DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Georgia Department of Medical Assistance
Docket No. 88-32
Decision No. 987

DATE: September 27, 1988

DECISION

The Georgia Department of Medical Assistance (Georgia/State) appealed a determination by the Health Care Financing Administration (HCFA/Agency) disallowing $502,858 in federal financial participation (FFP) claimed by the State under Title XIX (Medicaid) of the Social Security Act (Act) for the period September 30, 1984 through August 31, 1985.1/ HCFA based the disallowance on the results of a review of Georgia's Inpatient Hospital Reimbursement Plan, which is part of the approved Medicaid State plan. HCFA found that the State had not levied penalties against hospitals which had failed to file cost reports within 90 days of the close of the fiscal year and that this violated Georgia's approved State plan. HCFA determined that the State had received an overpayment in the amount of the federal share of the difference between the rates paid the hospitals and the rates the hospitals would have been paid if the State had imposed the penalties (reducing the rates by 20%). Generally, Georgia agreed that the reports were not filed within 90 days (although the reports were filed later), but denied that its actions violated its State plan and that any overpayment had occurred.

For the reasons explained below, we conclude that the disallowance should be reversed. We reject HCFA's reading of the State plan because that reading is contrary to the State's own official, written interpretation of the plan, which is reasonable in light of the purpose of the provision, HCFA's own interpretation of a comparable provision in the Medicare program, and the flexibility afforded the State by the Act and HCFA's regulations. We

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1/On May 5, 1988, the Presiding Board Member permitted intervention by several state hospitals and the Georgia Hospital Association. The intervenors' status was based on two conditions: 1) the substantive rights and obligations of Georgia and HCFA would not be affected; and 2) the intervenors were not allowed to raise issues beyond those which the State could raise.

find that the State plan did not mandate the imposition of rate reductions here and that, in any event, such reductions are only temporary, pending filing of the cost reports. Thus, we conclude that, even if the plan required reductions after 90 days (which it does not), there would be no overpayment of FFP since the cost reports have been filed and the State is entitled to FFP at the full rates.

Relevant Law and Background

In order to qualify for FFP, a state's claim for the costs of medical services must be in accordance with the approved Medicaid state plan. Section 1903(a) of the Act. The plan must fulfill certain statutory and regulatory requirements, and be approved by the Secretary.

Prior to 1980, states were required under section 1902(a)(13) of the Act to reimburse hospitals for inpatient hospital services at rates determined on a "reasonable cost" basis, using methods and standards reviewed and approved by the Secretary. Section 2173 of Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, amended section 1902(a)(13)(A) of the Act to require that state plans provide for payment of such services --

> through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . .

This provision, known as the "Boren Amendment," was intended to provide the states greater flexibility in developing methods of provider reimbursement. The amended law clearly reduced HCFA's involvement in the rate-setting process. Under the new law, a state merely had to provide satisfactory assurances that its rates were adequate to meet the costs of an efficiently and economically operated facility, as opposed to the more stringent "reasonable cost" standard of the earlier law. As HCFA noted in rules promulgated to implement the Boren Amendment, the legislative history indicates that Congress intended to keep requirements on states to the minimum level necessary to assure accountability, and not to burden states with

unnecessary paperwork requirements. See 46 Fed. Reg. 47969 (September 30, 1981); see also 48 Fed. Reg. 56053 (December 19, 1983).

As part of the Boren Amendment, states were required to make satisfactory assurances for the filing of uniform cost reports and for periodic audits of those reports. In implementing this requirement, HCFA determined to take the same basic approach as it took with respect to a similar Boren Amendment applying to reimbursement for long-term care facilities. 46 Fed. Reg. 47970 (September 30, 1981). With respect to cost-reporting for those facilities, HCFA stated: "In general, we believe each state is best equipped to develop its own standards and procedures for cost reporting." Thus, HCFA's regulations simply require the state plan to provide for filing of uniform cost reports by each participating provider. 42 C.F.R. 447.260. The regulations contain no requirements with respect to the timing of such filing or the result of an untimely filing.

The Georgia State plan nonetheless provides that --

> C. A hospital which does not file a cost report within three (3) months . . . after the close of the reporting period will have its per-case rate reduced by twenty (20) percent. Failure to submit a cost report within an additional 30 days may result in termination from the program.

Georgia Exhibit (Ex.) 12.

Georgia had an agreement with its Medicare fiscal intermediary to conduct a common audit of hospitals participating in Medicaid, and used the Medicare cost report forms to meet the Medicaid reporting requirement.2/ Consequently, the cost reporting requirements set out in Georgia's Manual of Policies and Procedures for Hospital Services (Medicaid Manual) reflects the Medicare provisions on filing of cost reports. Specifically, the Medicaid Manual provides --

> 1002.2 A hospital must furnish a cost report within ninety days after its fiscal year end. If the report has not been received

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2/Medicare (which provides health insurance for the elderly) is administered by HCFA under Title XVIII of the Act.

