Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mission Regional Hospital Medical Center,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-446

Decision No. CR2458

Date: November 2, 2011

DECISION

Petitioner, Mission Regional Hospital Medical Center, appeals the Medicare enrollment determination of the Centers for Medicare and Medicaid Services (CMS) and argues that Petitioner's Medicare enrollment date for its newly acquired Laguna Beach campus should be effective from July 1, 2009. However, I find the undisputed facts in this case support a March 18, 2010 effective date, which is based on when the Joint Commission, a national accrediting organization with Medicare deeming privileges, completed a successful survey of the new acquisition. Therefore, I grant CMS's Motion for Summary Judgment and deny Petitioner's Cross-Motion for Summary Judgment.

I. Background

Petitioner is a Medicare-approved acute care hospital located in Mission Viejo, California. On July 1, 2009, Petitioner acquired the assets of another Medicare-approved hospital, South Coast Medical Center (South Coast), located in Laguna Beach, California. CMS Exs. 2, 4, 6; P. Ex. 9. While Petitioner acquired its assets, Petitioner expressly declined to accept South Coast's outstanding liabilities under South Coast's existing Medicare provider agreement. P. Ex. 9, at 1; CMS Ex. 2, at 89-90. Petitioner treated the assets of South Coast, which Petitioner planned to operate under Petitioner's licenses and accreditations, as a separate campus of its hospital at Mission Viejo. P. Ex. 10, at 2.

On June 5, 2009, Petitioner submitted an application to enroll its new campus under Petitioner's Medicare provider number and requested an effective date of July 1, 2009, the date of the finalization of the asset acquisition. CMS Ex. 2. Petitioner believed that CMS would allow Petitioner to bill Medicare starting July 1, 2009 for services rendered at the newly acquired campus because Petitioner simply would be adding a new location to its provider number. P. Ex. 9, at 2; P. Ex. 2, at 1-2.

The Joint Commission had previously accredited Petitioner's Mission Viejo location effective May 9, 2009. P. Ex. 6, at 1. Prior to the asset acquisition, the Joint Commission had also accredited South Coast Medical Center. P. Ex. 5, at 1. On December 15, 2009, the Joint Commission sent South Coast Medical Center a letter stating that the Laguna Beach campus, formerly known as South Beach Medical Center, had been extended accreditation under Petitioner's Mission Viejo accreditation, contingent upon a successful completion of an extension survey. *Id.* The Joint Commission also informed South Coast Medical Center that, as a result of the acquisition, South Coast Medical Center will be listed as not accredited effective December 31, 2009. *Id.*

By letter dated February 10, 2010, CMS notified Petitioner that, where a different entity acquires ownership of a Medicare certified provider, CMS assigns the provider agreement only if the new owner accepts the liabilities as well as the assets associated with the agreement. P. Ex. 8, at 1. Unless the new owner assumes the former owner's provider agreement, including both the assets and the liabilities, CMS will terminate the former owner's provider agreement. *Id.* CMS regards this as a voluntary termination. *Id.* Once termination occurs, a full Medicare certification survey of the previously certified facility is required as a prerequisite to billing Medicare. *Id.* CMS notified Petitioner that it may not bill Medicare for services provided at the new location until the State survey agency, or a Medicare deemed accrediting organization, has completed a Medicare certification survey, and CMS has determined that all applicable Medicare requirements have been met. *Id.*

On March 18, 2010, the Joint Commission completed the extension survey for the Laguna Beach campus. CMS Ex. 7, at 1. Based on a successful survey, the Joint Commission provided accreditation to the Laguna Beach campus effective March 18, 2010. *Id.* By letter dated March 10, 2011, CMS reaffirmed that the effective date of Petitioner's Laguna Beach campus for certification and reimbursement was March 18, 2010, the date that the Joint Commission completed a successful survey of the Laguna Beach campus. P. Ex. 8. The March 10, 2011 letter provided Petitioner appeal rights to the Departmental Appeals Board (DAB).

On May 6, 2011, Petitioner filed a hearing request with DAB's Civil Remedies Division. An Acknowledgment and Pre-hearing Order was sent to the parties on May 13, 2011. On June 17, 2011, CMS filed a Motion for Summary Judgment and brief (CMS Br.),

accompanied by nine proposed exhibits (CMS Exs. 1-9). On August 11, 2011, Petitioner filed Petitioner's Pre-Hearing Brief, Response to CMS's Summary Judgment Motion, and Cross-Motion for Summary Judgment (P. Br.), accompanied by 10 proposed exhibits (P. Exs. 1-10). Absent any objection, I admit all proposed exhibits into evidence.

II. Issue

The issue in this case is whether CMS had a legitimate basis for determining that March 18, 2010 was the effective date of Medicare enrollment for Petitioner's newly acquired medical campus.

III. Discussion

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

a. This case is appropriate for summary judgment.

CMS argues that it is entitled to summary judgment. The DAB Board Members (Board) explained the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law . . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). An Administrative Law Judge's (ALJ's) role in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009).

