DEPARMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Maryland Department of Health and Mental Hygiene
Docket Nos. 78-30-MD-HC
78-60-MD-HC
78-95-MD-HC
Decision No. 124

DATE: October 2, 1980

DECISION

Three separate disallowance determinations are being considered jointly at the request of the parties as the determinations involve common questions of law and fact.

In notifications of disallowance dated May 1, 1978, June 9, 1978, and July 13, 1978, the Health Care Financing Administration (HCFA, the Agency) informed the Maryland Department of Health and Mental Hygiene (the State) that the State's claims for Federal financial participation (FFP) for intermediate care facility (ICF) services provided at the Caton Ridge Nursing Home during, respectively, September 1977, March 1, 1977 through May 31, 1977, and June 1, 1977 through August 30, 1977, were being denied. The amounts of the disallowances were, respectively, $17,215, $51,466, and $53,767. In addition, the July 13, 1978 notification of disallowance denied a claim of FFP in the amount of $82,078 for skilled nursing facility and intermediate care facility (SNF/ICF) services rendered by the Key Circle Hospice Nursing Home from June 1, 1977 through August 30, 1977. The stated reasons for each of the disallowances were the failure of the facilities to have valid provider agreements.

The State sought Board review of the Agency disallowance in letters dated, respectively, May 18, 1978, June 28, 1978 and August 4, 1978. The appeals were assigned Board Docket Nos. 78-30-MD-HC, 78-60-MD-HC, and 78-95-MD-HC.

The record on which this decision is based includes the applications for review, the Agency's responses thereto, the parties responses to a May 19, 1980 letter from the Board's Executive Secretary that requested additional information, and the State's response to an Order dated August 4, 1980, in which the State was requested to show cause why the disallowances should not be sustained on the basis of specified prior Board decisions; the Agency was not required to respond to the Order and did not do so.

Caton Ridge Nursing Home

I. Statement of the Case

Since 1972 the Caton Ridge Nursing Home has been classified as an intermediate care facility for Medicaid participation. The State had found the facility in violation of the Life Safety Code, but agreed to waive compliance with the regulations because of the facility's stated intention to construct a new replacement building. The waivers were renewed each year until 1977, and provider agreements were executed with the facility throughout this period, the last one being for the period January 27, 1976 through January 26, 1977. In this last agreement the State agreed to provide the facility with a hearing in the event Caton Ridge's participation in the Medicaid program was suspended or cancelled by the State.

In a letter dated January 28, 1977 the State's Division of Licensing and Certification notified the facility that the waivers of the Life Safety Code granted in 1972 were rescinded and that the renewal of its license was being denied effective January 27, 1977 because of two continuing violations, overly narrow corridors and stairways. The letter also stated, "In addition we are not recommending certification in the Title XIX, Medicaid Program. Your agreement expired 1/26/77. It is evident that without continuation of the previously granted waivers, neither Title XIX certification or State licensure can be granted."

Pursuant to a request of Caton Ridge, the Division of Licensing and Certification held a revocation hearing on March 31 and April 1, 1977. On August 17, 1977 the Division issued a recommendation, affirmed the same day by the Secretary of the State's Department of Health and Mental Hygiene, that Caton Ridge be decertified. Payments to Caton Ridge on behalf of 65 patients residing there were accordingly terminated on September 17, 1977, at which time the patients were transferred to other facilities.

In notifications of disallowance dated May 1, 1978, June 9, 1978, and July 13, 1978, the State was informed that its claims for FFP for services provided at Caton Ridge during, respectively, September 1977, March 1, 1977 through May 31, 1977, and June 1, 1977 through August 30, 1977, were being denied. The stated reason for each of the disallowances was the failure of Caton Ridge to have a valid provider agreement.

In applications for review dated May 18, 1978, June 28, 1978, and August 4, 1978 the State has argued that it could not revoke the license and/or certification of Caton Ridge without first providing the facility the opportunity for a due process hearing. During the period in which the facility is appealing its delicensing and/or decertification, the State contends, the Agency must continue to reimburse the federal portion of the payments for the Medicaid recipients in the facility.