> after this ninety-day period, a written warning will be issued. This warning will indicate that if, after an additional thirty days (total one-hundred and twenty days), the cost report has not been received, a twenty percent reduction will be imposed on all payments. If the cost report is not received after another thirty days (total one-hundred and fifty days) or a request for extension has not been granted, the hospital's agreement of participation will be terminated.

The disallowance was based on HCFA's finding that the Georgia State plan required the State to impose a 20% reduction in the rates paid to any hospital which did not submit a cost report within 90 days and that, therefore, the State had received an overpayment of FFP to the extent of the difference between the federal share of the rates paid and the rates as reduced by 20%.

Georgia acknowledged a conflict between the filing requirements in its State plan and its Medicaid Manual, but said that HCFA erred in not reading the provisions in pari materia (that is, construing the provisions with reference to each other). Georgia argued that there was no federal statutory or regulatory requirement that Medicaid cost reports be filed within a specific period after the close of a fiscal year. Thus, Georgia contended that it had not violated federal law. Rather, Georgia asserted, its actions fell within the broad discretion which Congress had given to the states to administer the Medicaid provider reimbursement program.

Georgia indicated that, given the parallel requirements for Medicaid and Medicare, the State concluded that it would adopt the provisions in the Medicare reimbursement manual (HIM-15) regarding filing of cost reports. In light of this, and the further fact that the cost report forms for the period in question were new and had not been sent to the providers by HCFA in a timely manner, the State said it would be inequitable to impose reductions starting at the end of the 90 days.3/

3/HCFA said that it took the delay in mailing of the cost report forms into account in calculating the disallowance, and the record supports HCFA's claim.

Finally, Georgia asserted that regardless of what reporting requirement applied, any rate reduction imposed on a facility was only a temporary measure, under Medicare and the State plan. That is, once a delinquent hospital had submitted its cost report, the State would adjust the hospital's interim rate to return any previously imposed penalty. Given that these penalties were only temporary incentives used to spur facilities into submitting their cost reports on time, Georgia argued, HCFA could not reasonably conclude that there had been an overpayment of FFP. Georgia Br., pp. 2-7.4/

HCFA conceded that states are given considerable flexibility in administering their Medicaid programs. Nonetheless, HCFA argued that a state is obligated to enforce the valid provisions of its own state plan and that a state is entitled to receive federal funds only for amounts expended in accordance with an approved state plan. HCFA argued that under this State plan provision, there has clearly been an overpayment of federal funds, which should be disallowed. HCFA argued that the conflict between the provisions of the Manual and the State plan is clearly a problem of the State's creation and, however it affects the State-provider relationship, it clearly has no bearing on the State's obligations as a participant in the Medicaid program. HCFA Br., pp. 3-5.

HCFA did not dispute the State's contention that its Medicaid Manual provisions parallel Medicare filing provisions and that, under Medicare, only a temporary rate reduction would be imposed for late filing. HCFA argued, however, that the Medicare provisions were irrelevant because the State plan controlled here.

Analysis

As this Board has previously held, a state plan must specify the methods and standards used by the state to set

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4/Both Georgia and the intervenors argued that, under section 1904 of the Act, only substantial noncompliance with a state plan could be a basis for HCFA action. Georgia also argued that a state plan provision which was not federally mandated could not support an overpayment determination. We reject these arguments, and our decision is not based on them, since we agree with HCFA that a state plan provision voluntarily adopted by a state may support a determination that an overpayment has been made. See section 1903 of the Act.

the payment rates for providers, and the rates paid must be established in accordance with those methods and standards. See, e.g., Massachusetts Dept. of Public Welfare, DGAB No. 730, 1986; DGAB No. 867 (1987); Texas Dept. of Human Services, DGAB No. 981 (1988). Here, however, the methods and standards used by Georgia to determine adequate reimbursement rates are not in issue; there is no question that services were provided to Medicaid eligible recipients and that the State followed the methods and standards in its State plan intended to establish rates adequate to reimburse an efficiently and economically operated facility. But see Texas, supra (rate calculation directly in issue); Georgia Dept. of Medical Assistance, DGAB No. 798 (1986) (eligibility of recipients directly in issue). Instead, the issue here is whether the State plan mandated imposition of a 20% reduction in the rates for cost reports not filed within 90 days or permitted the State to extend that deadline.

The Act itself merely requires that a state make assurances "for the filing of uniform cost reports by each hospital, . . . and periodic audits by the State of such reports." Section 1902(a)(13)(A). The Act does not establish criteria for the submission of Medicaid cost reports. Further, not only did Congress provide states with a significant amount of flexibility in administering provider reimbursement systems when it enacted the Boren Amendment, but HCFA itself emphasized the states' independence in establishing cost reporting requirements, both in the regulations and in the preamble to the regulations.

