DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Maryland Department of Health and Mental Hygiene
Docket No. 78-28-MD-HC
Decision No. 210

DATE: August 31, 1981

DECISION

On April 21, 1978, the Acting Assistant Director for Financial Management, Health Care Financing Administration (HCFA, Agency), issued a notification of disallowance to the Maryland Department of Health and Mental Hygiene (State), denying $375,413 in Federal financial participation (FFP) for skilled nursing facility (SNF) services rendered under Title XIX of the Social Security Act, the Medicaid program. The disallowance, based on an HEW Audit Agency review (Audit Control No. 03-70154) of Title XIX payments made to nursing homes in Maryland for the period July 1, 1972 through June 30, 1976, involved three nursing facilities:

Nursing Home A	$286,636
Nursing Home B	17,484
Nursing Home C	71,293
	$375,413

On May 16, 1978, the State submitted to the Board an application for review of the disallowance in the amount of $357,929 for Nursing Homes A and C. The State did not appeal the disallowance of $17,484 for Nursing Home B.

There are no material issues of fact in dispute. We have, therefore, determined to proceed to decision based on the written record and briefs, including the parties' responses to an Order to Show Cause issued on July 8, 1981.

Applicable Regulations

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

FFP in payments to a facility providing skilled nursing services is available only if the facility is certified as having met all the requirements for participation in the Medicaid program as evidenced by an agreement (provider agreement) between the single state agency

and the facility. 45 CFR 249.10(b)(4)(i)(C). The execution of the provider agreement is contingent upon certification of the facility by an agency designated as responsible for licensing health institutions in the state (state survey agency). 45 CFR 249.33(a)(6).

The state survey agency is required to certify that the facility is in compliance with each condition of participation. 45 CFR 249.33(a)(4)(i). In order for the state to obtain FFP, the execution of the provider agreement must be in accordance with the federal regulations. 45 CFR 249.33(a)(6). A facility which does not qualify under §249.33 is not recognized as a skilled nursing facility for purposes of payment under the Medicaid program. 45 CFR 249.33(a)(10).

While a state may grant waivers for an intermediate care facility found to have deficiencies under the Life Safety Code (45 CFR 249.33(a)(2)), any waivers of deficiencies under the Life Safety Code for a SNF must be approved by the Agency. See Section 1861(j)(13) of the Social Security Act and 45 CFR 249.33(a)(1)(i).

Nursing Home A

Factual Background

Nursing Home A had a history of Life Safety Code (LSC) deficiencies, particularly the housing of non-ambulatory and disabled patients above the ground floor and no acceptable means of exiting from the building during an emergency. In 1971 the State notified the facility that no waivers would be granted and that the facility should discontinue housing non-ambulatory patients above the ground floor. In June 1972, the facility was given a six month provider agreement which was subsequently extended through June 30, 1973. Another agreement was then entered into with an expiration date of March 31, 1974. While these agreements were in effect, conditions at the facility, including the housing of non-ambulatory patients above the ground floor, remained virtually unchanged.

A new provider agreement was not executed with the facility because of these LSC deficiencies. On January 16, 1975 the State survey agency, the Division of Licensing and Certification (DLC), received a letter from the Agency's Regional Office of Long Term Care Standards Enforcement (ROLTCSE) stating that requested LSC waivers were denied. The record does not indicate when the waivers were requested or whether the waivers would have covered all of the LSC deficiencies existing at the time of the provider agreement's expiration. On March 3, 1975 DLC informed the facility of its intent to decertify. In March 1975 the facility formally appealed the decertification action.

Negotiations then began between the facility and ROLTCSE which resulted in the ROLTCSE's forwarding to DLC of a "conditional acceptance" of the waivers, apparently pertaining to some of the deficiencies, but again citing the non-ambulatory issue. Further negotiations then ensued among the facility, DLC and ROLTCSE concerning patient placement and the possibility of erecting stairtowers. Because of these negotiations, DLC discontinued decertification procedures, but still did not recertify the facility.

On October 20, 1975, DLC, not having heard anything further from ROLTCSE, again recommended decertification and also sent a letter to ROLTCSE requesting a decision denying all LSC waivers. On October 28, 1975 ROLTCSE rescinded whatever waivers were in effect. On November 20, 1975 a meeting was held with DLC, ROLTCSE, the facility, and other participants concerning the issue of stairtower construction. DLC, as a result of commitments made by ROLTCSE and the facility, again terminated its decertification procedures. The facility and ROLTCSE then began to communicate with each other in order to develop a revised plan of correction, excluding DLC from the negotiations despite its protests. Ultimately, in August 1976, a plan of correction was developed as a result of negotiations between the facility and ROLTCSE.

