DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: New Jersey Department of Human Services DATE: April 30, 1981
Docket No. 79-231-NJ-HC
Decision No. 164

DECISION

The New Jersey Department of Human Services (State) filed an application for review of a determination by the Director, Bureau of Program Operations, Health Care Financing Administration (Agency), disallowing $91,392 claimed for the period June 1, 1978 to March 31, 1979 under Title XIX of the Social Security Act for payments to Mountainview Nursing Home, a combined skilled nursing/intermediate care facility. The costs were disallowed on the ground that the State did not have a valid provider agreement with the facility in accordance with the applicable regulations. This decision is based on the State's application for review, the Agency's response to the appeal, the State's response to an Order to Show Cause issued by the Board Chair, and the Agency's response to a subsequent inquiry by the Board's Executive Secretary. The arguments in the State's response to the Order are substantially the same as those advanced in its application for review. Accordingly, we adopt the Order's tentative conclusion and sustain the disallowance.

Applicable Regulations

The applicable regulations are set forth in 42 CFR Part 449 (1977), "Services and Payment in Medicaid Assistance Program." (The regulations were recodified without any significant changes at 43 FR 45233, September 29, 1978.) Federal financial participation (FFP) in payments to a facility providing skilled nursing and intermediate care services is available only if the facility is certified as having met all the requirements for participation in the Medicaid program as evidenced by an agreement (provider agreement) between the single state agency and the facility. Section 449.10(b)(4)(i)(C) for skilled nursing services, Section 449.10(b)(15)(i)(E) for intermediate care services. The execution of the provider agreement is contingent upon certification of the facility by an agency designated as responsible for licensing health care institutions in the state (state survey agency). Section 449.33(a)(6). The single state agency is required to certify that the facility is in compliance with each condition of participation. Section 449.33(a)(4)(i). Certification can be based on an acceptable plan of

correction. Section 449.33(a)(4). The effective date of the provider agreement may not be earlier than the date of certification. Section 449.33(a)(6).

A provider agreement between the state agency and a facility is not necessarily a sufficient basis to claim FFP, however. The provider agreement may be determined invalid if the Secretary establishes that any of five provisions in Section 449.10(b)(4)(i)(C)(1) - (5) for a skilled nursing facility or in 449.10(b)(15)(vi)(A) - (E) for an intermediate care facility were violated in the certification of the facility. A facility which does not qualify under Section 449.33 is not recognized as a skilled nursing facility or an intermediate care facility for purposes of payment under Title XIX. Section 449.33(a)(10).

Statement of the Case

Mountainview Nursing Home had a provider agreement with the State, the validity of which is uncontested by the Agency, with an expiration date of May 31, 1978. In January 1978, the State Department of Health surveyed the facility and found that it was out of compliance with applicable standards. (Agency response to appeal, Tab B.) The inspection revealed over 115 violations of State and Federal law. (Application for review, Exhibit D, p. 6.) Accordingly, the Department of Health recommended that the facility's provider agreement not be renewed. (Agency response to appeal, Tab B.) The facility was not certified for the period after the expiration of the provider agreement, and no new agreement was executed. (Response to Order, p. 4.) The State nevertheless continued payments to Mountainview for Medicaid services beyond May 31, 1978, and continued to claim FFP in such costs.

In August 1978, the Department of the Public Advocate of New Jersey filed a complaint for receivership of Mountainview, alleging that conditions at the facility "have been found to be habitually in violation of minimum standards of health, safety and patient care mandated by law." (Application for review, Exhibit D, p. 2.) The complaint was filed pursuant to a State statute, the purpose of which was to provide an alternative to revocation of a nursing home's license or Medicaid decertification. N.J.S.A. 26: 2H-36 (1977), Note. The State Departments of Human Services and of Health subsequently intervened in the action as parties plaintiff. (Application for review, Exhibit E.) In September 1978, a receiver assumed control of the facility. (Application for review, Exhibit G, p. 18.) Under the receiver's management, many of the deficiencies were corrected, and on April 27, 1979, the facility was certified for the period February 28, 1979 to

September 30, 1979. (Response to Order, Exhibit G.) A new provider agreement effective February 28, 1979 was forwarded to the facility on June 21, 1979. (Agency response to appeal, Tab C.)

The Agency disallowed FFP claimed for the period June 1, 1978 to March 31, 1979 on the ground that the facility had not had a valid provider agreement since June 1, 1978. (Notification of disallowance, p. 1.) The Agency later stated that no costs for March 1979 were included in the claim for FFP with respect to which the disallowance was taken. (Further Response of the Health Care Financing Administration to the Board's March 20, 1981 Inquiry, dated April 16, 1981, pp. 1-2.)