The State has argued that on the basis of the U.S. Constitution and the State Administrative Procedure Act it was required to afford Caton Ridge an opportunity for a due process hearing before it could revoke the facility's license and/or certification. The State contends that the Agency "must continue to reimburse the Federal portion of the payment for nursing home services to Maryland Medicaid recipients for the period during which the facility has appealed a decision regarding certification until there has been a decision by the hearing officer." (State's application for review dated May 18, 1978.) Thus the State appears to be claiming that from January 27, 1977, the date on which Caton Ridge's provider agreement expired and its license renewal was denied, until August 17, 1977, the date on which the Secretary of the State's Department of Health and Mental Hygiene affirmed the decision to decertify the facility, the State was unable to order that the Medicaid recipients be removed from Caton Ridge as that facility was in the process of exercising its appeal rights. The State further contends that it "should not be forced to assume the full burden of providing care for the patient care provided by the Caton Ridge Nursing Home" during this period; rather, the State should receive FFP for the provided services.

The Agency's counterargument to the State's claim is that by regulation no FFP can be claimed without the existence of a provider agreement, and Caton Ridge did not have a provider agreement after January 26, 1977; therefore the disallowances must be sustained.

II. Applicable Regulations

The Medicaid regulations have been recodified several times in recent years, but for the period in question (March through September 1977) the applicable regulations are set forth in 45 CFR Part 249 (1976), "Services and Payment in Medical Assistance Programs."

Caton Ridge during this period provided ICF services. To obtain FFP for payments made to an ICF, the State must comply with the requirements in 45 CFR 249.10(b)(15)(i)(E) requiring the single State agency and the provider facility to execute an agreement which the single State agency determines is in accordance with 45 CFR 249.33 and meets all of the conditions of 45 CFR 249.10(b)(15)(i). The regulations require that prior to the execution of the provider agreement and the making of payments, the agency designated pursuant to § 250.100(c) (the survey agency) must certify that the facility meets the definition in § 249.10(b)(15) and is in full compliance with standards prescribed in the regulations (See 45 CFR 249.33(a)(i)).

Upon certification by the survey agency, the single State agency then executes a provider agreement with the facility in accordance with the federal regulations. § 249.33(a)(6). The regulations permit the State to continue to claim FFP for 30 days after the expiration of its provider agreement if the individuals in the facility were admitted before the date of expiration and the State agency

makes a showing satisfactory to the Secretary that it has made reasonable efforts to facilitate the orderly transfer of the individuals to another facility. (See 45 CFR 249.10(b)(4)(i)(C) and 45 CFR 249.10(b)(15)(v).)

III. Discussion

The issue raised by the State in the appeal of the Caton Ridge disallowances, the entitlement of a State to receive FFP for services rendered by a nursing facility during the period the facility is appealing the State's refusal to renew its license, has been before the Board in various forms previously. See Delaware Department of Health and Social Services, DGAB Docket No. 78-108-DE-HC, Decision No. 87, February 29, 1980, and Nebraska Department of Public Welfare, DGAB Docket No. 78-36-NB-HC, Decision No. 111, July 16, 1980.

In both these cases the Board explicity recognized the inherently difficult situation a state such as Maryland confronts. Whether by the terms of a provider agreement itself or a state statute, a state may be required to afford a facility a hearing before it can revoke the facility's license or decertify the facility from participation in the Medicaid program. The hearings can, and usually do, run beyond the duration of the facility's then existing provider agreement, with patients remaining in the facility throughout the course of the hearing process. In those cases the Agency has argued for a strict interpretation of the Medicaid regulations: without a valid provider agreement in effect, no FFP is available.

The Board sustained the Agency's disallowances in those cases, upholding the Agency's position that the health and safety of the patients in the facility is the paramount concern of the Agency and that to continue the payment of FFP throughout an appeals process of indefinite duration, with the patients remaining in a possible life-threatening environment, would run contrary to that concern. The Board stated, "To require the Department to continue payments when a facility does not meet minimal statutory and regulatory requirements would disarm the Department of its main weapon, the denial of FFP, to ensure that quality care is received." Nebraska, supra, page 9.

