DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Nebraska Department of Public Welfare
Docket No. 78-36-NB-HC
Decision No. 111

DATE:
July 16, 1980

DECISION

On May 23, 1977, the Nebraska Department of Health (the survey agency) conducted a survey of the Warren Hospital Annex (Annex) pursuant to the State's Regulations and Standards for Aged or Infirm. According to the State, an acceptable plan of correction was agreed upon subsequent to the survey. The Annex's Medicaid Certification and Transmittal, dated June 28, 1977, indicates that the facility had been certified by the Department of Public Welfare (DPW), the single state agency, for participation under Medicaid for the period August 1, 1977 to July 31, 1978 (HCFA Response, Attachment B). It is assumed, absent an indication to the contrary, that a provider agreement was executed for the certification period. On July 15, 1977, the Department of Health conducted a "complaint visit" to the facility. On August 9, 1977, the Annex's intermediate care facility (ICF) license was revoked by the Department of Health. The director of the DPW, on August 12, 1977, notified the administrator of the Annex that the facility was being decertified as a participant in the Nebraska Medical Assistance Program effective August 9, 1977.

According to the notification, this action was based on the revocation of the ICF license by the Department of Health for violation of its regulations. The director of the DPW also stated that the "counties of fiscal responsibility" were being notified that all Medicaid recipients in the facility must be relocated as soon as possible (DPW Application, Exhibit 2). The Department of Health conducted an audit of the facility on August 18, 1977. On September 2, 1977, the Department of Health rescinded its August 9 revocation and revoked the ICF license as of September 2. The revocation document (HCFA Response, Exhibit A) noted serious deficiencies in the areas of fire safety, resident care and administration, as well as the intentional misrepresentation of information about nursing schedules. Violations of State fire regulations included the lack of a 1 3/4 inch solid wood bonded core door to the utility building and the lack of a sprinkler system throughout the wood frame building.

On September 6, 1977, the Annex appealed the license revocation to the Department of Health pursuant to Nebraska Revised Statutes (N.R.S.) Section 71-2023 (1971). On September 15, 1977, the State Division of Medical Services wrote to Saline and Thayer Counties that, because the Annex had appealed the decertification, "all the plans for relocation of the Medicaid recipients in this facility should be suspended until you are notified of the findings of the appeal hearing" (DPW Application, Exhibit 4).

On September 16, 1977, the DPW notified the facility that its decertification had been amended to September 2, 1977 to coincide with the license revocation by the Department of Health (DPW Application, Exhibit 3).

On November 17, 1977, the Annex was notified by the DPW that:

> Effective immediately no new admissions of Medicaid recipients...will be approved for Medicaid payment. Only after the state Department of Health has made a determination in the appeal of the license revocation and has notified this office that your facility is in compliance with standards for recertification can new admissions be approved. (DPW Application, Exhibit 5).

The situation within the Annex with regard to the patients was, therefore, that no new admissions were to be accepted but that patients did not have to be moved to another facility until the appeal was resolved.

On January 12, 1978, the Director of the Department of Health "affirmed and upheld" the license revocation and ordered all of the residents and patients but one to be removed by March 1, 1978 unless an inspection prior to that date showed that the violations had been remedied (DPW Application, Exhibit 8).

The Annex did not appeal the decision to the district court of Lancaster County, as is provided for in N.R.S. Section 71-2027 (1971).

The DPW submitted its Quarterly Statement of Expenditures for the Medical Assistance Program for the quarter ended December 31, 1977 to the Regional Office of the Health Care Financing Administration (HCFA). The Statement requested FFP in payments to the Annex for services provided between September 1, 1977 and November 30, 1977. On May 19, 1978, HCFA notified the DPW of the disallowance of $3,403 for the period September 1 to November 30, 1977 stating that the action was taken because:

> To qualify for FFP under 42 CFR 449.10(b)(15)(i)(A), ICF services must be provided by a facility which fully meets requirements for licensure under State law to provide such services. ICF services provided by the...Annex subsequent to September 2, 1977 do not meet the requirements for FFP.

Since the State did not act within 30 days after the decertification to transfer patients from the Annex to another facility, FFP was not available during the 30 days following decertification under 42 CFR 449.10(b)(15)(v).

The Board's decision is based on the State's application for review dated June 13, 1978, the Agency's response to the appeal, an Order to Show Cause and the responses, responses to requests by the Board's Executive Secretary for additional information, and briefs filed in conjunction with an informal conference which both parties attended, held in a Delaware case (Board Docket No. 78-108-DE-HC) which involved a similar issue.