State's Arguments

The State concedes that, at least until February 28, 1979, Mountainview did not meet the applicable standards for certification for participation in the Medicaid program. (Application for review, p. 2.) Noting that the parties did not disagree on the essential facts of the case, the State admits that "Mountainview was an unacceptably poor facility in May 1978 and did not merit renewal of its Title XIX provider agreement." (Response to Order, p. 6.) It argues, however, that no purpose would have been served by ceasing payments to the facility, and that appointment of a receiver to correct the deficiencies while continuing to provide Medicaid services was a more constructive action. In support of this argument, the State notes that it had a shortage of Medicaid beds at the time in question, so that there was in fact no place to relocate the patients; that had it been able to relocate the patients, it might have been subject to claims based on "transfer trauma," harm to the patients precipitated by relocation; and that under current case law, it would have had to continue payments to the facility if the revocation or non-renewal of the provider agreement were to be appealed by patients in the facility. (Application for review, pp. 2-4.) Included with the State's application for review is a copy of a proposal (undated) for amendment of the Federal regulations to permit "certification with deficiencies on account of receivership." (Application for Review, Exhibit G, p. 1.) The State also argues that the Social Security Act does not authorize the Secretary to require "extensive provider agreements," and that even if the regulations requiring such agreements are valid, the Secretary has no authority to inquire into the validity of a provider agreement since the Federal government is not a party. (Application for review, pp. 9-10.)

Discussion

Both the State of New Jersey and other states have in prior appeals called to the attention of this Board the problems noted by the State in the instant case which may be involved in terminating or refusing

to renew a provider agreement. See, for example, New Jersey Department of Human Services, Decision No. 104, June 9, 1980, p. 5; Nebraska Department of Health and Mental Hygiene, Decision No. 111, July 16, 1980, p. 7; Maryland Department of Health and Mental Hygiene, Decision No. 124, October 2, 1980, p. 4. It may well be that the State successfully avoided those problems here with the appointment of a receiver charged with bringing the facility into compliance with applicable standards. As the State itself has recognized in proposing the amendment of the Federal regulations to permit certification of a facility with deficiencies if a receiver is appointed, however, the regulations do not now contain any such exception. Furthermore, they clearly require that a provider agreement based on a certification by the survey agency be in effect in order for a state to receive FFP for Medicaid services provided by a skilled nursing or intermediate care facility. In the instant case, there was no provider agreement and no underlying certification, and FFP was therefore properly disallowed.

As noted previously, according to the Agency, the State had not as of the date of the disallowance claimed FFP for costs incurred in March 1979. It is not clear from the record whether the State claimed costs which can be specifically identified as incurred on February 28, 1979. As also noted previously, that was the effective date of the certification and the provider agreement. Even if the disallowance does include costs for February 28, 1979, however, we still sustain the full amount of the disallowance. This Board has held that a certification becomes effective on the date the survey agency indicates its approval. Maryland Department of Health and Mental Hygiene, Decision No. 107, July 2, 1980. In the instant case, that approval was given on April 27, 1979. Accordingly, the certification and provider agreement were not effective until April 27, 1979, and the State was not entitled to FFP claimed for any costs incurred prior to that date.

Since this case turns on the facility's lack of certification for the period in question, the State's argument that the Social Security Act does not authorize the Secretary to require "extensive provider agreements" is not relevant. The State's further argument that the Secretary may not inquire into the validity of a provider agreement is also without merit. Sections 449.10(b)(4)(i)(C)(5) (for skilled nursing facilities) and 449.10(b)(15)(vi)(E) (for intermediate care facilities) both specifically allow the Secretary to "look behind" the provider agreement itself, before FFP is allowed, and determine that the agreement does not constitute valid evidence that the facility met all requirements for certification if certain conditions were not in fact met. One of these conditions is that execution of the provider agreement was contingent upon certification by the state survey agency under Section 449.33(a)(6).

In its response to the Order, the State contended that the Order was deficient because it did not indicate that the Agency's regional office had been aware before taking the disallowance that the facility was in receivership. The State indicated that a hearing on this point might be desirable. (Response to Order, p. 4.) We do not believe that a hearing would serve any purpose, however, since the Agency was not required to advise the State that it would be subject to a disallowance regardless of the receivership arrangement.

Conclusion

Since there was no valid provider agreement in effect from June 1, 1978 through February 28, 1979, we sustain the disallowance taken by the Agency for that period.

/s/ Cecilia Sparks Ford

/s/ Alexander G. Teitz

/s/ Norval D. (John) Settle, Panel Chair