The Agency disallowed FFP in the amount of $286,636 in payments to Nursing Home A for the period May 1, 1974 through June 30, 1976 (the audit on which the disallowance is based only concerned the time up to June 30, 1976).

Parties' Arguments

In response to the Agency's position that the facility lacked a valid Medicaid provider agreement, the State argues that the actions of the Agency's ROLTCSE prevented the decertification of the facility. The State claims that its DLC "twice attempted to decertify and was thwarted in each attempt by contravening Regional Office measures which further encouraged the facility to pursue alternative solutions." (Application for Review, p. 3.)

The State further argues that "the facility should be considered certified during this period, since a final decision on Life Safety Code waiver approvals or denials was not made by the Regional Office, as is their responsibility." (Application for Review, p. 4.) Terming a provider agreement a "paper agreement," the State considers that the facility was certified during the period that "the Regional Office did ... unnecessarily prolong the process, and by providing alternatives, prevented the Division from taking proper administrative action." (Application for Review, p. 4.)

The Agency argues in response, "There is nothing in the Social Security Act or Federal regulations that supports [the] contention nor in any way mandates HEW to act upon a waiver request, much less a requirement that Federal funding must continue pending a decision on waiver requests." (Agency Response, p. 7.)

Discussion

The central issues regarding the disallowance for this facility are whether the State's claim that the actions of the Agency's ROLTCSE prevented the State from decertifying the facility is valid, and, if so, whether that provides a basis for the Board to reverse the disallowance.

Certain relevant facts are uncontested. The facility's provider agreement expired on March 31, 1974. After that date patients remained in a facility with serious LSC deficiencies. In spite of this facility's history of LSC deficiencies involving patient placement, the State waited until March 3, 1975, nearly a year after the expiration of the provider agreement, before initiating any action regarding the facility's decertification.

For the period of the disallowance the State neither certified Nursing Home A nor executed a provider agreement with it. The facility's period of Medicaid certification expired along with its provider agreement on March 31, 1974. The Medicaid regulations are explicit in requiring both a certification and a provider agreement for FFP to be claimed. The mere pendency of an appeal relating to certification questions does not create a presumption of continued certification. In this sense, it is irrelevant whether the State was deterred from using its administrative appeals process to decertify the facility since FFP is available only for the duration of the provider agreement.* Accordingly, there is no basis for FFP throughout the disallowance period arising from a certification and a provider agreement.

Furthermore, the State has not shown that it was reasonable to believe, given the history of the facility, that ROLTCSE might approve the waivers or that it might do so within a particular time frame. When, starting in March 1975, the State did begin decertification proceedings and the facility appealed, the State

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* The State has not argued that its provider agreement with Nursing Home A was effectively continued beyond the expiration date while decertification actions were pending and that the first part of PRG-11, discussed <u>infra</u>, provided a basis for the payment of FFP. As we conclude with regard to Nursing Home C, however, the State has not demonstrated that its State law would trigger operation of PRG-11.

twice unilaterally ceased the decertification action upon learning of negotiations between the facility and ROLTCSE concerning the stairtower alternative.

The State's allegation that ROLTCSE was solely responsible for its inability to decertify this facility is unwarranted. The facility's administrator offered on several occasions counter plans to ROLTCSE's stairtower proposal. (Audit Report, p. 5.) The State has not denied that this contributed to the length of the negotiations. ROLTCSE's willingness to enter into negotiations with the facility should not have been viewed by the State as a directive for the State not to pursue its own course of action in regard to the facility. We do not see how these negotiations "thwarted" the State's attempts to decertify the facility.

In its July 8, 1981 Order, the Board directed the State to show cause why the disallowance for Nursing Home A should not be sustained on the grounds that there is no federal regulation authorizing FFP after the expiration of a provider agreement while waiver requests are being considered by the Agency and that there was no reasonable reliance by the State, given the facility's history of LSC problems, that ROLTCSE would grant waivers for the facility. The Order also asked the Agency to explain the role of ROLTCSE in the process of granting or denying waivers for LSC deficiencies.

In its response to the Order the State has answered, apparently by mistake, the questions that were directed to the Agency and has not offered any new arguments as to why the disallowance should not be sustained on the grounds cited in the Order. The State continues to maintain that "the involvement of ROLTCSE in the waiver negotiations indicated a federal desire to continue the certification of the facility if at all possible, as ROLTCSE could have initially denied the waiver request, and ended the facility's Title XIX participation . . ." (State's response to the Order, p. 3.) The State concludes its argument, "ROLTCSE, by negotiating the waiver request directly with the facility, and excluding the State from this process, effectively took responsibility for the decertification negotiations and prevented the State from exercising any authority or responsibility concerning the issue of LSC violations, the very issue upon which the question of decertification hung." (State's response to Order, p. 4.)