Relevant Statutory and Regulatory Provisions

The provider agreement between the Annex and the DPW was for ICF participation in the Title XIX program. Section 1905(c) of the Social Security Act, 42 U.S.C. 1396d(c), defines an intermediate care facility as an institution --

> which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition required care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, and (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law....

Part 449 of 42 CFR (1977) outlines the "services and payment in medical assistance programs." To obtain FFP for payments made to an ICF, the State must comply with the requirements in 42 CFR 449.10(b)(15)(i)(E) requiring the single State agency and the provider facility to execute an agreement which the single State agency determines is in accordance with 42 CFR 449.33 and meets all of the conditions of 42 CFR 449.10(b)(15)(i). The regulations, with certain exceptions which do not appear to be applicable here, require that prior to the execution of the provider agreement and the making of payments, the "survey agency" designated pursuant to section 450.100(c) must certify that the facility meets the statutory definition in section 1861(j) of the Social Security Act and is in full compliance with standards prescribed in the regulations (See 42 CFR 449.33(a)(1)(i)).

Upon certification by the survey agency, the single State agency then executes a provider agreement with the facility in accordance with the Federal regulations. 42 CFR 449.33(a)(6).

The availability of FFP is, however, subject to the "look behind" provisions in 42 CFR 449.10(b)(15)(vi). This section permits the Secretary to declare the provider agreement of any ICF invalid if:

> (A) The survey agency failed to apply the Federal standards for certification of an intermediate care facility required under §449.33(a)(2);
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> (B) The survey agency failed to follow the rules and procedures for the certification of an intermediate care facility set forth under §449.33(a)(4)(ii) through (v);
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> (C) The survey agency in connection with its duties in determining whether a facility meets Federal standards, failed to

perform any one of the functions in §449.33(a)(5);

(D) The survey agency failed to use the Federal standards and the forms, methods and procedures required under §450.100(c)(1); or

(E) The terms and conditions of a provider agreement do not meet the requirements of §449.33(a)(6),(7), (8) and (10).

In addition, 42 CFR 449.10(b)(15)(i)(A) requires, as one of the conditions for FFP, that ICF services be provided in an institution which "meets fully all requirements for licensure under State law."

As a result of 42 CFR 449.10(b)(15)(i)(A) quoted above, the State statutory laws governing licensure, and in particular, N.R.S. Sections 71-2023 and 71-2027 (1971), become applicable.

N.R.S. Section 71-2023 (1971) states, in pertinent part:

> The Department of Health shall issue licenses for the operation of institutions....The Department of Health shall deny, or suspend or revoke licenses....The denial, suspension, or revocation shall become final thirty days after the mailing of the notice, unless the applicant or licensee, within such thirty-day period, shall give written notice of desire for hearing. Thereupon the applicant or licensee shall be given a fair hearing....On the basis of such evidence the determination involved shall be affirmed or set aside...
>
> The decision shall become final thirty days after a copy thereof is mailed, unless the applicant or licensee within such thirty-day period appeals the decision under section 71-2027....

N.R.S. Section 71-2027 (1971) states:

> Any applicant or licensee, who is dissatisfied with the decision of the Department of Health as a result of the hearing provided in section 71-2023 may, after receiving a copy of the decision, appeal to the district court of Lancaster County at any time within thirty days after the mailing of such copy of the order....

License Revocation

The State admits that the ICF license of the Annex was revoked effective September 2, 1977 and that it was decertified as a participant in the Nebraska Medicaid program as of that date. The State argues, however, that the revocation was held in abeyance as soon as the facility appealed the revocation, and that FFP should have been continued during the period between September 2, 1977 and January 12, 1978 when the revocation became final.

The State's argument centers on the use of the word "unless" in the State law, viz: "...The denial, suspension or revocation shall become final thirty days after mailing of the notice unless the applicant or licensee...shall give written notice of desire for hearing." The State claims that, since a timely notice of appeal was filed in this case, "the license revocation was held in abeyance pending the outcome of the appeal..." (DPW Application, p. 2).

As support for its argument, the State submitted an opinion from its Attorney General dated July 12, 1979 which states in pertinent part --

> If the Department of Health suspends or revokes the license of a nursing home, its decision is final unless the licensee makes a timely request for an evidentiary hearing before the department. After such a hearing, a decision of the department affirming the revocation is final unless the licensee makes a timely appeal to the district court as provided in sections 71-2023 and 71-2027, R.R.S. 1943. Otherwise those statutes are silent about the effect of an appeal on the licensee's right to continue to operate its facility and the time when the suspension or revocation takes effect...
>
> We have concluded that the licensee can continue to operate its facility as though its license were in full force and effect pending a final determination of its appeal. If the order of the department is affirmed on appeal, the suspension or revocation will commence at the time of the final judgment, not at the time of the department's order.