Both parties agree that there are no material facts in dispute, and each party has moved for summary judgment. Specifically, the parties concur that Petitioner did not accept the liabilities of South Coast. Therefore, as explained below, summary judgment is appropriate in this matter.

b. South Coast's existing Medicare provider agreement did not transfer to Petitioner because Petitioner did not accept South Coast's liabilities.

For purposes of Medicare certification and payment, a change of ownership occurs upon "the merger of the provider corporation into another corporation," and, when such a change of ownership occurs, "the existing provider agreement will automatically be assigned to the new owner." 42 C.F.R. § 489.18(a)(3), (c). The surviving owner must accept assignment of all applicable statutes and regulations and the terms and conditions under which the provider agreement was originally issued, as well as all outstanding liabilities associated with the agreement, including Medicare overpayments. *U.S. v. Vernon Home Health, Inc.* 21 F. 3d 693, 695 (5th Cir. 1994), *cert denied*, 513 U.S. 1015 (1994) (holding that, if an entity accepts assignment of the provider agreement, federal requirements necessitate an entity to assume the overpayment liabilities that go along with the provider agreement).

In this case, Petitioner expressly declined to accept South Coast Medical Center's outstanding liabilities, including those liabilities under South Coast Medical Center's existing Medicare provider agreement. P. Ex. 9, at 1; CMS Ex. 2, at 89-90. Because of this, South Coast's provider agreement did not transfer over to Petitioner, and Petitioner does not dispute that it did not acquire South Coast's provider agreement. Instead, CMS considered South Coast's provider agreement terminated at the time the asset acquisition on July 1, 2009 was finalized. P. Ex. 8, CMS Ex. 9.

c. The effective date of Medicare enrollment for Petitioner's acquisition is governed by the date the accrediting organization completed its survey.

At the time of these events, 42 C.F.R. § 489.13(d) governed the effective date of Petitioner's new acquisition. This section provided:

> (d) Accredited provider or supplier requests participation in the Medicare program—
>
> (1) General rule. If the provider or supplier is currently accredited by a national accrediting organization whose program had CMS approval at the time of the accreditation survey and accreditation decision, and on the basis of accreditation, CMS has deemed the provider or supplier to meet Federal requirements, the effective date depends on whether the provider or supplier is subject to

> requirements in addition to those included in the accrediting organization's approved program.
>
> **(i)Provider or supplier subject to additional requirements. If the provider or supplier is subject to additional requirements, the effective date of the agreement or approval is the date on which the provider or supplier meets all requirements, including the additional requirements.**
>
> (ii)Provider or supplier is not subject to additional requirements. For a provider or supplier that is not subject to additional requirements, the effective date is the date of the provider's or supplier's initial request for participation if on that date the provider or supplier met all Federal requirements.
>
> **(2) Special rule: Retroactive effective date. If the provider or supplier meets the requirements of paragraphs (d)(1) and (d)(1)(i) or (d)(1)(ii) of this section, the effective date may be retroactive for up to one year to encompass dates on which the provider or supplier furnished, to a Medicare beneficiary, covered services for which it has not been paid.**

42 C.F.R. § 489.13(d)(2009) (emphasis added).[1]

Petitioner argues that 42 C.F.R. § 489.13(d)(1)(i) applies in this matter because it was subject to the additional requirement of the submission of a Medicare application for a provider's change of enrollment to include the new acquisition. P. Br. at 8. In its Medicare application, Petitioner requested an effective date of July 1, 2009, the date it finalized the asset purchase transaction.[2] *Id.*

I agree that 42 C.F.R. § 489.13(d)(1)(i) applies in this matter. However, contrary to Petitioner's position that it met all federal requirements on the transaction closing date of July 1, 2009 (or in the alternative on July 17, 2009), I find that not only is the acquisition subject to CMS application requirements but also subject to the accreditation requirements that were not fulfilled until March 18, 2010.

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[1] 42 C.F.R. § 489.13 was amended to delete subpart (d) in August 2010.

[2] Petitioner alternatively argues that, at the latest, the effective date is July 17, 2009, the date that the CMS contractor approved the enrollment application. CMS Ex. 3; P. Br. at 8 n.2. It is interesting to note, however, the Medicare contractor's July 17, 2009 letter specifically states that, "[i]f this application is for an additional location, please note that this letter should not be construed as a determination that the additional practice location meets the provider-based requirements . . . [a] separate recommendation will be made regarding that status." CMS Ex. 3 (emphasis in the original).

To qualify for Medicare certification as a Medicare provider, a hospital must meet the conditions of participation set forth at 42 C.F.R. Part 482. With certain exceptions not relevant here, entities that the Joint Commission accredits "are deemed to meet all of the Medicare conditions of participation." 42 C.F.R. § 488.5(a). On December 15, 2009, the Joint Commission wrote South Coast stating that it understood that Petitioner had acquired South Coast, now known as the Laguna Beach campus, and would provide accreditation to the new site contingent upon the successful completion of an unannounced extension survey to be conducted of the Laguna Beach location. P. Ex. 5. The December 15, 2009 letter stated that all programs under South Coast will be listed as not accredited effective December 31, 2009, as a result of Petitioner's 's acquisition of South Coast, and that the Joint Commission would notify CMS regarding the change in accreditation and deemed status. *Id.* The letter further explained that CMS "will initiate appropriate action regarding your continued Medicare participation." *Id.*

