DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Ohio Department of Public Welfare DATE: April 30, 1981
Docket Nos. 78-22-OH-HC
80-30-OH-HC
80-89-OH-HC
Decision No. 173

DECISION

These are three appeals by the Ohio Department of Public Welfare (Ohio or State) from decisions of the Health Care Financing Administration (HCFA or Agency) disallowing Federal financial participation (FFP) in the cost of services to Medicaid recipients by nursing homes whose provider agreements had not been renewed or had been terminated. A total of $3,219,951 was involved in the three cases. Inasmuch as the three appeals concern the same parties, the same issues, and similar facts, the cases are being considered jointly for purposes of this decision.

Some details of the appeals follow:

Docket Number	Quarters Ended	Date of Disallowance	Amount Disallowed	Date of Appeal
78-22	12-31-77	4-7-78	$ 617,410	5-2-78
80-30	3-31-77 6-30-77 9-30-77	2-6-80	$2,493,469	3-6-80
80-89	12-31-77 through 3-31-79	4-14-80	$ 109,072 1/	5-16-80

1/ At the time that Ohio filed its appeal, it complained that HCFA had not honored a federal court order directing HEW to reimburse Ohio for payments to Tepper Nursing Home. The Board called this to the attention of HCFA, and HCFA withdrew $6,772 of the disallowance, reducing it to $102,300.

Issue

These cases concern the circumstances under which FFP is available subsequent to the nonrenewal or termination of a provider agreement. The primary issue is whether FFP is available when a facility appeals the nonrenewal or termination and, pending review, payments are continued under operation of State law, including judicial order. The Board here decides that FFP is available to reimburse a State for court-ordered payments during provider appeals for up to 12 months from termination or nonrenewal of a provider agreement. The decision is based on the appeals; HCFA's responses; the records submitted by HCFA; copies of court orders and related papers submitted by Ohio; the Order to Show Cause issued October 16, 1980 for these and related appeals; responses by Ohio and HCFA to that Order; transcripts of informal conferences held October 9, 1979 and February 11-12, 1981; and briefs and other materials submitted by HCFA and some of the states attending the February 1981 conference (referred to hereinafter as the Conference). 2/

Background

Since 1965, under Title XIX of the Social Security Act (Medicaid), Congress has made available federal matching funds to states for medical assistance to eligible individuals. To qualify, a state must have a plan approved by the Secretary of the Department of Health, Education, and Welfare (HEW), now Health and Human Services (HHS), requiring among other things:

1) such safeguards as may be necessary to assure that care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

2) agreements with persons and institutions providing services (providers) that they will keep necessary records and furnish information to the state or the Secretary upon request;

3) periodic inspections (surveys) of skilled nursing and intermediate care facilities;

2/ The Board invited to the Conference Ohio and 11 other States -- Colorado, Georgia, Illinois, Louisiana, Michigan, Minnesota, Missouri, Nebraska, New York, Pennsylvania, and Wisconsin. These 12 states had 50 cases pending before the Board with provider appeal issues common to disallowances totalling approximately $20 million and involving over 300 facilities. Ohio attended only the October 1979 conference (which dealt with those same issues), but was sent transcripts of and given an opportunity to comment on both conferences.

4) full and complete reports of the findings resulting from the inspection;

5) a determination by the state agency responsible for licensing health institutions to the single state agency administering the plan whether an inspected facility meets the requirements for participation in the program (certification); and

6) public disclosure of the findings by the survey agency.

The foregoing is a summary of 42 USC §1396a(19), (26), (27), (31), (33), (36) (section 1902(a) of Title XIX).

In implementing the statutory Medicaid requirements, the Secretary has adopted a regulatory scheme of provider agreements, surveys, and certifications under approved state plans. For the time in question the regulations specify that the duration of a provider agreement is coterminous with the period of certification, and a provider agreement could not have an effective date earlier than the date of certification. Under regulations adopted April 29, 1970, provider agreements must be renewed on a frequency of 12 months or less. In 1974, the regulations were amended to permit a two month extension where there is written notice from the state survey agency in advance of the original expiration date that the extension would not jeopardize the patients' health and safety and the extension is needed either 1) to prevent irreparable harm to the facility or hardship to the recipients in the facility; or 2) because it is impracticable to determine, before the expiration date, whether the facility meets certification standards. Federal financial participation would be available for another 30 days after an agreement expires or terminates where the Secretary determines that there have been reasonable efforts to transfer patients to another facility or to alternate care. See 42 CFR §§431.107, 441.11, 442.12, 442.15, 442.16 (1978-1980) and previous codifications generally at 45 CFR Part 249 (1973-1976) and 42 CFR Part 449 (1977). 3/

The nursing homes in these cases had at one time signed provider agreements with Ohio but at various times prior to the quarters for which FFP is claimed all of the provider agreements had either 1) expired and not been renewed; or 2) been terminated or cancelled.