It does not appear from the actions of the State that it considered the license (and therefore its certification according to the State) to be in full force and effect after September 2, since the State notified the facility on November 17 that no new admissions of patients would be eligible for Medicaid payments.

HCFA has agreed, subsequent to the Order to Show Cause issued by the Board, that the Attorney General's opinion holds that an appeal of a license revocation pursuant to 71-2023 suspends the effective date of license revocation until the revocation is affirmed on appeal. As discussed below, HCFA now argues that the survey of the facility revealed violations of federal as well as State standards and, therefore, that the operation of State law does not govern HCFA's actions.

Decertification

HCFA has argued that surveys of the facility conducted by the State not only revealed noncompliance with state standards but also noncompliance with federal standards such as fire safety, resident care and administration and intentional misrepresentation of nursing schedules. HCFA points out that in order to qualify for FFP, a facility must satisfy both state and federal standards. But it argues that, notwithstanding the stay of revocation of the state license, the facility still was not certified as being in compliance with federal standards. Since the

facility was not certified, its provider agreement was no longer valid, and its ICF services were not reimbursable.

The State argues that the license revocation action was the sole basis for the initiation of decertification, and that since the license revocation is stayed on appeal by statute, so is the decertification. Thus when a timely appeal is filed, the State asserts, a final determination as to the material facts involved cannot be made until a hearing is held, an order entered, and, potentially, judicial review completed. The State contends that when there is one set of deficiencies which form the basis for both license revocation and decertification, the DPW cannot legally decertify when a timely appeal has been filed since there can be no legal, final determination as to the cited deficiencies under State law. Continuing payments during this period protects the due process rights of both patient and provider.

The State cites Hathaway v. Mathews, 546 F.2d 227 (7th Cir. 1976) and Klein v. Mathews, 430 F. Supp. 1005 (D.C.N.J. 1977) in support of its assertion that there are two parallel sets of due process rights inuring to the benefit of providers and patients which must be safeguarded in non-emergency situations by the provision of pretermination evidentiary hearings. The State contends that the facts of this appeal do not indicate that "emergency" situations existed. It further contends that the facts clearly do not support a conclusion that there were conditions that were so deplorable and dangerous so as to outweigh the due process rights of the provider and patients.

The State argues that it is obvious from the cases cited that had DPW chosen to attempt decertification of the provider without a pretermination hearing, the patients could have brought a lawsuit and obtained an injunction which would have required the continuation of Medicaid payments pending the outcome of administrative and, if necessary, judicial review. It points out that the due process safeguards are embodied in the Nebraska Revised Statutes, thus obviating the necessity of such a lawsuit. The State concludes that it should not be penalized for safeguarding the due process rights of providers and patients alike in non-emergency situations.

In reply to the State's due process arguments, HCFA asserts that the cases cited by the State deal only with the rights of patients to a hearing prior to the termination of a provider's participation in the Medicaid program. In the present appeal before the Board, however, there is no evidence that any patients were instrumental in exercising the appeal rights under N.R.S. 71-2023 or were, in fact, involved in the hearing before the Department of Health. It thus appears that the provider was the only one seeking the appeal or represented at the hearing. HCFA asserts that the requirements for a survey, certification, and provider agreement were designed to safeguard the interests of recipients of federally funded medical assistance by ensuring that they receive quality medical care in safe and healthful surroundings. HCFA contends that the purpose of these laws is to protect low income individuals from the very kind of conditions they continued to experience in this nursing facility.

Discussion

In the decision in Delaware Department of Health and Social Services, DGAB Docket No. 78-108-DE-HC, Decision No. 87, February 29, 1980, the provider agreement itself stated that a hearing would be held if the single State agency suspended or cancelled the facility's Medicaid participation. As the Board's Chairman stated in his decision at page 2 --

> There is no good solution to the dilemma which the parties...face. Residents of the facilities participating in the Medicaid program should be protected against substandard conditions but also have an interest not to be moved unnecessarily from facilities they have chosen. The State in good faith may feel that it must extend due process to a facility which has had its participation in the Medicaid program suspended or canceled and that if the State does not provide a hearing, it may be required by a court to do so. If it is forced to continue reimbursing the facility for its Medicaid costs, it naturally looks to the Federal government for participation in the costs. On the other hand, the Federal government has not committed itself to continue to fund poor, inadequate, even harmful services to individuals while review proceedings, possibly protracted, possibly deliberately stalled, are conducted. HEW's decision not to participate appears to be consistent with the Medicaid regulations and not in conflict with current case law.

