DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Missouri Department of Social Services DATE: June 30, 1981
Docket No. 79-230-MO-HC
Decision No. 193

DECISION

The Missouri Department of Social Services (Missouri, State) requested reconsideration of a disallowance by the Health Care Financing Administration (HCFA, Agency) of $204,095 in amounts claimed for Federal financial participation (FFP) in the cost of services to persons alleged by the State to be eligible, pursuant to a court order, for Medicaid under Title XIX of the Social Security Act. The request for reconsideration covers claims submitted in reports for the quarters ended March 31, June 30, and September 30, 1978.

Issues

Missouri initially denied Medicaid benefits to certain Supplemental Security Income (SSI) recipients. After litigating the issue of Medicaid eligibility in federal court, the State was ordered to pay for medical services provided to the SSI recipients retroactive to the date of the July 1975 district court decision, even if that meant making Medicaid payments directly to the recipients.

The principal issues are whether HCFA may deny FFP:

1) In payments for services during the period between the original district court decision in July 1975 and the October 1, 1977 effective date of a State Plan amendment to implement that decision;

2) In payments made directly to recipients; and

3) In payments for services rendered by providers which did not have provider agreements with the State at the time.

The State concedes that it must document that it made individual determinations of eligibility and that the payments were for services authorized under Medicaid.

The Board here decides that FFP is available in payments for services beginning July 1975 provided individual determinations of eligibility were made and the payments were only for care and services authorized under Medicaid. Payments made directly to recipients are covered but not payments to non-participating providers.

The decision is based on 15 documents listed in an appendix to this decision.

Background

This case has its origin in court proceedings interpreting federal legislation intended to ease the potential burden on the states caused by the enactment of the SSI program. SSI is a federally administered program for the aged, blind, and disabled under Title XVI of the Social Security Act.

Subsequent to the commencement of SSI on January 1, 1974, states wishing to qualify for FFP under the Medicaid program were required to include in their state Medicaid plan, as categorically needy, recipients of SSI benefits. 1/ This potentially increased the number of Medicaid eligibles since the SSI program used broader eligibility requirements than some state plan programs SSI replaced. Recognizing that the states would bear a part of any increased cost, Congress provided in section 1902(f) of the Social Security Act (42 U.S.C. 1396a(f)):

> [N]o State...shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of Title XVI)...unless such State would be (or would have been) required to provide medical assistance to such individual...had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month...

1/ Prior to 1974, states qualified for FFP under the Medicaid program as long as a state made eligible as categorically needy those persons meeting the standards for the Old Age Assistance (OAA), Aid to Families with Dependent Children (AFDC), Aid to the Blind (AB), Aid to the Permanently and Totally Disabled (APTD), and Aid to the Aged, Blind, or Disabled (AABD) programs. FFP was also available if a state made eligible as "medically needy" persons who met the physical standards for those programs and had insufficient income and resources to pay specified medical expenses although financially too well off to qualify as categorically needy.

Under Missouri law as of January 1, 1972, any person receiving State General Relief (GR) benefits also was given State-funded medical assistance as part of those benefits. §208.151, Revised Statutes of Missouri (R.S. Mo.). In 1973 the State amended this provision to require that a person eligible for GR benefits had to first apply for SSI benefits. If the person were found eligible for SSI, he or she could not receive GR benefits. §§208.015, 208.030, R.S. Mo.

Mrs. Hariece Lewis applied to the State for medical assistance in February 1974. She was at that time receiving SSI benefits based on a disability. The State determined that Mrs. Lewis did not meet the standards for Medicaid eligibility under OAA, AB, or APTD as in effect on January 1, 1972, and denied her application.

The State determined Mrs. Lewis did meet the standard for General Relief benefits, but pursuant to the 1973 State law she was also denied GR medical assistance because as a recipient of SSI she was ineligible for GR benefits. RR, pp. 71-72.