3/ Hereinafter when we refer to the term of a provider agreement, we include per se the possibility of the two month extension and the 30 days additional FFP, where applicable, even though we may not always mention those provisions.

Some facilities sought hearings on the adverse determinations (provider appeals); some were reinstated. The record does not show if any were reinstated as a result of a reversal of the State decision after review. Some withdrew from the program entirely. The State alleges that pursuant to court orders some facilities continued to receive payments pending appeal (see Appendix to this decision).

Ohio argues in these cases that it is entitled to FFP because in a number of instances it was directed to continue payments to the nursing homes by orders of state and federal courts. In those situations not covered by court orders either because court orders were not sought or were not issued until many months after the expiration or termination of the provider agreement, Ohio argues that it chose not to remove the Medicaid patients until the facility had had another opportunity to achieve compliance. Ohio contends that this policy was vindicated by the number of nursing homes recertified - allegedly two-thirds of the overall number. Ohio claims that in a number of instances it could not find suitable alternative facilities within the 30 days allowed for transfer or removal and points to the risk of transfer trauma to the patients as a reason for not wanting to move the patients.

HCFA relies primarily on the absence of any regulation specifically making FFP available during a provider appeal and contends there are regulations which prohibit reimbursement to a state for such payments. As for the effect of the court orders, HCFA argues that where it is not a party to a court proceeding it is not required to pay FFP outside the scope of the Medicaid program.

In Delaware Department of Health and Social Services, Decision No. 87, February 29, 1980, this Board dealt with the provider appeals issue. Delaware did not involve a court order but it does afford some insight into reasoning applicable here.

In Delaware, the issue was the availability of FFP during the pendency of an administrative hearing process afforded by the State under the terms of a provider agreement which had expired and not been renewed. The Delaware Office of Health Facilities, Licensing, and Certification determined that the nursing facility had not met certification standards; a hearing was held some six weeks later, and four months after that hearing a decision was issued affirming the State agency action and refusing to renew the facility's participation in the Medicaid program.

In sustaining the Agency's disallowance, the Board held:

> There is no provision in the Social Security Act or Federal regulations authorizing HEW to make payments to a State because it has bound itself to make payments to a facility during a fair hearing process that extends beyond the expiration of a valid provider agreement. The applicable regulation states that FFP is only available when the facility in question meets all the requirements of certification as evidenced by a valid provider agreement; the provider agreement in this case expired... and was not renewed. (Page 6.)
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> The purpose of the Medicaid program is to ensure that qualified recipients receive health care in facilities which comply with Federal and state standards. Its main tool of enforcement is to deny FFP for facilities which are substandard, whether they are found to be so by the state or by HEW itself. FFP is not available for a facility with an expired agreement. (Page 9.)

See also Nebraska Department of Public Welfare, Decision No. 111, July 16, 1980; and Maryland Department of Health and Mental Hygiene, Decision No. 124, October 2, 1980.

Discussion

1. Facilities which did not appeal

Ohio concedes that some of the facilities to which it made Medicaid payments after nonrenewal or termination did not appeal, contending that the alleged eventual recertification of some of those facilities vindicates the decision of the State not to stop payments. See initial appeal documents in 78-22 and 80-30. Even assuming arguendo that the State could prove that it erroneously decertified a facility, we find that under the regulations the Agency properly disallowed FFP in payments to facilities which did not appeal since there is no other provision for payment of FFP except to a properly certified facility with a current provider agreement. See 42 CFR Part 442. Ohio's concerns about patient trauma, conserving Medicaid resources, and simplicity of administration may be worthwhile policy and equitable considerations for the Agency to address in an appropriate way, but consistent with prior decisions of the Board these factors do not overcome the clear and unequivocal thrust of the regulatory scheme for payment of FFP. See, e.g., Delaware, supra, pp. 6, 9. Also, in Maryland, supra, the Board upheld the Department's position that on balance the "potential physical danger" of leaving patients in a facility found in violation of Life Safety Code requirements "arguably outweighs any speculative emotional injury" from transfer trauma.

