DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Colorado Department of Social Services
Docket No. 79-10-CO-HC
Decision No. 169

DATE: April 30, 1981

DECISION

The State of Colorado Department of Social Services (State) appealed a penalty disallowance of $21,377 made by the Health Care Financing Administration (Agency) pursuant to Section 1903(g) of the Social Security Act (the Act) for the quarter ending March 31, 1978. The penalty disallowance was made after an Agency validation survey, required by Section 1903(g)(2) of the Act, because the Agency determined that the records for one patient in one facility did not meet the certification requirement of Section 1903(g)(1)(A) of the Act. For reasons stated below, we conclude that the disallowance 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 that deals directly with an issue presented in this appeal, and the parties' responses to the Board's Order to Show Cause issued January 21, 1981. We have determined that there are no material facts in dispute which a conference or hearing would help resolve, and that a conference or hearing would not assist the development of the issues.

Statement of the Case

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 certain facilities, including intermediate care facilities (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 in ICFs, 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 impl ' 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, contains 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."

The Agency conducted a validation survey for the quarter ending March 31, 1978 in 20 ICFs during June and July 1978 in the State of Colorado. 1/ This survey disclosed that one patient in one facility was certified the day after his admission; the Agency construed this to be an untimely certification under Section 1903(g), its implementing regulations, and SRS-AT-75-122. The reviewer's remarks, contained in his findings for the validation survey, regarding the patient whose certification is in question, noted:

> Certification date is based on the adm
> being forwarded after 3:00 pm
> per Mrs Betty Sullivan
> No Dr.s sig anywhere prior to 1/27/78.
> The attending physician certified the patient
> 1/28/78, 1 day after admission records date.
> (Agency's Response to the Appeal, May 9, 1979, Appendix E)

DISCUSSION

Certification

The first issue is whether there is a timely certification for the patient. The Agency's regulation, 42 CFR 450.18(a)(2), does not define "at the time of admission." SRS-AT-75-122 describes certification as "the process by which a physician attests to an individual's need for a specific level of institutional care not later than the date of admission ...." This Action Transmittal lists "conditions which must be met in order for the certification to be considered valid." Condition number 3 gives examples of documentation a State may require for certification. Among these examples are two which state that physician orders or medical evaluations signed and dated by a physician on or before admission would be acceptable documentation of a valid certification. Thus, the Agency's policy is that "time of admission" is date of admission.

1/ HCFA-AT-78-37 (MMB), April 17, 1978, addressed to State Agencies administering medical assistance programs, describes the criteria used for the selection of states and facilities to be surveyed and describes the procedures to be used in the survey.

Section 1903(g)(1)(A) provides that a 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; 2/

Section 450.18(a)(2) and Action Transmittal SRS-AT-75-122 state that for individuals who apply for assistance "while in an institution," certification may take place "prior to authorization of payment." Thus, under some circumstances, the regulation allows more time for certification than a strict reading of the statute would require, i.e., prior to authorization of payment rather than at the time of application for assistance. Although the State admits in its Response to the Board's Order to Show Cause (page 2) that the patient applied for assistance the same day he was admitted, the State alleges in its short Factual Summary that the patient was "found eligible ... on February 1, 1978, retroactive to January 27, 1978." The State does not indicate why it thinks this is relevant; however, we assume it is related to the possibility that, under the regulation, certification may occur up to the point of authorization for payment where the patient applies for assistance "while in an institution." The statute provides two categories: those who apply for assistance before or concurrently with admission and those who apply for assistance later than the time of admission. The regulation also sets out two categories: those who have applied before or at the time of admission and those who make application "while in an institution." We cannot conclude that the two categories overlap, allowing those who apply for assistance the same day as they are admitted to fall into the more generous second category. We do not feel constrained to interpret the statute and regulation in such a manner, in the absence of any Agency interpretation of the phrase "while in an institution," and in the absence of any arguments for such an interpretation.