Mrs. Lewis then brought suit in federal district court on behalf of herself and all SSI recipients similarly situated. The plaintiffs prevailed, 2/ and, pursuant to the district court's orders, in

---

2/ In its July 9, 1975 decision, the district court held that on January 1, 1972 Missouri's "approved medical assistance plan" required it to provide medical assistance to all recipients of OAA, AFDC, AB, APTD, and General Relief. On July 22, 1975, the court ordered the State to pay the medical assistance claims of persons who were found to meet the standards of eligibility for SSI and who also met the standards of the General Relief program under Missouri law. RR, pp. 68-69, 74.

The State appealed, but in April 1976 the court of appeals affirmed. The State petitioned the Supreme Court for a writ of certiorari but the Court did not take the case.

At the invitation of the Supreme Court, the Department of Justice had filed a memorandum as amicus curiae. The Department had taken the position that the lower courts were in error but had opposed certiorari on the ground that the situation was unique to Missouri. Earlier, Missouri had urged the (then) Department of Health, Education, and Welfare (HEW) to participate as amicus curiae in the court of appeals, but HEW chose not to do so.

The case is cited as Lewis v. Shulimson, 400 F. Supp. 807 (E.D. Mo. 1975), affirmed 534 F. 2d 794 (8th Cir. 1976), cert. denied sub nom Gourley v. Lewis, 430 U.S. 940 (1977).

June 1977 Missouri began to accept the SSI determination of disability in lieu of the APTD definition to establish Medicaid eligibility. However, the State was found to have otherwise implemented the district court's orders contrary to that court's intent and on November 30, 1977, the district court found the Director of the Missouri Division of Family Services to be in contempt for not providing medical assistance coverage retroactive to July 1975. 3/ The court ordered the Director to:

> (b) Immediately review the records... and immediately redetermine the eligibility of each and every such [plaintiff's] class member not now receiving Medical Assistance. All class members shall immediately be granted Medical Assistance coverage...
>
> (d) ...With respect to paid medical bills...the defendant shall immediately provide a direct cash reimbursement to the claimant for the amounts paid to the vendors by the claimant.

Request for Reconsideration, Exhibit F, pp. 1, 4, 5.

On December 21, 1977 Missouri proposed an amendment to its State plan removing the APTD definition of disability because the SSI disability determination was being used. RR, pp. 38-40. 4/ The amendment was approved January 23, 1978, but was effective October 1, 1977, pursuant to 45 CFR 205.5(b) (1977) and the State's request.

3/ Among other actions, the State had made coverage under the court order depend on the return of a notification form by medical assistance claimants. For bills which claimants had already paid, they were required to seek reimbursement from the provider, on the condition that it was a participant in the Missouri Vendor Program. Request for Reconsideration, Exhibit C.

4/ The definition removed read:

> Permanent and total disability is established by medical examination. "Permanent and total disability means that the individual has some physical or mental impairment, disease, or loss from which recovery or substantial improvement cannot be expected, and which substantially precludes him from engaging in any occupation within his competence, such as holding a job."

In a memorandum to its employees dated January 18, 1978, the State noted its understanding that the court:

> has ordered us to reimburse the claimant directly for paid bills and to pay the vendor (whether a participating vendor or not) for services whether or not they are covered by Title XIX.

The State also observed that federal regulations prohibited payment to non-participating vendors or for non-covered services. Although the State noted it was appealing that part of the contempt order, it urged its employees to "make every effort to comply" with the order. Exhibit D, p. 3, Request for Reconsideration. The record does not reflect the outcome of the appeal.