Accordingly, we uphold those disallowances where the facility did not appeal its nonrenewal or termination.

2. Provider Appeals

MSA-PRG-11 and Maxwell v. Wyman

This brings us to the main issue -- whether FFP is available pending a provider appeal. Neither the statute nor the regulations explicitly address the subject of the availability of FFP during the time when providers are seeking to obtain administrative or judicial review of decisions to terminate or not renew their participation in the Medicaid program. On December 20, 1971, the Commissioner of the Medical Services Administration (MSA), Social and Rehabilitation Service (predecessor to HCFA), issued a Program Regulation Guide (PRG) setting out two exceptions to the rule that FFP is not available where a provider agreement has expired and not been renewed or has been terminated:

> 1) [If] State law provides for continued validity of the provider agreement pending appeal (hereinafter referred to as "Part 1"); or
> 2) [If] the facility is upheld on appeal and State law provides for retroactive reinstatement of the agreement ("Part 2").

PRG-11 (Tab F, Order to Show Cause).

The meaning of "State law" was clarified to include "judicial action" in a May 14, 1973 memorandum from Marie Callender, Special Assistant for Nursing Home Affairs, to the Regional Directors for HEW. Ms. Callender communicated a decision by the Secretary of HEW that FFP is available "if State law or judicial action requires that a provider agreement remain in force during the course of an appeal." Tab G, Order to Show Cause.

There are two decisions by the United States Court of Appeals for the Second Circuit which are key to an understanding of PRG-11. In Maxwell v. Wyman, 458 F.2d 1146 (1972), the court reversed a district court decision and ordered the New York Department of Social Services (DSS) to continue reimbursing nursing home proprietors for services to Medicaid recipients — even though the homes had been terminated from the Medicaid program -- until DSS had given the homes a hearing on the question of whether DSS had properly denied requests by the homes for Life Safety Code waivers. The court of appeals noted its assumption that "HEW procedures will have sufficient flexibility to allow the State to afford appellants hearings if it does so on an accelerated basis." Id. at 1152.

Following the 1972 decision, the State and HEW entered into a stipulation that FFP would be continued until a decision based on the administrative hearing was rendered, but HEW later refused to reimburse the State for payments made pursuant to the orders of a State court pending review by that court of the administrative hearing decision. In a subsequent decision the federal court of appeals held that HEW was required under PRG-11 to give the same treatment pending judicial review of an administrative proceeding as it does pending the proceeding itself "or as it concedes that it would if a nursing home operator was able to have the administrative determination reversed on appeal." Maxwell v. Wyman, 478 F. 2d. 1326, 1328 (1973).

Analysis of HCFA's Position

Ohio and the other States litigating these cases before the Board argue that FFP should be available indefinitely throughout a provider appeal. State and federal courts have held that in some circumstances a facility may have a due process right to a pretermination hearing and to continued payments pending such review but, as the Board indicated in its Delaware decision, supra, such decisions are not a basis (Page 9):

> to require HEW to continue to pay FFP for an unlimited amount of time while a facility wends its way through an administrative appeals process that might take years to complete...

See also the discussion of 45 CFR §205.10(b)(3), infra.

HCFA concedes that both parts of PRG-11 continue to govern the availability of FFP during provider appeals but maintains that under Part 1 (provider agreement continued in effect pending appeal) FFP is limited to the duration of 12 months from the execution of the provider agreement which is terminated or not renewed, plus an additional two months and/or 30 days if qualifying conditions are met. HCFA Post-Conference Memorandum, pp. 14, 29; 42 CFR §§ 442.15, 442.16. On the other hand, HCFA argues that under Part 2 (facility prevails and provider agreement retroactive to date of erroneous determination) FFP is available for the 12 month period following the nonrenewal or termination of the provider agreement or until there is a determination on the findings of the next survey, whichever comes first. The availability of FFP beyond 12 months appears to be conditioned on a state's performing surveys and making certification decisions annually. HCFA Post-Conference Memorandum, pp. 18-19; Conference Transcript, pp. 334-335.