The facts in the record do not show any circumstances that might fit into the Agency's stated interpretation of a valid certification. Although the record shows the existence of physician's orders (State's Response to the Board's Order to Show Cause, March 6, 1981, Appendix) dated the same day as admission,

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2/ The State argues in its Response to the Board's Order to Show Cause, at pages 4 and 5, that the language of Section 1903(g)(1)(A), in its use of the past tense in the words "were required" and "needed", can be construed to allow certifications after the date of admission. We conclude that these words refer only to the certification made later because application for assistance was made after admission. Thus, the pertinent portion of the provision would read "or, if later, the time the individual applies for medical assistance under the State plan ... that such services ... were required to be given on an inpatient basis

they were not signed by the physician. The physician's name appears on the orders but an L.P.N. signed them. This is inadequate under the statutory and regulatory requirements that a physician must sign the certification. The record does not show the existence of any other document meeting all the requirements for a valid certification.

Here the patient was admitted late in the day and the certification was signed and dated the day after the patient's admission. We do not agree with the Agency that a policy to accept certification under these circumstances would be a contravention of the statutory intent to prevent unnecessary utilization of long-term institutional services. The legislative history, however, does not shed any light on how much flexibility should be given to the words "time of admission" and the statutory language does refer to certifications occurring later than the time of admission only when applications are made after admission. Furthermore, the Agency has argued that such a policy is necessary for administrative convenience (Agency Response to Board's Order to Show Cause, p. 8). Agency policy does not include acceptance of certifications after the date of admission except where an individual applies for assistance "while in an institution." We defer to that policy and conclude that the certification dated one day after the patient's admission is invalid.

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2 cont./

because the individual ... needed such services." This implies that, where payment is to be made retroactively for the period between time of admission and time of application for assistance, a certification made after admission because the individual did not apply for assistance at the time of admission would have to certify retroactively that the services provided from the time of admission were necessary.

The State also argues that an interpretation that certification may be made shortly after admission or application is supported by "studying the relationship of 42 U.S.C. 1396a(a)(34) (Section 1902(a)(34)) and 42 C.F.R. 435.914 to the statute at issue here" (Response to Order to Show Cause, page 5). We do not find this a meaningful argument. A statutory provision requiring that assistance be provided retroactive to application where the patient was eligible for such assistance during that time has no direct relevance for utilization control requirements, other than to indicate that there are instances when payment will be made retroactive to the time of admission and thus, certification that the patient needed the services for the period during which he was eligible and for which payment was authorized, would be necessary under the statutory intent of Section 1903(g). This does not automatically lead to the conclusion that all certifications may be made later than admission.

Relationship between Sections 1903(g)(1) and (2)

The State raises several other issues. It argues that an analysis based on Section 1903(g)(1) is inappropriate since the disallowance was based on Section 1903(g)(2). The Board does not agree with this argument because the statute cannot be read in a way that isolates Section 1903(g)(2) from Section 1903(g)(1). Both methods of showing a state's adherence to the utilization control requirements, quarterly showings under paragraph (1) and validation surveys under paragraph (2), must meet the same standard, i.e., the requirements set forth in Section 1903(g)(1)(A) through (D). The validation survey is a check on the quarterly showings submitted by the states, which consist merely of certifications by the Agency Director that the standards have been met. The purpose of the validation survey is to assure actual -- rather than paper -- compliance with the statutory requirements (S. Rep. 92-1230, September 26, 1972, page 45).

Interpretation of the 60-day Language in Section 1903(g)(1)

The State also argues that Section 1903(g)(1) is to be interpreted so as to allow the following conclusions to be reached:

> HCFA cannot take any action unless and until the individual has been receiving services for sixty days. ... a penalty cannot be taken if the state can make a satisfactory showing of compliance for each calendar quarter beyond the initial sixty days for which the state requests for reimbursement. Thus, if the state can show that it has corrected the deficiency within sixty days, it cannot be penalized. (State's Response to Board's Order to Show Cause, page 4)

Again, the statute cannot be read so as to isolate one paragraph from another paragraph, in derogation of the intent of the statute. Under Section 1903(g)(1) utilization control requirements do not apply to patients who receive medical services for less than 60 days. Here, however, the patient had been in the institution for 60 days by March 31, the end of the quarter (he was admitted on January 27), and therefore, the requirement of Section 1903(g)(1)(A) that he be certified at the time of admission applied to him. This requirement is logical in view of the Congressional intent that patients not be admitted unless such long-term institutional care is considered necessary (S. Rep. 92-1230, September 26, 1972, page 44). Nothing in Section 1903(g) directly or indirectly allows the Secretary to waive a penalty for noncompliance during the first sixty days of a patient's stay, once the patient has been institutionalized for over 60 days and is therefore subject to the requirements of Section 1903(g). There is only one waiver in the statute, that of Section 1903(g)(3)(B), and it does not apply to this appeal, as will be discussed in full below. Under the State's interpretation, certifications need only occur sometime during the first 60 days. We do not agree that the statute can be so interpreted.