In its response to the Board's Order to Show Cause why the disallowances should not be sustained on the basis of the Board decisions in Delaware and Nebraska, the State has referred to the possible physical and emotional harm, popularly know as "transfer trauma", patients would be subjected to if they were forced to vacate a facility during its appeal. While the Board is certainly not unsympathetic toward the possibility of transfer trauma, it must balance that possibility against the greater possible physical harm the patients might receive while remaining in a facility such as Caton Ridge which was found to be in violation of the Life Safety Code. Such potential physical danger arguably outweighs any speculative emotional injury.

The State has also termed this area of law "arguably unclear," and while conceding that the recent Supreme Court decision in O'Bannon v. Town Court Nursing Center, 100 S.Ct. 2467 (1980), held that Medicaid nursing home recipients do not have a constitutional right to participate in a facility's pre-termination hearing, the State argues that the Court did not rule on the facility's right to continued payment during the hearing process. In the absence of any such ruling, the State contends that it acted with regard for rights believed to be secured by the Constitution and by regulations promulgated under the Social Security Act. Terming the Agency's interpretation of the regulations as a "narrow construction," the State contends that the Agency's refusal to participate in the cost of services at a facility during a post-termination proceeding defeats the purpose of 42 U.S.C. § 1396a(a)(19) which requires the states to provide such safeguards as may be necessary to ensure that care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.

We find the State's arguments unpersuasive. We find the Agency's interpretation of the regulations to be reasonable in view of its stated concern for the health and safety of the facility's patients. The administrative hearing procedure for Caton Ridge in this case took nearly seven months. In other cases currently pending before the Board, such procedures in other states have taken as long as two years. If the State's arguments were to prevail and FFP would be continued throughout the hearing process, there would be no incentive for the State to expedite the process as quickly as possible. Consequently, the patients would continue to be exposed to the conditions that led to the State's initial decision that the facility's license should be revoked.

On the basis of our prior decisions and our belief that the Agency's interpretation of the regulations then in effect is clearly reasonable, we conclude that the disallowance of FFP for services rendered by the Caton Ridge Nursing Home should be sustained.

Key Circle Hospice Nursing Home

I. Statement of the Case

A valid provider agreement existed between the State and the Key Circle Hospice Nursing Home (facility) that was due to expire on May 31, 1977. On February 14, 1977 the facility was notified by the State Division of Licensing and Certification that its license would be revoked within sixty days because of health and safety violations. The facility then apparently requested a hearing concerning the proposed license revocation, the result of which was an April 28, 1977 consent agreement between the State Division of Licensing and Certification and the facility.

In a July 13, 1978 notification of disallowance, the Administrator of HCFA affirmed a December 29, 1977 decision by the Acting Director of the Medicaid Bureau to disallow $82,078 in FFP claimed by the State for services rendered

by the Key Circle Hospice Nursing Home during the period June 1, 1977 through August 30, 1977. The stated reason for the disallowance was the failure of the facility to have a valid provider agreement.

In its August 4, 1978 application for review the State furnished copies of executed SNF and ICF provider agreements with the facility. These provider agreements were for a twelve-month period running from June 1, 1977 through May 31, 1978. Each agreement contained an automatic cancellation clause; the agreement would be terminated on December 31, 1977, unless unnamed deficiencies had been corrected or a resubmitted plan of correction had been approved. Both agreements were signed in December 1977 (the exact date is indecipherable).

The Agency in its December 26, 1978 response to the State's appeal denied that the facility had a valid provider agreement during the period in question. The Agency noted that the provider agreements submitted by the State were not executed until December 1977, over six months after the expiration of the facility's previous provider agreement on May 31, 1977.

In a later submission to the Board the State supplied copies of the Medicare/ Medicaid Certification and Transmittal forms (HCFA Form 1539) for the Key Circle Hospice. Forms were executed for both ICF and SNF participation by the facility in the Medicaid program. The period of certification (line 13) was from June 1, 1977 through May 31, 1978. The forms were signed, evidencing the approval of the State survey agency of the facility's certification, on December 7, 1977 (line 20).