For reasons stated below, we conclude that Part 1 of PRG-11 is limited by statutory and regulatory provisions which make FFP available for no more than a period of 12 months following nonrenewal or termination or until the next survey/certification cycle has been completed, whichever comes first. This limitation was in effect at the time PRG-11 was issued and has remained in effect ever since. We further conclude that the limitation which HCFA wishes to impose on Part 1 of PRG-11 (12 months from execution of the provider agreement) is not a necessary interpretation of its 1974 two-month-extension regulations and has never been expressly adopted by the Agency as a limitation affecting FFP during provider appeals.

We find that the purpose of re-executing provider agreements on a frequency of 12 months or less is not to give new life to a perennial record-keeping requirement, but to reinforce the pattern of surveying facilities at least once a year. The survey requirement predates and necessarily limits PRG-11. As HCFA correctly observed in its Post-Conference Memorandum (p. 18):

> The point ... is not that the state must certify, but that it must make certification decisions annually, based on proper surveys. (Emphasis added.)

The Marie Callender memorandum to HEW Regional Directors in May 1973, supra, reaffirmed the Secretary's intent that FFP generally should be available during provider appeals. The significance of this memorandum is heightened by an unsuccessful attempt by the Commissioner of the Medical Services Administration in September 1972 to limit Part 1 of PRG-11 to FFP only during administrative review. This attempt was deterred by the May 17, 1973 decision of the Second Circuit in Maxwell v. Wyman, 478 F.2d. at 1328. Against this backdrop, we must examine the absence of any reference to provider appeals in the July 1973 Notice of Proposed Rulemaking or in the Preamble to the January 1974 final regulations adding the two month extension. 38 Fed. Reg. 18616, 39 Fed. Reg. 2254.

HCFA bases its limitation on Part 1 of PRG-11 -- that pertaining to the availability of FFP where payments are continued pursuant to state law — on the 1974 regulations allowing a two month extension for provider compliance. 39 Fed. Reg. 2254, now 42 CFR §442.16. These amendments are sufficiently ambiguous that they may be interpreted to apply where there is a provider appeal; but in the absence of a showing that they were intended at least in part to apply to limit FFP during a provider appeal, we do not find that the very specific rule of PRG-11 on FFP during provider appeals was nullified. See also our discussion on repeal by implication, infra.

HCFA admits in its Post-Conference Memorandum (p. 30) that the "degree to which they perceived PRG-11 as a problem is not clear "(referring to the persons responsible for the 1973 and 1974 regulations). Moreover, the (then) Board Chair noted in the decision in Delaware, supra, that a Regional Attorney for HEW advised Delaware on December 24, 1975: PRG-11 is "the present policy of the Department." (Page 4). The Board found that PRG-11 did not apply in the Delaware case because the State had not found any "statutory or case reference which would provide for the continued validity of the provider agreement pending appeal." Page 8).

Despite HCFA's insistence in these cases and in court litigation 4/ that there is the aforesaid limit of 12 months from the inception

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4/ See e.g., the Willging Affidavit, Attachment D, Order to Show Cause issued October 16, 1980. This affidavit was executed by Paul R. Willging, then Acting Deputy Director, Medicaid Bureau, HCFA, and filed in federal court in July 1978 (Creasy v. HEW, Civil Action No. C-2-78-21 (S.D. Ohio)). In his affidavit Dr. Willging asserts:

> In tailoring its practice to correspond to the decision in Maxwell v. Wyman, 478 F. 2d 1326 (2d Cir. 1973), HEW has followed a policy of reimbursing State welfare agencies for Medicaid payments made to providers which the State has decertified or failed to renew when the State agency has been ordered by a court to continue payments to the facility pending appeal of the decertification or non-renewal. It has been HEW's policy to continue such payments to the State agency where the effect of the injunction against the State has been to extend the term of the provider agreement but in no event are payments to extend beyond twelve months past the execution of the provider agreement which is the maximum period permitted by federal regulations without another survey and certification.