Discussion

Retroactivity

Missouri argues that the Medicaid eligibility of these SSI recipients should be retroactive to July 1975, in keeping with the court order and 45 CFR §205.10(b)(3) (hereinafter referred to as §205). 5/ HCFA contends that §205 does not require FFP for payments to those recipients prior to October 1, 1977, the effective date of the State Plan amendment, because the decision of the court was "erroneous." March 17, 1981 Supplemer Response, p.2. HCFA claims its position is consistent with this 1973 opinion by the HHS Office of the General Counsel (in pertinent part):

> [I]t is to be noted that the provision [§205] deals only with situations where the State has the option all along, under Federal policy, of including the groups or the assistance in its plan; it does not extend to payments that could not be included in the plan because they are not within the scope of the Federal program.

There is no dispute here that the State could have included SSI recipients in its Medicaid plan as of July 1975, insofar as Federal policy was concerne Contrary to HCFA's contention, under the 1973 General Counsel opinion and §205, the State is entitled to FFP for payments retroactive to July 1975 because such payments are within the scope of the program.

We do not overlook that the State Medicaid Plan did not authorize such payments prior to October 1, 1977, the effective date of the plan

5/ 45 CFR §205.10(b)(3) makes FFP available for:

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

amendment implementing the court order. However, under 45 CFR § 205.5(b), FFP may be available sooner than the effective date of a plan amendment if other regulations so provide. 6/ We find that 45 CFR § 205.10(b)(3) does provide that if a court order directs that payments be made as of an earlier date, FFP is available for payments so made.

We reach this result even though neither HCFA nor Missouri agree with the basis for the court's decision. Indeed, here notwithstanding the opinion of the parties on the correctness of the district court's decision, the Supreme Court refused to review the affirmance by the court of appeals. In any event, the test is not whether the court is right or wrong, but whether it ordered the payments and the payments are otherwise within the scope of the program. That test is met here insofa as eligibility to July 1975 is concerned. In New York Department of Social Services, Decision No. 181, May 29, 1981, the Board applied §205 to a court order directing the State to continue Medicaid payments to a nursing home whose provider agreement had been terminated, pending a hearing request by patients on the issue of their transfer to other facilities. Noting that the Supreme Court subsequently decided that a patient did not have a due process right to such a hearing, the Board held that §205 applied nonetheless to the court order issued prior to the Supreme Court decision.

Payments Made Directly to Recipients

The State initially sought to reimburse individuals who had already paid bills for care and services by seeking out the providers, but in the comptempt proceeding the court ordered that the State pay recipients directly in retroactive situations. HCFA contends that FFP is not available because payments to individuals are not authorized by either the State Medicaid plan or federal statutory and regulatory provisions.

Missouri does not dispute that under its State Medicaid plan it may not reimburse Medicaid recipients directly. This state plan requirement derives from 42 USC §1396d(a) and 42 CFR §449.31 and §449.32. 7/

6/ 45 CFR §205.5(b):

> Except where otherwise provided, Federal financial participation is available in the additional expenditures resulting from an amended provision of the State plan as of the first day of the calendar quarter in which an approvable amendment is submitted or the date on which the amended provision becomes effective in the State, whichever is later.

7/ These and other CFR citations are to the 1977 edition of the Code of Federal Regulations. The parties in briefing sometimes cited later editions with different codifications.

However, the court ordered the State to pay individuals directly in lieu of having those individuals be reimbursed by providers. Applying the analysis that was applied to retroactive payments above, we find that such court ordered payments are not outside the scope of the Medicaid program simply because the court bypassed what would have been a time consuming and burdensome procedure for recipients.

The Agency itself recognized this principle of flexibility in a regulatory amendment adopted September 29, 1978 (43 Fed. Reg. 45253) permitting states to make payments "in accordance with a reassignment by a court order." 42 CFR § 447.10(e). Under §205, even prior to September 29, 1978, FFP would be available if a court reassigned a provider's claim to a recipient. Constructively, that is what occurred in Lewis and we find that FFP is available for such payments. 8/

Payments to Providers Without Valid Agreements

The State also relies on §205 and the court order to justify payments to providers which did not have valid provider agreements with the State for the retroactive period. HCFA argues that such payments are prohibited by 42 U.S.C. §1396a(27) and 42 CFR §450.21. 9/

The State's reliance on the court order is misplaced. The court did not specifically direct Missouri to pay providers without provider agreements. The State might have inferred such a direction from the tenor of the contempt order, but that is not enough to bind the Agency to pay FFP under §205.