II. Discussion

The central issue here is whether or not valid provider agreements, meeting all the requirements of the Medicaid regulations, were in effect for the Key Circle Hospice for the period of June 1, 1977 through August 31, 1977. The State contends such agreements were in effect, while the Agency maintains no valid agreements existed.

The State in its application for review has furnished executed SNF and ICF provider agreements for the facility in support of its contention. These agreements are for the period June 1, 1977 through May 31, 1978. The agreements were not signed, however, until December 1977. Thus it appears that the State is claiming that the provider agreements executed in December 1977 had retroactive effect to include the disputed quarter.

In response to this argument the Agency asserts that it was not until December 1977 that the facility was certified as a qualified provider of Title XIX skilled nursing and intermediate care services by the State agency. The Agency claims that "in the interim from June 1977 until sometime in December 1977, Key Circle operated under provisional State licensure; there was no provider agreement in effect throughout this period of time." (Agency's submission of December 15, 1978, page 3.) The Agency adds that the State

has failed to supply any proof that required improvements (apparently the subject of the consent agreement) were accomplished by the facility or that the facility was certified by the State survey agency as acceptable prior to June 1, 1977.

On July 3, 1980 the Board issued its decision in the case of the Maryland Department of Health and Mental Hygiene, DGAB Docket No. 79-157-MD-HC, Decision No. 107. In that case, involving the same parties as this appeal, the Board addressed the question of the requirements of a valid provider agreement, the same issue involved in the Key Circle Hospice disallowance.

In that case the State advanced the argument that a provider agreement could be backdated. The Agency accepted the proposition that a provider agreement signed at a later date could be made effective to an earlier date. In that case, however, the Agency focused on the date of the certification of the facility (as meeting the required sanitary, safety, health care, and administrative standards) by the state survey agency as the key date in the certification-provider agreement process. The Agency argued that the correct time sequence to be followed is a survey of the facility, certification by the state survey agency, and then the execution of a provider agreement between the facility and the state medicaid agency, the duration of the certification period and the provider agreement to be identical, not commencing until after the date of certification. The State's position, on the other hand, was that a certification issued by the state survey agency could be made effective to an earlier date; a corresponding provider agreement could then also be made effective to the same earlier date.

In Decision No. 107 the Board held, at page 4:

> The Agency's interpretation of [the applicable regulations] as meaning that a provider agreement can only be effective from the date of a facility's certification as meeting certain requirements is not arbitrary in view of the Medicaid program's aim to ensure quality care in sanitary and safe conditions. Under the Agency's interpretation, a facility is unable to participate in the Medicaid program until it has shown it has met basic requirements as evidenced by certification by the single State agency. This certification becomes effective on the date the survey agency indicates its approval by completing a HCFA Form 1539. No interval where the facility could fall below these standards is permitted under this interpretation, while under the State's reasoning such a possibility could occur. . . A recent HCFA regulation announcement (45 FR 22933, April 4, 1980) would appear to allow a provider agreement to become effective on the date of the onsite health and safety survey, but that rule [did] not become effective until July 3, 1980. Nevertheless, we find that the Agency's interpretation of the regulations in effect during the period of the disallowance represents a valid exercise of its administrative

responsibilities. The fact that the Agency has now decided to change its policy does not invalidate its prior actions.

Concerning Key Circle Hospice, both 45 CFR 249.33(a)(1) and (2) require certification prior to the execution of a provider agreement. 45 CFR 249.33(a)(6) states that a provider agreement is contingent upon a facility's certification by the state survey agency; the regulation further states that "the effective date of such an agreement may not be earlier than the date of certification."

In an Order to Show Cause the State was asked to explain why the disallowance for the Key Circle Hospice should not be sustained on the basis of the reasoning contained in Board Decision No. 107. In its response the State did not present any such explanation or offer any new arguments in support of its position. We have therefore decided that Decision No. 107 is applicable to the facts of this case, and we accordingly conclude that the disallowance of FFP for services rendered at the Key Circle Hospice should be sustained.

Conclusion

For the reasons stated above, we sustain the disallowances in the amounts of $122,448 for the Caton Ridge Nursing Home and $82,078 for the Key Circle Hospice Nursing Home.

/s/ Clarence M. Coster

/s/ Donald G. Przybylinski

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