We note that Dr. Willging refers not to the 1974 regulations, but to the 1973 Maxwell v. Wyman, decision, supra, which, as we have seen, was centered on Part 1 of PRG-11. We think that Dr. Willging misrepresents the Maxwell ruling (by implying that limiting FFP to a maximum of 12 months past the execution of the provider agreement is a practice corresponding to the Maxwell decision), but the significance of his reference to Maxwell -- and, inferentially, Part 1 of PRG-11 -- as though it were still viable further discredits the argument that HCFA has looked elsewhere for the rule since 1974. If the 1974 regulations had indeed superseded PRG-11, Maxwell would not have been applicable at the time of the affidavit — a position which HCFA continues to espouse in its responses to the appeals in each of these cases.

of a provider agreement even where a provider appeal is pending, HCFA was not able to produce a single agency issuance (external to these disallowances) to support this position. An attempt to develop a memorandum setting forth the Agency position in March 1980 did not get beyond the draft stage. See February 23, 1981, Submission of Documents by HCFA.

We also find it significant that on February 15, 1979, the Administrator of HCFA, in a statement approved by the Secretary, described a regulatory provision proposing to make FFP available for some provider appeals as being intended "to clarify the point at which Federal funding of Medicaid payments would cease for a facility that had been terminated from the Medicaid program." 44 Fed. Reg. 9749. 5/ If, as HCFA argues in these appeals, the 1974 regulations resolved the issue by setting an absolute outside limit, no clarification would have been necessary. On the other hand, reference to the need for clarification would be appropriate in the context of a still-valid PRG-11 since the latter is only an interpretation of the statute and regulations.

Effect of other regulations on PRG-11

This brings us to the question of what effect, if any, other regulations have on PRG-11 -- namely 45 CFR § 205.10(b)(3) and 42 CFR §442.30. In the October 16, 1980 Order to Show Cause (at p. 19) the Board

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5/ The provision was part of a January 1977 Notice of Proposed Rulemaking which indicated that if the provision was adopted:

> Federal financial participation will not be available as of the effective date of a survey agency certification expiration or cancellation or in the absence, for any other reason, of a valid provider agreement. If the decision in either hearing and appeal proceedings is in the provider's favor, FFP would be available retroactively to the effective date of a valid provider agreement...

The basis given for the proposed regulations was the Secretary of HEW's determination that:

> Federal payments should not be made in the absence of a valid and in-force provider agreement, and that facilities are entitled to a reasonable opportunity for review of adverse actions.

42 Fed. Reg. 3665, 3666.

On February 15, 1979, the final regulation requiring the availability of appeals proceedings was announced. Final rules on "the Federal financial participation questions" were withheld because "these issues were not adequately addressed in the Notice." 44 Fed. Reg. 9749.

indicated that 45 CFR §205.10(b)(3) might be a basis for holding that FFP is available during a provider appeal, where a state has been ordered by a court to continue payments. That subsection makes FFP available for:

> Payments of assistance within the scope of Federally aided public assistance programs made in accordance with a court order.

Both Ohio and HCFA agree that subsection 205.10(b)(3) is relevant to this issue, but differ as to the meaning of the key phrase "within the scope."

Ohio contends that the disputed phrase means "that when a court orders payment in the Medicaid program it must be for a covered service to an eligible recipient (eligible but for the matter at issue)." As a result Ohio concludes that FFP is available indefinitely during a provider appeal as long as the court order remains in effect. March 26, 1979 Memorandum of State in Response to HEW "Brief", in Docket No. 78-22-OH-HC, p. 3; March 6, 1980 Request for Reconsideration in Docket No. 80-30-OH-HC, p. 5; see also submission by Ohio dated May 30, 1980 in Docket No. 80-89-OH-HC.

HCFA argues that "within the scope" means that FFP is available only for payments made during a period of 12 months from the execution of a provider agreement, plus the two month extension and 30 days for removal or transfer, where applicable. HCFA contends that by implication PRG-11 was repealed by the adoption of subsection 205.10(b)(3) in 1973 and two other sets of regulations in 1974 — the "look-behind" provisions (42 CFR §442.30), and the previously discussed two month extension rule. Post-Conference Memorandum, pp. 7, 9-13, 41.