The State in its response to the Order stated that the usual time frame for approving or denying a request for LSC waivers encompassed up to 90 days for a preliminary determination by the State Fire Marshall, and up to 90 additional days for a final response by ROLTCSE. The Agency stated that it is difficult to generalize about the length of time necessary to process waiver requests because of the complexity of issues raised in waiver requests. Both the State

and the Agency did agree, however, that it is unusual for ROLTCSE to negotiate directly or exclusively with a facility.

While ROLTCSE arguably may have been dilatory in reaching its decision on the LSC waivers for the facility and may have departed from usual practice by negotiating directly with the facility, the State has failed to show how ROLTCSE in any way prevented the State from decertifying the facility. Furthermore, the State has not demonstrated that ROLTCSE or any other Agency office suggested that the State not proceed with the decertification of the facility. Indeed, the State delayed for 12 months before initiating any decertification action. The State, not ROLTCSE, has responsibility for the certification and execution of a provider agreement, which in turn provide the basis for FFP. The State must bear the risk for making payments to the facility after its provider agreement and certification had expired. Even though LSC waivers were pending during the period of the disallowance, there is no federal regulation allowing FFP for a Medicaid SNF, absent a provider agreement, while the Agency is considering waiver requests. We therefore sustain the disallowance for Nursing Home A in the full amount of $286,636.

Nursing Home C

Factual Background

Nursing Home C was issued a provider agreement for the period February 1, 1975 to January 31, 1976. The agreement contained an automatic cancellation clause providing that, if certain health and LSC deficiencies found during a survey conducted in October 1974 were not corrected prior to September 30, 1975, the agreement would be cancelled on that date. In an October 7, 1975 letter, the single State agency notified Nursing Home C that the cancellation clause would be invoked and that its certification would be cancelled. Pursuant to Maryland State law, the facility appealed the single State agency's determination. In a November 29, 1975 pre-hearing conference it was determined that the facility did not have as many deficiencies as the survey report noted and that a lack of understanding existed as to the required documentation for certain certification standards. It was decided that the State survey agency and the facility's owner-administrator would work together to provide the necessary documentation.

Over the next four months all the deficiencies, with the exception of the lack of a required emergency generator on the premises, were apparently corrected. The State claims that a hearing was scheduled for August 5, 1976, at which time the State and the facility agreed

that the generator had been installed and the action to decertify the facility was dropped. (Application for Review, p. 4.)

The Agency disallowed FFP in the amount of $71,293 for SNF services rendered at Nursing Home C for the period November 1, 1975 to June 30, 1976.

State's Arguments

Concerning Nursing Home C, the State argues that it cannot revoke licensure or certification without affording the facility the opportunity for a due process hearing. The State contends that, when a facility appeals a DLC determination to invoke the automatic cancellation clause of a provider agreement, "[a] contract exists until the nursing home exhausts its right of appeal, and payments must be made to a facility during this period." (Application for Review, p. 4.) In its Application for Review the State argued that its State law requires that facilities facing revocation action must be afforded a hearing, and that FFP is available until all appeals have been exhausted. In response to the Board's Order, the State claims that State departmental regulations contemplate the continuance of the facility's certification throughout the available administrative appeals process.

Discussion

The central issue regarding the disallowance concerning this facility is the availability of FFP during a provider appeal.

The Board has recently issued a series of decisions in which it has given close examination to the question of the availability of FFP during provider appeals. In Ohio Department of Public Welfare, Decision No. 173, April 30, 1981, the Board examined the effect of a 1971 Agency Program Regulation Guide, MSA-PRG-11, on provider appeals. PRG-11 set out two instances in which FFP would be allowable in payments by a state to a facility even where the provider agreement has not been renewed or has been terminated:

1) [If] State law provides for continued validity of the provider agreement pending appeal; or

2) [If] the facility is upheld on appeal and State law provides for retroactive reinstatement of the agreement.

In Ohio the Board found that PRG-11 was still in effect during the period in question and that PRG-11 allowed for FFP to be paid for a period up to twelve months, subject to certain conditions, after

the termination or nonrenewal of a provider agreement where a state was directed by a court order to continue payments to a facility while it appealed its decertification.

