DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Ohio Department of Public Welfare DATE: June 24, 1981
Docket No. 79-164-OH-HC
Decision No. 191

DECISION

The State of Ohio Department of Public Welfare (State) appealed from an estimated penalty disallowance of $123,807 made by the Health Care Financing Administration (Agency) pursuant to Section 1903(g) of the Social Security Act (the Act) for the quarter ending September 30, 1978. The Agency determined, after it conducted a validation survey, required by Section 1903(g)(2) of the Act, that the records for 17 Medicaid patients in six facilities did not meet the certification requirement of Section 1903(g)(1)(A) of the Act. The Agency reviewed documentation submitted by the State in its appeal regarding these violations, and accepted the submissions as evidence of valid certifications for nine of the 17 patients. The Agency reduced the disallowance to $46,007. We conclude that the disallowance, as modified, should be upheld.

This decision is based on the State's application for review; the Agency's response to the appeal; a supplemental memorandum filed by the Agency informing the Board of a Comptroller General's decision concerning 1903(g); a letter submitted by the State supplementing its application for review; documentation submitted by the State as evidence of its allegations that no violations existed for these 17 patients; the Agency's responses to these submissions; a telephone conference call between the parties' representatives, the Board Panel Chair, and a Board staff attorney; and a response by the State to the Agency's most recent modification of disallowance. We have determined that there are no material facts in dispute, and that a conference or hearing would not assist the development of the issues.

Pertinent Statutes, Regulations, and Other Agency Policy

Section 1903(g) of the Act is concerned with utilization of long-term care at four levels: skilled nursing, intermediate, inpatient hospital, and care in a hospital for mental diseases. Section 1903(g) of the Act requires that the State agency responsible for the administration of the State's Medicaid plan under Title XIX of the Act show to the satisfaction of the Secretary that there is an "effective program of control over utilization of" long-term inpatient services in facilities providing care at these levels. In the case of SNFs and ICFs, this showing must be made for each quarter that the federal medical assistance

percentage (FMAP) is requested with respect to amounts paid for such services for patients who have received care for 60 days, or the FMAP will be decreased according to the formula set out in Section 1903(g)(5). The satisfactory showing must include evidence that "in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan ... that such services are or were required to be given on an inpatient basis because the individual needs or needed such services." (Section 1903(g)(1)(A)) This statutory requirement is implemented by regulation. The applicable regulation for the period in question in this appeal was 42 CFR 450.18(a)(2), which stated that certification must occur "at the time (sic) admission or, in the case of an individual who makes application for assistance while in an institution, prior to authorization of payment ...." Action Transmittal SRS-AT-75-122, dated November 13, 1975, contained statements that "define and clarify what is required in order for States to be considered in adherence" with the regulatory requirement. This Action Transmittal was addressed to State Administrators and "other interested agencies and organizations," and listed several conditions which must be met in order for the certification to be considered valid, including: the certification must be in writing, it must be signed by a physician using his/her signature or initials, and the certification must be dated at the time it is signed or initialed.

Statement of the Case

The Agency conducted a validation survey in the State during December 1978 for the quarter ending September 30, 1978. The purpose of the survey was to review utilization of skilled nursing services in 20 facilities (HCFA-AT-78-98, November 3, 1978). The survey reviewed patients whose names were submitted by the State. While conducting the review, however, the Agency learned, apparently from the records it reviewed, that 27 of the names submitted by the State were patients receiving ICF care rather than SNF care. The federal reviewers decided not to consider those 27 patients when determining whether there were violations of the utilization control requirements (Agency Response, November 16, 1979, pages 21-24, 29-30). After completing the review, the Agency determined that the records for 17 patients, whom the Agency believed to have received SNF care, did not meet the certification requirements of Section 1903(g)(1)(A), 42 CFR 450.18(a)(2), and SRS-AT-75-122. In its appeal to the Board, dated July 27, 1979, the State submitted documentation concerning some of these 17 patients. The Agency examined the documentation and accepted documents for six patients as valid certifications. The Agency modified the amount of the disallowance (Agency Response, November 16, 1979). On June 27, 1980 the State submitted further documentation for nine of the remaining 11 patients. After examination of the documentation, the Agency found three more patients'