We find persuasive elements in the arguments of both parties. To the extent that provider appeals are involved, we agree with Ohio that subsection 205.10(b)(3) authorizes FFP for court-ordered payments for services to Medicaid recipients by providers who are seeking review of the State's action refusing to renew, or terminating, their participation in the program. We also agree with HCFA that "within the scope" was intended to, and does set limits on the availability of FFP pursuant to the court's order in such situations. But these limits are drawn from regulatory requirements which are not the subject of the court's order (as opposed to those which may be affected), as HCFA itself observed on the occasion of a recent non-substantive recodification of this regulation:

> The provision contained in 45 CFR 205.10(b)(3) was especially important since it restricted FFP to Medicaid services under the scope of the Federal program. For example, even when there is a court order against a State to provide services beyond the limits of the program, FFP is not available when there are other regulatory provisions which impose limitations (such as separate time limits or limitations on types of services) upon the receipt of Federal funds. (Emphasis added.)

45 Fed. Reg. 24878 (April 11, 1980).

In the instance of a provider appeal, the State's action would have denied the facility the provider agreement needed for participation in the Medicaid program. The court order overcomes the limiting effect of that action but does not overcome other limits. If the State had made a new agreement with the facility, we assume that the new term could not have been longer than 12 months from that date because of other regulations calling for the annual survey/certification cycle. In ordering continued payments under the court-revived old agreement, the court could not give that agreement greater effect than if the State had approved the facility and made a new agreement. The "within the scope" language thus limits FFP in court-ordered payments to a period of 12 months or completion of the next survey certification cycle, whichever is sooner.

For the same reasons advanced in our discussion of PRG-11, infra, we find that the 1974 regulations are not the critical limiting factor in determining what is within the scope of the program. Similarly, we are not persuaded that the look-behind regulations were intended to, or do, affect the "within the scope" rule. To the contrary, the condition for invoking the look-behind authority is that a state has certified or issued a provider agreement in disregard of program requirements. Here the State has refused those incidents of participation. The court order is merely to preserve the status quo pending review and does not pretend that the provider is in compliance. 6/

6/ In December 1980, Congress passed and the President signed Public Law 96-499, the Omnibus Reconciliation Act of 1980. Section 916 of this Act may be read to authorize the continuation of FFP for up to 12 months during review of a determination that because of deficiencies a facility no longer substantially meets the standards for participation in Medicaid. If the deficiencies immediately jeopardize the health and safety of the patients, FFP is not available for new patients admitted after a specified date.

Repeal by implication

HCFA effectively concedes that the 1973 and 1974 regulatory provisions discussed above do not specifically nullify Part 1 of PRG-11 but argues rather that they repeal it by implication. Post-Conference Memorandum, p. 14. HCFA's position is that there is "clear and positive conflict" between PRG-11 and the above mentioned regulations and thus PRG-11 must necessarily give way to them.

HCFA's reference to this rule of statutory construction may be misguided, however. In discussing the rule, the Supreme Court has noted:

> It is not sufficient to establish that subsequent laws cover some or even all of the cases provided for by [the prior act]; for they may be merely affirmative, or cumulative, or auxiliary.

Wood v. United States, 16 Pet. 342, 362 (1842). The Court has also stressed that "the intention of the legislature to repeal 'must be clear and manifest.'" Morton v. Mancari, 471 U.S. 535, 551 (1974), citing United States v. Borden Co., 308 U.S. 188, 198 (1939).

Applying this reasoning to the regulations in question, we do not find a "clear and manifest" intent to repeal PRG-11. We agree with HCFA's characterization:

6/cont.

HCFA attached to its Post-Conference Memorandum the affidavit of Jeffrey Merrill, who was Director of the Office of Legislation and Policy for HCFA during the time that Section 916 of P.L. 96-499 was being developed. In pertinent part, the Merrill affidavit concludes:

> There was definitely no intent, nor do I believe that the legislation does change the existing rules with respect to the availability of Federal funding during an appeals process. We had no intention to require such funding throughout a provider's appeal at either the administrative or judicial level. (Emphasis added.)

HCFA Post-Conference Memorandum, pp. 26-27 and Attachment 1.

Inasmuch as these disallowances precede P.L. 96-499, that Act would not apply to them, nor do we mean to suggest here how it might be interpreted in other cases. However, Mr. Merrill's characterization of existing rules as not requiring FFP throughout a provider's appeal is in apparent harmony with our holding that FFP is not available in court-ordered payments for longer than 12 months.

> In this case, the problems pertaining to FFP with respect to unqualified providers were dealt with by a progression of regulations addressed to different aspects of the problem.

Post-Conference Memorandum, p. 30.