In Colorado Department of Social Services, Decision No. 187, May 31, 1981, the Board found that PRG-11 also applied to provider appeals arising under a state law that explicitly provided that a facility's certification continued in effect throughout an appeals process. In Nebraska Department of Public Welfare, Decision No. 174, April 30, 1981, however, the Board held that the provisions of PRG-11 did not apply to a Nebraska law which provides for the continued validity of licenses pending appeal, but is silent as to certifications. The Board found that the Nebraska appeals pertained solely to specific state licensing requirements and were not regarded as appeals of Medicaid decertifications.

The exceptions to the general rule that FFP is not available where a provider agreement has expired and not been renewed or has been terminated, elucidated in the Board's Ohio and Colorado decisions, do not apply to this facility.

Unlike the Colorado Administrative Procedure Act (COLO. REV. STAT. §§ 24-4-101 et seq., 1973), neither the Maryland Administrative Procedure Act (MD. ANN. CODE, art. 41, §§ 244 et seq., 1957) nor other relevant Maryland law (art. 43, §§ 556-563) provides that a facility's Medicaid certification remains in effect throughout an appeals process.

No court order is involved here as was the case in Ohio. Furthermore, the March 5, 1976 letter from a Maryland Assistant Attorney General, submitted by the State in its Application for Review, states, "There is not a specific [Maryland] statutory requirement that the validity of the Title XIX only provider agreements continue pending appeal." The letter only refers to the effect of the Maryland State statutory law on a license revocation, and not a Medicaid decertification.

In its July 8, 1981 Order the Board asked the State why the disallowance for Nursing Home C should not be sustained on the basis of the Board's Nebraska decision. In its response to the Order the State argues that "the decertification (under a contract with six months to run) was not effective prior to the decision of the Secretary of the Department of Health and Mental Hygiene (DHMH)." (State response, p. 1.) The State, while conceding that the Maryland APA does not address the issue of when an administrative decision becomes final, contends that DHMH regulations "contemplate . . . continuation of the certification throughout the available administrative appeals process." (State response, p. 2.) The State adds

that the act of decertification was never officially ratified by the DHMH Secretary because the deficiencies were remedied and the decertification proceedings dropped during the hearing process. Therefore, the State argues, "[R]etroactive reinstatement of the certification and the provider agreement were accomplished by the ultimate resolution of the appeal in favor of the provider." (State response, p. 2.)

We do not find anything in the State's arguments that would lead us to depart from our tentative conclusion, expressed in the Order, that PRG-11 does not apply here. The facility's provider agreement is contingent upon the facility's certification. The original certification, and consequently the provider agreement, had an automatic cancellation date of September 30, 1975 if corrections of deficiencies were not made. The deficiencies were not corrected at that time. Therefore, both the certification and provider agreement ended as of that date; the agreement did not then have six more months to run.

Contrary to the State's assertion that the appeal was resolved in favor of the provider, which, if true, might invoke the second exception of PRG-11, we find that the provider was not actually upheld on appeal. One of the stated deficiencies that led to the invocation of the automatic cancellation clause, the lack of an emergency generator, was not found to be erroneous during the appeals process. Rather, the facility corrected the deficiency by installing a generator. We do not consider this to be a situation where during the appeals process the State's determination regarding a deficiency has been proven to be incorrect.

The requirement of the first exception of PRG-11 is that State law provide for the continued validity of a provider agreement pending appeal. The State of Colorado met that requirement in its APA. The burden was on Maryland to demonstrate that under its State law the facility's certification and provider agreement continued in effect pending appeal of the initial determination of the State survey agency. In response the State has referred to DHMH regulations. These regulations, COMAR 10.01.03, generally set forth the procedures for hearings before the DHMH Secretary. The cited regulations are deficient for the State's case before us because they do not clearly indicate who has the right to have a case reviewed by the Secretary and because there is nothing in the regulations that specifically bars the immediate implementation of an initial determination. The regulations are ambiguous as to whether an initial determination could be implemented at once or must be affirmed first by the DHMH Secretary.

In Colorado the Board found that under Colorado State law a provider agreement continued in effect during the pendency of an appeal. The State has not shown that there is a comparable Maryland law. We find that the cited State's departmental regulations are inadequate to trigger the operation of PRG-11 so that FFP may be allowed during the facility's appeal. Accordingly, we sustain the disallowance for Nursing Home C in the full amount of $71,293.

Conclusion

For the reasons stated above, the disallowances for Nursing Homes A and C are sustained in full.

/s/ Cecilia Sparks Ford

/s/ Norval D. (John) Settle

/s/ Donald F. Garrett, Panel Chair