documentation valid and again modified the disallowance (Agency Response, March 20, 1981). The Agency has not accepted the documentation submitted for the remaining patients as valid because it does not include certifications signed by a physician and dated in a timely fashion. The State informed the Board, in its submission of May 21, 1981, that it would not submit any further documentation and that it accepts the Agency's findings with regard to the documents submitted by the State for these eight patients.

Both times that the Agency modified the disallowance, it recalculated the penalty. The Agency often recalculates these penalties after it accepts additional documentation submitted by a State upon appeal as proof that violations which had formed the basis of a disallowance were, in fact, not violations. The recalculation of a penalty may also occur because the State submits exact recipient data. In this appeal, the recalculation was due partly to the fact that the Agency accepted documentation as evidence of valid certifications for first six and then three more of the 17 patients on whom the penalty was based. When reviewing the first submission of documentation, however, the Agency discovered that some of the patients upon whom the penalty calculation was based actually received intermediate care (Agency Response, November 16, 1979, page 30). The Agency, therefore, recalculated the penalty by reducing the FMAP for both SNF and ICF levels of care.* Eventually the Agency learned from the State's documents that 15 of the 17 patients were receiving intermediate care. Of the eight patients still in violation, seven of them received ICF level of care.

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* The Agency divides quarterly showings made by States into the four levels referred to by the statute and takes reductions, by level of care, for any levels in which unsatisfactory showings are made (SRS-AT-76-88, June 3, 1976, page 1). The Agency is required to take a reduction for each level of care in which a satisfactory showing is not made (Section 1903(g)(1)). Section 1903(g)(5) requires that a percent of the FMAP for a particular type of service be reduced, where there is an unsatisfactory or invalid showing with respect to a type of facility or institutional service. Since a validation survey frequently checks only one level of care in a particular quarter, a reduction taken after a validation survey would reflect only the level of care checked by the survey.

Here, the Agency took a fraction of the FMAP for both SNF and ICF levels of care because the State supplied a list of names which resulted in a completed review of some patients at each of the two levels of care. If all the violations in a particular facility were for one level of care, that facility was included only in the penalty calculation for that level of care. If the violations in a facility were at both levels of care, then the facility was included in the calculation for both levels.

DISCUSSION

Remaining 8 Patients for Whom Violations Were Found

The Agency has not accepted as satisfactory any of the documentation submitted for eight patients; the reasons stated in its responses for not accepting the documentation as satisfactory and valid are consistent with the Agency's requirements for valid certifications, i.e., that they be signed by a physician and timely dated. The State has raised no other issues regarding these patients, and has accepted the Agency's findings regarding the documentation submitted (State Response, May 21, 1980, page 1). Therefore, we conclude that the Agency's determination that there are violations for these eight patients should be upheld.

Calculation of the Penalty

The State has raised three issues with regard to the calculation of the penalty.

1) The State objected to the Agency's recalculation of the penalty based on two levels of care, calling it an "attempt ... to somehow extend the specific scope of ... [the] survey and ... [the] disallowance letter ...." (State letter to Executive Secretary, Departmental Grant Appeals Board, June 27, 1980, pages 2-3). The State argued that because the disallowance letter stated that it was based upon the State's failure to make a satisfactory and valid showing that there was an effective program for controlling services in SNFs, it was procedurally improper for the Agency to extend the penalty to ICFs. Furthermore, the State argued that the Agency failed to give the State timely notice under Section 1903(g)(3)(A) of the determination that the State had failed to make a satisfactory and valid showing with regard to ICFs.

Section 1903(g)(1) requires a reduction in the FMAP for each level of care in which utilization control requirements are not met. The States are required to make a quarterly showing for each level of care, and the Secretary must take reductions for showings that are unsatisfactory. Section 1903(g)(2) states in part:

> The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, ...