The court dealt with the Medicaid eligibility of SSI recipients, not the qualifications of the provider. Moreover, the court did not even constructively validate or set up a provider agreement. These circumstances distinguish this case from Ohio Department of Public Welfare, Decision No. 173, April 30, 1981, where the Board held that FFP was available for

8/ This conclusion is strengthened by Agency remarks in the September 30, 1968 Handbook Transmittal No. 47 that an identically worded regulatory predecessor to §205 makes FFP available:

> where a court orders payments that would not otherwise be made under the State plan, but which are within the scope of the Federal statute ...

State Response January 15, 1981, Exhibit A.

9/ HCFA actually cited 42 CFR §431.107(b) (1978), an identical provision.

court ordered payments during an appeal by a provider from the nonrenewal or termination of its provider agreement. Discussing the application of §205, the Board concluded:

> "[W]ithin the scope" was intended to and does set limits... [b]ut 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)...

See also New York Department of Social Services, Decision No. 181, May 29, 1981, and 45 Fed. Reg. 24878 (April 11, 1980).

In Ohio and New York the Board found that the courts addressed the subject of the need for a provider agreement by constructively extending the prior agreement. Here the court did not deal with the provider agreement and payments to nonparticipating providers would not be within the scope of the Medicaid program as required by §205. 10/

Individual Determinations of Eligibility

Although HCFA relies on other factors as a basis for its disallowance, the notification of disallowance discusses chiefly the alleged failure of the State to make individual determinations of eligibility. During the February 24, 1981 telephone conference, the State conceded that it had the burden of proving eligibility. HCFA agreed, subject to further clearance, that the State could meet this burden by showing that a person name appeared on the SSI list of eligibles for the period in question. Confirmation of Telephone Conference dated February 25, 1981. In a March 17, 1981 Supplemental Response, HCFA did not comment on the specific means of proof suggested at the telephone conference, but insisted that the Agency must be able to ascertain that the State paid claims for "only those individuals who were eligible except for the disability determination." Page 5. HCFA would do this by a sample of individual files drawn from lists submitted by Missouri of all claimants.

10/ The State points out that HCFA's notification of disallowance was based solely on the State's alleged failure to make individual determinations of eligibility and argues that the disallowance cannot be sustained on any other basis. The other issues raised by HCFA in this appeal were referred to in the notification and Missouri has had ample opportunity to brief them during the appeal. Under such circumstances, we believe that these issues are properly before the Board.

Payments for Care and Services Not Covered

The notification of disallowance also listed a finding that the State made payments without the use of "edit screens" to ensure that the payments were only for care and services authorized under Medicaid. The State at first contended that it was entitled to FFP without having to prove that payments were only for covered services (citing §205 and the court order), but in the February 24 telephone conference the State abandoned this argument. Accordingly, we do not reach this issue. We note, however, that the court order did not specifically require the State to use Medicaid funds to pay for services not covered under Medicaid.

Laches

The State argues in its Request for Reconsideration that HCFA "is barred by the equitable principle of laches" from making this disallowance because the Agency declined to participate in Lewis and failed "to actively object" to the court orders although it agreed with Missouri's position in the case. On HCFA's part, the March 1980 response points to Missouri's failure to seek joinder of the Agency as a party (pp. 6-9).