The submission of a cost report itself has no direct bearing upon the delivery of services to Medicaid recipients. Instead, the report is merely part of a state's overall accounting mechanism. Both the Boren Amendment and the regulatory history place this facet of the program clearly within a state's control.

Here, the Medicare fiscal intermediary was also performing similar accounting services for hospitals participating in Medicaid. The cost reporting procedures for these Medicaid providers so closely paralleled Medicare that the same reporting forms were used. Given the latitude provided to states by the Act and regulations, the State could logically conclude that the language in its State plan did not preclude it from interpreting the filing requirement for the Medicaid reports to parallel the Medicare provisions, that is, to permit extensions of the 90-day due date and to provide for a warning notice before

a reduction would actually be imposed. HCFA's narrow reading of a clearly technical provision conflicts with the State's own reasonable reading to which, as we have noted in the past, we will defer.5/

Although the State plan provides that the State "will" impose a reduction when a report is not filed within 90 days, the Medicaid Manual (containing the State's official implementation of its reimbursement system, published essentially contemporaneously with the State plan) indicated that the State did not view this language as mandatory. Not only did the Medicaid Manual provide for a grace period and extensions, but the Medicaid Manual further described the 20% reduction as a penalty which the State "may" impose for late filing. Georgia Ex. 1, p. IV-3.

Contrary to what HCFA argued, the Medicaid Manual provisions do not contradict the State plan; they simply address a question not addressed by the State plan: whether the State has discretion to extend the deadline. HCFA provided no evidence that the State itself had any intent other than that indicated in the Medicaid Manual with regard to the filing requirements. In essence, HCFA's disallowance would impose on the State an interpretation of its plan not mandated by federal requirements and at odds with an official State policy.

Further, we would find in any event that there has been no overpayment of FFP upon which a disallowance could be based. Generally, an overpayment is that amount of federal funds found to be in excess of what was properly payable as "medical assistance" (or related administrative costs) under a state plan. See, e.g., California Dept. of Health Services, DGAB No. 734 (1986). The State argued that any penalty assessed against the hospitals would be a

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5/In South Dakota Dept. of Social Services, DGAB No. 934 (1988), the Board explained circumstances under which it would defer to a state's interpretation of its state plan. Those circumstances exist here. The provision was not federally mandated and was part of a reimbursement system which HCFA was required to approve so long as the State provided the requisite assurances. The State's interpretation was reasonable and was not simply an after-the-fact attempt to justify its actions, but was reflected in its Medicaid Manual provisions. See also Arkansas Dept. of Human Services, DGAB No. 540 (1984); Georgia Dept. of Medical Assistance, DGAB No. 601 (1984).

temporary sanction in the nature of an incentive to promote timely filing of costs reports. Georgia noted that the reductions were intended "to encourage hospitals to file cost reports in a timely manner and not to punish hospitals with additional financial burdens." Georgia Reply Br., p. 3; and accompanying Attachment A, p. 2. Georgia asserted that once the cost report is filed, any "penalty" reduction in the hospital's interim rate is readjusted, so that effectively there was no penalty.

In rebuttal, HCFA argued that the State policy regarding late filing of a cost report is "explicitly and unambiguously" contained in the State plan. However, there is no evidence in the record to support HCFA's position that a nonrefundable penalty was mandated. As the intervenors noted, the State plan and the Medicaid Manual were silent on this point. Intervenors' Reply Br., p. 6; Georgia Ex. 12.

Based on the record, Georgia's treatment of the penalty for an untimely filed cost report as a temporary sanction is reasonable. The reductions do not constitute penalties in the usual sense of the term, but instead are incentives to promote timely filing; this purpose could be fulfilled by a temporary withholding of funds from the hospitals pending filing of the reports. Further, HCFA acknowledged that any reduction under Medicare would only be temporary; given the parallel nature of the provisions and the fact that the same report forms and intermediary were used, this fact is relevant in showing that the State's interpretation is a reasonable one.

Since the State could reasonably reinstate the 20% withheld from any hospitals following submission of the cost reports (and all of the providers here submitted the reports either within the quarter during which the 90 days expired or within the following quarter), there would be no payment of federal funds in excess of what was properly payable as medical assistance under the State plan. Thus, even if we found that the plan mandated imposition of the penalty after 90 days (which we do not), we would further find that there was no overpayment of FFP.

In summary, the State plan did not mandate imposition of 20% rate reductions, but, even if it did, the State would be entitled to the full rates since the cost reports have been filed and the 20% could properly be restored.

Conclusion

For the reasons discussed above, we reverse the entire disallowance of $502,858.

Cecilia Sparks Ford

Norval D. (John) Settle

Judith A. Ballard
Presiding Board Member