The purpose of this requirement is to "assure actual -- rather than paper -- compliance with the ... statutory requirements." (S. Rep. 92-1230, September 26, 1972, page 45.) The Secretary has considerable

discretion, based on this provision, about how to conduct these surveys. The usual procedure involves selecting one State in each region of the country for a particular validation survey. The State chosen is that with the greatest percentage of stays over 60 days, based on reported data, provided that the State was not surveyed during the recent past. The Agency then surveys the 20 facilities providing a particular level of care that have the greatest number of Medicaid admissions and authorizations for that quarter. Usually only one level of care is chosen per survey (HCFA-AT-78-98, November 3, 1978).

The Agency became aware of the violations at the ICF level of care in this instance because of information submitted by the State during the appeal process. The Agency, in its Motion for Modification of the Disallowance, March 20, 1981, pp. 5-6, argued that it cannot ignore obvious violations of the law, since it is required to take a reduction for each level of care in which the requirements have not been met. A Comptroller General Opinion, dated March 4, 1980 (Attachment, Agency Supplemental Memorandum, April 23, 1980) concludes that if the requirements of Section 1903(g) are not met in every case, the Secretary has no alternative but to consider the State's showing unsatisfactory or invalid and impose a penalty according to the statutory formula. Therefore, while the adjustment of the penalty to reflect reductions in two levels of care may be unusual compared to the Agency's ordinary procedure, and even though the Agency did not intend for that particular survey to review ICF care, we conclude that the adjustment is mandated once a determination is made that violations exist at both levels. Furthermore, there is no difference in the federal requirements that must be met for SNF and ICF patients and the same patients were involved throughout the process of modification of the disallowance. The State had adequate opportunity to document that the requirements were met for these patients. Thus, the only change in the disallowance was that the FMAP for two levels of care was reduced because most of the patients for whom violations had been found were not receiving skilled nursing care.

The State further argued that Section 1903(g)(3)(A) applies to this appeal. Section 1903(g)(3)(A) says, in part,

> No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect --
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> * * *
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> (iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or .

> (iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

The Agency gave notice of an estimated penalty calculation within the required time, and included the names of the patients and the violations found for each patient. The Agency was not able to provide the State with notice that the reduction would be based on two levels of care by the fourth quarter after the quarter for which the invalid showing was made, because it was not aware of that fact at the time. It did, however, give the State notice of that fact as soon as the Agency discovered, through examination of the State's application for review, that most of the patients on whom the penalty was based had actually been receiving ICF care. Furthermore, Section 1903(g)(3)(A)(i) does not specifically require such details in a notice of reduction. The legislative history of that provision shows that Congress was concerned about the fact that the Agency had, in the past, performed validation surveys and imposed reductions "months and even years" after the quarter involved (H. R. Rep. 393, 95th Cong., 1st Sess. 85 (1977); S. Rep. 453, 95th Cong., 1st Sess. 41 (1977). The legislative history shows the purpose of Section 1903(g)(3)(A) to be that States "not be subjected to the uncertainty of a possible reduction years later." Such notice was provided to the State by the Agency's original letter.

Neither the statute nor the legislative history requires that the notice specifically state what level of care is involved. The modification of the penalty based on two levels of care was a result of the State's own errors and the State has not shown that it has been prejudiced by the failure of the original notice to specifically refer to ICF services. The State admits that the violations existed; it submitted the patients' names to be surveyed and it had notice that a reduction would be taken based on violation for named patients. There were no new patients or violations included in the recalculation of the penalty. Accordingly, we conclude that the Agency may reasonably calculate the penalty based on two levels of care.

2) The State, in its application for review, also alleged that the amount of the disallowance was erroneous because the method of penalty calculation did not comply with the statutory formula. Section 1903(g)(5) states that one-third of the FMAP claimed for the quarter at a particular level of care is to be multiplied by a fraction composed of a numerator equal to the number of patients receiving services in that quarter "in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter," and a denominator equal to the "total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made."