We think that the events of 1973 and 1974, as HCFA itself describes them, do not meet the standard enunciated by the Supreme Court for repealing Part 1 of PRG-11. As we understand PRG-11, there is no clear and positive conflict between that interpretive ruling and the regulations cited by HCFA. See our discussion of PRG-11, supra.

3. Summary of Our Holding

The following summarizes what we have decided on the issue of FFP pending a provider appeal:

1. The interpretation of the statutory and regulatory requirements affecting the availability of FFP expressed in PRG-11 remains in effect and no part of it has been nullified, repealed, or amended by subsequent regulations or official Agency guidance materials.

2. Pursuant to PRG-11 and 45 CFR §205.10(b)(3), FFP is available in the cost of covered services to Medicaid recipients in nursing homes with provider agreements that have been terminated or have not been renewed, where a facility appeals the adverse determination and a state or federal court orders the state to continue payments because of that appeal, thereby effectively continuing the provider agreement.

3. The Agency is authorized to reimburse a state the federal matching share if the facility is not upheld on appeal, but the period of reimbursable services may not exceed 12 months from the termination or nonrenewal determination; except that if within the aforesaid 12 months a state surveys the facility and makes a new determination on certification, FFP may not be available beyond the date of that determination if the only basis for FFP would be the pendency of the court order and the provider appeal.

4. Application of this Decision

This brings us, then, to the application of the Board's decision.

In its October 16, 1980 Order to Show Cause the Board tentatively found in Docket No. 78-22-OH-HC that an unspecified number of the facilities involved appealed their loss of certification, and in some instances courts ordered Ohio to continue payments to the facilities pending

appeal. Order, p. 8. In Docket No. 80-30-OH-HC the Board tentatively found that an unspecified number of the facilities involved appealed their loss of certification, and in 21 instances Ohio had been ordered by courts to continue payments pending appeal. Ibid., pp. 8-9. In Docket No. 80-89-OH-HC, the Board tentatively found that both facilities involved had obtained court orders continuing payments by the State pending review of their loss of certification. Ibid., p. 9.

In its January 16, 1981 Response to the Order, HCFA asserted that it was reserving until after the Board's ruling on the legal issues HCFA's statement of its position on the application of that decision to each case. Response, p. 2. HCFA recited its "understanding that the Board is going to rule on the legal issues and then separately apply them to each case," suggesting that the Board issue post-decision orders to apply its ruling to each case.

In its January 16, 1981 Response to the Order, Ohio reserved the right to provide documentation on the outcome of the provider appeals after the Board's ruling on the law. Response, p. 3.

In deference to the parties, we will not make findings on the particular facts regarding each facility, nor will we invite the parties to comment on or add to the exhibits and other documentation in the record. Now that a decision on the legal issues has been rendered, the parties can promptly and fairly work out between themselves the implementation of that decision. If the parties are not able to work out their differences or there is undue delay by the Agency, the State may return to the Board.

By way of guidance to the parties, we have made tentative findings about the material in the record and those are set out in an Appendix to this decision. We have included court orders obtained before or shortly after the nonrenewal or termination, unless the order specifically referred to the pendency of an appeal. We have also included court orders that either enjoined the State not to transfer or remove the patients or directed the State to continue payments, but not orders intended merely to give the facility more time to achieve compliance.

/s/ Cecilia Sparks Ford

/s/ Donald F. Garrett

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

APPENDIX

Ohio has submitted copies of court orders directing continued payments to nursing homes involved in all three Board appeals. In Docket No. 80-30-OH-HC, which Ohio alleges dealt with totals of 32, 69, and 68 nursing homes in consecutive quarters ended March 31, June 30, and September 30, 1977, Ohio submitted copies of court orders pertaining to 20 facilities. 1/ See letter dated May 1, 1980, and enclosed exhibits. 2/ In its May 1 letter Ohio indicated it would submit additional court orders, but in a subsequent letter dated June 2, 1980 it withdrew that offer on the grounds that the other orders were issued after September 30, 1977.

In Docket No. 78-22-OH-HC, where 52 nursing homes are involved in the quarter ended December 31, 1977, Ohio submitted copies of court orders pertaining to an additional 12 facilities and cross-referenced its May 1, 1980 submission in Docket No. 80-30-OH-HC in support of the remaining 16 facilities listed. See letter dated January 16, 1981, and enclosed exhibits. 3/

In Docket No. 80-89-OH-HC, copies of the court orders pertaining to the two facilities involved in that case were enclosed with the Ohio letter dated May 30, 1980, and may also be found in the administrative record filed by HCFA on August 12, 1980.