We find that laches does not apply. Missouri does not cite any cases in support of its contention, and case law requires a conclusion to the contrary. A relevant discussion is contained in Concerned About Trident v. Schlesinger, 400 F. Supp. 454 at 478-479 (D.D.C. 1975). Noting that "the doctrine of laches... is essentially concerned with a delay by the plaintiff which induces a change in the defendant's position," the court recounted:

> [T]here are two essential elements of the doctrine of laches: lack of diligence by the plaintiff and injurious reliance thereon by the defendants. Lathan v. Volpe, 455 F. 2d 1111, 1122 (9th Cir. 1972). The crucial issue of the first element, unreasonable delay, is knowledge, i.e., did the plaintiff knowingly sleep on his rights. Ritter v. Rohm & Haas Co., 271 F. Supp. 313, 347 (S.D.N.Y. 1967). As to the second element, injurious reliance by the defendant, there are two kinds of prejudice which would support a defense of laches: where the plaintiff's delay has resulted in a loss of evidence or unavailability of witnesses that would support defendant's position; and where the defendant has changed his position in a manner which would not have occurred if the plaintiff had not

delayed. Tobacco Workers Int. U. Local 317 v. Lorillard Corp., 448 F. 2d 949, 958 (4th Cir. 1971). See Powell v. Zuckert, [366 F. 2d 634 (D.C. Cir. 1966)] supra... at 638.

The State contends in its January 15, 1981 submission that if it had known that FFP would not be available, it might not have appealed the Lewis case. Page 6. Presumably, by enrolling SSI recipients in Medicaid in 1975 the State would have avoided the problems with payments that generated the disallowance and this appeal. We do not agree that this meets the test of injurious reliance, nor does it otherwise excuse the State from having to meet Medicaid requirements.

Similarly, the State has not shown a lack of diligence by the Agency. HCFA could not have known in 1975 that the court would order the State to make payments contrary to federal regulations. Moreover, the State has an obligation of its own to know and observe the Medicaid rules.

Conclusion

We have held in this case that FFP is available:

(1) For services to persons who would have been eligible on July 1, 1975 and thereafter had the State Plan read as it did with the amendment effective October 1, 1977; and

(2) Where the State has made the required individual determinations of eligibility.

We have also held that FFP is available even where retroactive payments for services to the class of persons made eligible by the October 1977 amendment to the State Plan were made directly to those persons, provided:

(1) The care and services were rendered by a provider with a valid agreement; and

(2) Were authorized under the Medicaid program.

FFP is not available for payments to providers which did not have a valid agreement in effect with the State at the time the services were rendered.

Thus the disallowance is sustained in part and reversed in part. HCFA will have to calculate the effect on the amount disallowed after the State has had an opportunity to show what payments are entitled to FFP in accordance with the above.

/s/ Norval D. (John) Settle

/s/ Alexander G. Teitz

/s/ Donald F. Garrett, Panel Chair

APPENDIX

These are the record documents on which the Decision is based:

The request for reconsideration.
The Board's letter of January 14, 1980, asking HCFA to respond to the appeal and addressing questions to both parties.
Responses by both parties to that letter.
The Reconsideration Record (RR), enclosed with HCFA's response.
An Order to Show Cause dated May 27, 1980, calling upon Missouri to provide the documentation to sustain its case.
Missouri's response.
The Board's letter of August 14, 1980 asking HCFA to comment on Missouri's response and inviting rebuttal by Missouri.
HCFA's response.
The Board's letter of December 16, 1980, asking both parties to brief the applicability of 45 CFR §205.10(b)(3).
Missouri's response dated January 15, 1981.
The Board's letter of January 22, 1981 transmitting to the parties supplemental material for them to consider in briefing the applicability of 45 CFR §205.10(b)(3) and extending the time for reply, including a supplemental reply by the State.
HCFA's response.
The Board's letter of February 25, 1981 confirming the subjects and briefing schedule discussed in a telephone conference with the parties the preceding day.
The parties' responses.
The Memorandum in opposition to Missouri's Petition for a Writ of Certiorari, filed by the United States Department of Justice in Gourley v. Lewis, Supreme Court Docket No. 76-188.