The Agency policy is to use facility data in the fraction for its initial calculation since the Agency usually does not have the exact patient data at that time (Penalty Estimation Procedure, standard attachment to notices of disallowance). The Agency may accept exact patient data where the State submits it and will recalculate the penalty on the basis of data which the Agency accepts. The States routinely receive notice of this position with notices of disallowance. The Board has previously held that the Agency's use of facility data for the initial calculation is reasonable, and that such data need only be changed where the State submits exact patient data which is acceptable to the Agency (Ohio Department of Public Welfare, Decision No. 66, October 10, 1979, page 14). In its letter of June 27, 1980, the State submitted figures to the Agency concerning patient data for the two levels of care. The Agency accepted the statistical information regarding the total number of recipients receiving services at the two levels in the State for the quarter, but did not accept the State's statement regarding the average number of recipients in the cited facilities for that quarter (pages 5-6). The Agency stated:

> Considering the apparent confusion in Petitioner's records regarding the classification of recipients in these facilities, as evidenced by the erroneous lists submitted, Respondent is unwilling to accept Petitioner's statement as to the number of recipients at each level of care in the facilities in question without some supporting documentation. (Motion for Modification of the Disallowance, March 20, 1981)

The State, in the telephone conference call of April 30, 1981 (Board Confirmation of Telephone Conference, May 13, 1981, page 2), indicated that it would accept the Agency's use of facility data and that the State would make no further comments or submissions regarding the issue. Therefore, the Agency's use of facility data to calculate the penalty is upheld.

3) The State argued that the Agency's strict application of the penalty for these violations results in a harsh penalty (State's Response, May 21, 1981, pages 1 and 2). This Board has previously held that the statute does not provide the Secretary with discretion to waive or reduce a penalty once there is a finding that a violation has occurred, unless one of the specific waiver or exception provisions apply (Colorado Department of Social Services, Decision No. 169, April 30, 1981; Tennessee Department of Public Health, Decision No. 167, April 30, 1981).

The Secretary is required to impose a penalty calculated according to the statutory formula set forth at Section 1903(g)(5) unless the State agency makes a satisfactory showing that there are valid certifications "in each case." None of the waivers or exceptions specifically

provided in the Act apply to this appeal. The 1977 amendment of Section 1903(g) (P. L. 94-142, Sec. 20, 91 Stat. 1205 (1977)) altered the penalty formula, from a rigid requirement that 33 1/3 percent of the FMAP be deducted, to a more flexible formula that reflects the difference between significant and nominal violations by adjusting the reduction in proportion to the number of patients in only the facilities that were found to have violations. Thus, the penalty formula builds in a sliding scale that reflects the extent of the State's deviation from the requirements (123 Cong. Rec. S16008, daily ed., September 30, 1977). Furthermore, since a penalty was taken for violations discovered in a sample, presumably the penalty reflects the fact that further violations could exist in the population not sampled.

The Comptroller General reached the same conclusion with regard to the Secretary's discretion (Comptroller General's Opinion, File No. B-164031(3).154, March 4, 1980).

Conclusion

We conclude that this disallowance must be upheld. We conclude that it was not only procedurally justifiable but mandated by the statute for the Agency to recalculate the penalty based on two levels of care once the Agency determined that violations existed, based on the State's erroneous submissions. Furthermore, we conclude that the Agency did not violate the notice provisions of Section 1903(g)(3)(A) and that the State has not been prejudiced by the fact that the Agency did not notify the State in the original notice of disallowance that a reduction for the ICF level would be taken. We conclude that the Agency may reasonably calculate the penalty based on facility data where documented exact patient data has not been submitted, and that the Agency does not have the discretion to waive the disallowance. Therefore, we sustain the disallowance as modified by the Agency on March 20, 1981.

/s/ Donald F. Garrett

/s/ Alexander G. Teitz

/s/ Cecilia Sparks Ford, Panel Chair