successful survey, but HCFA insisted that the ESRD had not met all requirements until its operating arrangements were finally approved. In upholding HCFA's position, the Administrative Law Judge announced the rule that controls this case:

> The regulations provide plainly that, where a provider or supplier fails to meet certification requirements at the date of the inspection, it will be found to satisfy those requirements either on the date when it actually meets the requirements or on the date that it submits a plan of correction acceptable to HCFA, whichever comes first. 42 C.F.R. 489.13(a) and (b). Thus, a provider or supplier cannot be certified effective the date of survey where: (1) deficiencies are found to exist as of the survey date, and (2) the deficiencies are not corrected (or an acceptable plan of correction is not submitted by the provider or supplier) until a subsequent date.

SRA, DAB CR341, at 20.

In the two more recent cases to which I have referred briefly above, hospitals had "passed" a state survey or had received JCAHO accreditation, but had simply not yet met "all requirements" for certification because their operating entities had not been approved by the fiscal intermediary. Relying on the rule enunciated in *SRA*, I concluded in both cases that the hospitals could not be certified effective the dates of survey or accreditation as they asked because the approvals of their operating entities remained unresolved on that date. *Dublin Methodist Hospital*, DAB CR1894 (2009); *Physicians Medical Center of Santa Fé, LLC*, DAB CR1790.

There are no exceptions to these rules based on delays in the administrative process of reviewing the hospital's satisfaction of the participation requirements, and there are no exceptions based on a hospital's claimed misunderstanding of the rules. "The governing regulations are essentially unforgiving." *Tenet HealthSystem Philadelphia, Inc.*, DAB CR663, at 7 (2000). And insofar as CPRMC complains of the rigor with which TrailBlazer and CMS apply those regulations, it may be observed that the arcana applying to Medicare participation are the very matters that CPRMC is expected to accept and

master as a condition of participation in the Medicare program. *Cary Health and Rehabilitation Center*, DAB No. 1771, at 21 n.5 (2001); *Horizon Health Care*, *Inc.*, DAB CR1689 (2007); *Brookside Rehabilitation and Care Center*, DAB CR1541 (2006).

CPRMC's failures to acknowledge and master the specific requirements of Medicare participation are reflected in the position it asserted first in this appeal: that the terms of 42 C.F.R. § 489.13(d) allow it to claim the date of its JCAHO accreditation as the date it met all Federal requirements. Its assertion of that position depends on a serious misreading of the regulation and of the leading case interpreting it, *Oklahoma Heart Hospital*, DAB No. 2183. Although CPRMC's rather selective quoting of that decision might obscure the point, the rule there announced is quite plain and disposes of CPRMC's argument. The terms of 42 C.F.R. § 489.13(d) — both the "*General rule*" at section 489.13(d)(1) and the "*Special rule*" at section 489.13(d)(2) — are operative only in cases of a facility already accredited by an agency such as JCAHO at the time the facility submits its application. CPRMC submitted its application on or about October 31, 2007. TrailBlazer received CPRMC's application on or about November 2, 2007. JCAHO did not begin its survey of CPRMC's facility until December 19, 2007, and did not award accredited status to CPRMC until December 27, 2007. The terms of 42 C.F.R. § 489.13(d) do not apply in this situation.

CPRMC's later briefing advances another argument, but as I have suggested above, it appears to have been conceived in avoidance of certain aspects of this record. This later CPRMC briefing follows a two-step path to its conclusion. In its first step, CPRMC posits that there were no omissions, flaws, gaps, or shortcomings in the original Form 855A TrailBlazer received from it on November 2, 2007, because any subsequent changes should be "inferred to have been deemed by TrailBlazer to have been submitted along with the original application." P. Brief Regarding CMS Exhibit 1 at 5. CPRMC skirts the rocky part of this path as it ignores the patent changes to its Form 855A that TrailBlazer received from it as late as January 25 and 31, 2008 and February 1, 2008 — changes with effective dates of November 7, 2007, December 15, 2007, January 11, 2008, and January 31, 2008. CMS Ex. 1, at 28, 29, 31, 32, 34, 36, 38, 41-46. In reaching the end of this first step up its path, CPRMC asserts without the encumbrance of authority that TrailBlazer's eventual approval of that Form 855A on February 1, 2008, was actually retroactively effective November 2, 2007. Then, in its second short excursion, CPRMC begins where it rested on its earlier journey and asserts that since TrailBlazer's approval of its *operating entity* was actually retroactively effective November 2, 2007, then JCAHO's accreditation as of December 27, 2007, completed the final element of "all requirements" for Medicare participation. Weighted down by a burden of stubborn and hostile facts, and unsupported by any authority whatsoever, this argument's failure to win through to its goal is hardly surprising.

CPRMC's briefing complains "of the significant financial damage that has been inflicted upon [Petitioner]." P. Response at 14-15, and of the "substantial financial impact on the Provider, causing over one month worth of services provided to Medicare beneficiaries to go unpaid." P. Memorandum at 3. Because of that repeated assertion, an assertion pressed by CPRMC even as it evades discussion of its own failure to understand the nature of the process it attacks, it is important to emphasize why those complaints are immaterial and require no resolution of the factual disputes behind them. CPRMC's theory is based on the doctrine of equitable estoppel, although it never says so explicitly. That reluctance to name the doctrine it invokes may stem from CPRMC's awareness that equitable estoppel, particularly in cases involving the effective dates of Medicare provider agreements, is specifically beyond my authority to consider. *Oklahoma Heart Hospital*, DAB CR1719, at 10-11, *aff'd,* DAB No. 2183, at 16-17; *Maher A. A. Azer (Florence Dialysis Center, Inc.)*, DAB CR994 (2003); *Danville HealthCare Surgery Center*, DAB CR892 (2002); *Everett Rehabilitation and Medical Center*, DAB CR455 (1997), *aff'd*, DAB No. 1628 (1997). Even if CPRMC were able to conflate its argument in equity to constitutional dimensions, such constitutional challenges to the validity of the regulations governing these proceedings are by settled precedent similarly beyond my jurisdiction and authority. While the issues and arguments noted above may be suitable for discussion and debate in other forums, they are not legitimate subjects for litigation in this one. *Wisteria Care Center*, DAB No. 1892 (2003); *Hermina Traeye Memorial Nursing Home,* DAB No. 1810 (2002); *Sentinel Medical Laboratories, Inc.,* DAB No. 1762 (2001). I need not resolve CPRMC's factual assertions because they raise questions of fact that have no bearing on the issues I may properly consider. They are immaterial questions of fact and represent no bar to summary disposition.

VI. Conclusion

For the reasons discussed above, CPRMC's Motion for Summary Judgment is DENIED. CMS's Motion for Summary Judgment should be, and it is, GRANTED. I affirm CMS's determination to certify CPRMC to participate in the Medicare program as a Medicare provider effective February 1, 2008, but not earlier.

/s/
Richard J. Smith
Administrative Law Judge