The Joint Commission provided accreditation to Petitioner's newly acquired site based on a successful on-site survey verifying compliance with applicable health and safety requirements as of March 18, 2010. CMS Ex. 7. Therefore, I find that Petitioner's acquisition first met all additional federal requirements, pursuant to 42 C.F.R. § 489.13 (2009), on March 18, 2010, and its provider agreement became effective on that date. *Id.*

Alternatively, even if Petitioner accepts the effective date of March 18, 2010, Petitioner argues that the acquisition should be eligible to bill Medicare from July 1, 2009, under 42 C.F.R. § 489.13(d)(2)(2009). P. Br. at 9. Petitioner explains that it qualifies for a retroactive effective date (within a one-year period preceding approval) back to the date it provided Medicare covered services to Medicare beneficiaries for which it has not been paid. P. Br. at 9. Petitioner relies on *West Norman Endoscopy Center*, DAB No. 2331 (2010) to support its argument that the Board could decide this and not necessarily rely on the discretion of CMS to allow retroactive billing. *Id.*

Section 489.13(d)(2)(2009) uses the word "may" and gives CMS discretion to grant a retroactive certification of up to one year. I find CMS was authorized to exercise its clear discretion not to grant retroactive certification, considering CMS had a longstanding policy not to allow retrospective billing when there was a change in ownership without assumption of the seller's provider agreement. CMS Ex. 1 (Survey and Certification Memorandum S&C 09-08 (October 17, 2008)). I note that CMS asserts it never exercised its discretion to grant retroactive effective dates in cases involving the acquisition of assets where the purchaser failed to accept the seller's liabilities. CMS Br. at 4 n.1. *West Norman Endoscopy* is not analogous to this case because, when the Board granted retroactive billing in *West Norman Endoscopy*, the Board specifically acknowledged that the petitioner was already accredited at the time petitioner provided services for which the Board found it was retroactively eligible to bill Medicare. *See West Norman Endoscopy Ctr.*, DAB No. 2331, at 11.

I also note that the discretion to provide retroactive payment has since been eliminated in the version of the regulations amended August 16, 2010. 42 C.F.R. § 489.13 (2010). The preamble to that updated version of the regulations explains the reason for the revision was to further legitimize CMS's longstanding effective date policy:

> Under CMS regulations at 42 CFR 489.18(c), a "change of ownership" includes accepting assignment of the seller's existing provider agreement or supplier approval. Section 489.18(d) states that the provider or supplier continues to be subject to the same statutes and regulations, and to the terms and conditions under which it was originally issued. This means that the new owner receives the assets and liabilities associated with that agreement or approval. This has proven to be an important tool in protecting the Medicare Trust Funds through continuity in the ability to recover outstanding overpayments.
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> Under that policy, if a buyer of a Medicare-participating facility chooses not to accept assignment of the provider agreement or supplier approval, the provider agreement or supplier approval terminates. Then, the new owner must be treated as an initial applicant to the Medicare program. In this situation, Medicare will not reimburse the provider or supplier for services it provides before the date on which the provider or supplier qualifies as an initial applicant.
>
> Any requirement to make payments retroactive to the date of a State survey or accreditation decision, despite the fact that all other Federal requirements may not yet have been met, could provide an incentive for more buyers to refuse assumption of the seller's provider agreement or supplier approval, because there would potentially be no break in payments. **Therefore, effectively, a buyer who does not accept assignment of the seller's active provider agreement could potentially begin receiving Medicare payments immediately (assuming it meets all the requirements), but not be responsible for any existing liabilities of the provider agreement. This would also be an incentive for existing providers or suppliers with civil money penalties or overpayments to sell their facilities in order to escape any financial responsibility to the Medicare program.**

75 *Fed. Reg.* 50,401-02 (Aug. 16, 2010) (emphasis added).

Petitioner argues the CMS contractor, through both telephone conversations and email communications, told Petitioner that it would be able to bill back to July 1, 2009 for reimbursement of the Laguna Beach location's Medicare services. P. Br. at 3, P. Ex. 9, at 2, P. Ex. 2, at 1-2. I will infer, for summary judgment purposes, that these claims are true. However, Petitioner's argument amounts to a claim of equitable estoppel. Federal case law and Board precedent establish: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. Of Crawford County*, 467 U.S. 51, 63; *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009). Petitioner has not alleged or come forward with any evidence of affirmative misconduct by employees at WPS.

IV. Conclusion

It is undisputed that Petitioner did not acquire the provider agreement of its new campus when it refused to accept the acquisition's liabilities. Petitioner's new location met all federal requirements, pursuant to 42 C.F.R. § 489.13(d)(1)(i)(2009) when the Joint Commission provided accreditation on March 18, 2010. Thus, CMS had a legitimate basis for determining Petitioner's effective date for Medicare enrollment. Therefore, I grant CMS's Motion for Summary Judgment and deny Petitioner's Cross-Motion for Summary Judgment.

/s/
Joseph Grow
Administrative Law Judge