Waiver of the Penalty under Section 1903(g)(3)(B)

Section 1903(g)(3)(B) of the Act, as amended by the Omnibus Reconciliation Act of 1980, Pub. L. 96-499, December 5, 1980, Sec. 964, provides:

> The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978 is satisfactory under such paragraph and is valid under paragraph (2).

The State argues that under this provision this penalty disallowance should be waived. It is clear from the terms of the provision, however, that it does not apply to this appeal. The provision applies to any reduction made as a result of an unsatisfactory or invalid showing in quarters between January 1, 1977 and December 31, 1977 (i.e., "before January 1, 1978"). The disallowance in this appeal was taken for the quarter beginning January 1, 1978.

Application of the Penalty to a Violation for One Patient

The State argues that imposition of the penalty on the basis of a finding that one patient did not have a valid certification is arbitrary and capricious; however, the statute does not appear to provide the Secretary with the discretion to waive or reduce the penalty for such a violation. The Secretary is required to impose a penalty reduction calculated according to the statutory formula unless the State agency makes a satisfactory showing. That showing "must" include evidence of valid certifications "in each case for which payment is made under the State plan" (Section 1903(g)(1)(A)). None of the waivers or exceptions specifically provided in the Act apply to this appeal. The 1977 amendment of Section 1903(g) (Pub. L. 95-142, 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 more than the previous formula had. This suggests that Congress used this method, rather than giving the Secretary more discretion to waive penalties, to adjust the penalties in relation to the size of the violation (123 Cong. Rec. S16008, daily ed. September 30, 1977).

Then-Secretary of the Department of Health, Education and Welfare, Joseph A. Califano, wrote to the Comptroller General on March 5, 1979, specifically citing assessments made against four states, including this one, for very limited violations of the Act. The Secretary asked whether he had the authority to find a state's showing valid if the certification and other requirements were met with respect to all but one, or a few, of the patient records surveyed or of the facilities surveyed.

The Agency, in a supplemental memorandum filed with the Board on April 23, 1980, informed the Board of the Comptroller General's response. The Comptroller General's Opinion (File No. B-164031(3).154, March 4, 1980) concluded that if the requirements of Section 1903(g) are not met in every case, the Secretary has no alternative but to consider a state's showing unsatisfactory or invalid and impose the penalty according to the statutory formula. The Comptroller General based this conclusion on the legislative history of the Act and on the fact that amendments to the Act described specific circumstances in which the Secretary could waive application of the reduction or find a showing satisfactory. The Comptroller General concluded that Congress did not intend to permit waivers under circumstances other than those specifically provided for in the Act. This Opinion confirmed the Agency's interpretation of its authority and discretion.

This Board gives deference to the interpretation given a statute by the Agency, in accordance with principles established by the courts. New York Department of Social Services, Decision No. 101, May 23, 1980, p. 6. California Department of Health Services, Decision No. 158, March 31, 1981, p. 7. The primary rationale for this practice is the deference accorded to agency expertise. Southern Mutual Help Assoc., Inc. v. Califano, 574 F. 2d 518, 526 (D.C. Cir. 1977). The Agency's interpretation of the Act, based on the legislative history and specific amendments to Section 1903(g), is that it does not have the discretion to waive a penalty reduction once there is a finding that a violation has occurred. The Comptroller General's Opinion confirmed this interpretation. The Board concludes that such an interpretation is reasonable and that the Secretary does not have the discretion to waive the penalty for even one violation of the Act.

CONCLUSION

We conclude that the certification of one patient, signed and dated by the physician the day after the patient's admission to the facility, where the patient applied for assistance the date of his admission, is

invalid. We sustain the Agency's penalty disallowance for the violation of utilization control requirements with regard to one patient.

/s/ Donald F. Garrett

/s/ Alexander G. Teitz

/s/ Cecilia Sparks Ford, Panel Chair