1/ The administrative record filed with the Board on April 10, 1981, contains listings by HCFA for the quarters ended March 31 (Record, Tab 2) and June 30 (Record, Tab 5), but not for September 30, 1977. The HCFA lists support the Ohio figures for the two quarters, except that the June 30 list includes Annie Green's Christian Home for the Aged, which was removed from the list prior to the Administrator's February 6, 1980 decision -- thus reducing that total to 68. Some of the same facilities appear in listings for two or three of these quarters and for the quarter ended December 31, 1977 involved in Docket No. 78-22-OH-HC.

2/ The Ohio letter lists a Royal Haven which is represented as being the subject of a court order to be found in Exhibit 1-L. No court order or any other papers in 1-L or the other exhibits mention Royal Haven. There was a motion for a temporary restraining order for Mary Grove Nursing Home, but no court order in Exhibit 1-H or the other exhibits.

3/ There was no court order for Ro-Ker in Exhibit A-j or the other exhibits. Sturges Convalescent (Exhibit 1-o, Docket No. 80-30-OH-HC) was on the two lists supplied by HCFA in Docket No. 80-30-OH-HC, but not on the list attached to the April 7, 1978 decision of the Acting Director of the Medicaid Bureau in Docket No. 78-22-OH-HC.

By way of guidance and not as a mandate, then, the Board makes the following tentative findings about the exhibits and other data furnished by Ohio:

1) In Docket No. 78-22-HO-HC and 80-30-OH-HC, we found the documentation with respect to the following ten facilities would probably meet the standard set out in our holding:

Facility	Docket No.	Quarter(s) Ended	Exhibit No. Court(s) (Co)	Case No(s).
1. Carson Convalescent Center*	80-30	3-31-77	1-b Franklin	77CV-01-325
2. Danridge Nursing Home	80-30	9-30-77	1-c Mahoning	77CV1306
3. Little Forest Medical Center*	80-30	3-31-77 6-30-77	1-c Mahoning	77CV530
4. Marshall Nursing Home	78-22 80-30	3-31-77 to 12-31-77	1-f Franklin	77CV01-160
5. Mary & Fletcher 6. Health Care Center No. 1* & No. 2*	78-22 80-30	3-31-77 to 12-31-77	1-g Columbiana	77CIV29
7. Mayfair Nursing Care Center No. 2	80-30	6-30-77	1-i Franklin	77CV05-1954
8. Sarah's Rest Haven*	78-22 80-30	3-31-77 to 12-31-77	1-m Knox	77CI19

Facility	Docket No.	Quarter(s) Ended	Exhibit No. Court(s) (Co)	Case No(s).
9. Sturges Convalescent*	78-22 80 30	3-31-77 to 12-31-77	1-o Richland	7731M
10. Wright	78-22	12-31-77	A-m Hamilton	A770-8843

In the other instances we found that there was insufficient connection between the court order and the appeal, if any, from the nonrenewal or termination of the provider agreement -- usually accented by the length of time between the latter and the filing of the court action. We note that six of the ten facilities listed — those six with an asterisk — were reinstated in the program. Four of these reinstatements came less than 12 months after termination.

2) In Docket No. 80-89-OH-HC, the record indicates that Ohio continued on its own to make payments to the Lincoln Avenue Home for the Aged for the service period from June 1, 1977 to November 30, 1977. A temporary restraining order (TRO) issued January 9, 1978 directed Ohio to pay for services rendered on December 1, 1977 and thereafter. A letter signed by Judge Outcalt on March 31, 1978, reflects his intention to issue a preliminary injunction. Although separated by some months from the actual termination date, these orders are linked to the December 27, 1977 notification by Ohio that payments were to be stopped as of November 30.

The Tepper Nursing Home appears to be covered by both federal and State court orders. HCFA has already withdrawn the part covered by the federal court order after September 27, 1978, but there may be some question that the order against HEW extends back to the coverage of the August 14, 1978 order against Ohio. In any event, the State court orders commencing February 6, 1978 precede termination. Also, inasmuch as the State court orders possibly extend to September 11, 1978, they very likely provide any overlap needed. We also note that the patients were removed and the nursing home closed less than 12 months after termination.