The State has argued that case law indicates that due process rights inure to the benefit of providers and patients which must be safeguarded by pretermination hearings and that these due process safeguards are embodied in N.R.S. 71-2023. The State contends that it should not be penalized (by a loss of FFP) for safeguarding these rights.

The court cases relied on by the State do not fully support its contentions (see discussion at pages 7 and 8 of the Delaware decision). In Hathaway v. Mathews (cited supra), in which an HEW inspection team determined that the facility should not have been certified, the court emphasized the fact that the owner had not been given notice of what specific areas of the facility were allegedly out of compliance; the argument for requiring a pretermination hearing was thus stronger than in other situations in which a facility had been given notice. In this appeal, it is clear that the owner of the Annex had been aware of the deficiencies inasmuch as a plan of correction had been approved several months before decertification. In the Klein case (cited supra), in which HEW terminated FFP although the State and its surveyors disagreed with HEW's findings, the district court stated that the patients had a right to a hearing and that the patients' direct assertion of their interest not only undermined the government's interest in a pre-hearing termination but was a more compelling interest in postponing termination than that asserted by the nursing

home in Hathaway. The Supreme Court, on June 23, 1980, in the case of O'Bannon v. Town Court Nursing Center, 48 U.S.L.W. 4842, determined that the patients in the facility do not have an interest in receiving benefits for care in a particular facility that entitles them, as a matter of constitutional law, to a hearing, before HEW can decertify the facility. The trend of the case law as characterized by the State is that this Department must reimburse a state pending the outcome of a pretermination hearing. The O'Bannon case indicates that the trend is not as clear-cut as this.

The issue presented in this case is whether FFP can be provided to reimburse the State for payments to a facility after it has been decertified but prior to the time the decertification becomes final under the applicable state law. In order to find for the State, we would have to determine that there was valid certification of the facility during the appeal process.

The State law cited above, N.R.S. Section 71-2023, refers only to license revocation procedures. There is neither reference in this section to a decertification procedure nor has the State documented any provision in any other section of the State statutes. State law could have provided for such a procedure, but did not do so. Therefore, during the relevant time period, there was no statutory provision requiring any sort of hearing procedure when a facility was found not to comply with federal Medicaid standards. On the date of decertification, September 2, 1977, there was no valid provider agreement under the regulations, and FFP could no longer be given for services rendered by the facility.

The State has argued that the deficiencies which caused the delicensing procedures were the same deficiencies which HEW claims are violations of federal standards and were the cause for decertification. The Agency has not proved otherwise. Therefore, assuming arguendo that the violations were coterminous, there is merit in the contention that the State could not decertify until there was a final, legal determination under State law on the true nature and extent of the deficiencies. Nevertheless, the facility ultimately did lose its appeal and its license.

Even if we found that the language of the State statute could be interpreted to include decertification hearings, this Department, under the "look behind" regulations, 45 CFR 449.10(b)(15)(vi)(A), need not accept the final determination at the end of the appeals process as binding on its decision as to whether to provide FFP.

42 CFR 449.33(a)(2)(i)(C) states that an ICF having Life Safety Code deficiencies may be certified provided that during the period allowed for corrections, the institution is determined to be in compliance with existing State fire safety and sanitation codes and regulations. The record shows that one of the reasons for the delicensure action was that the facility did not comply with State fire Regulations 10-2327 and 10-2352 as well as the Life Safety Code. Under the Federal

regulations, therefore, because of the State code violations, the Department of Health improperly certified the facility, even though there was a plan of correction. The provider agreement was, therefore, invalid, and FFP cannot be awarded for the reimbursement of services by a facility with an invalid provider agreement.

As the State suggests in its argument, it is appropriate to apply a balancing test to the property rights of the providers, the interests of the patients and the interest of the state and federal governments in ensuring that the patients are provided a healthy and safe environment. In the instant case, the Board rejects the State's characterization of Warren Hospital Annex as a facility where conditions were not so deplorable and dangerous so as to outweigh the due process rights of the providers and patients. The record establishes that the patients, many of whom were not fully ambulatory, were housed in a wooden frame structure which was not fully protected by an automatic sprinkler system. In addition, the facility was not properly staffed and at times did not have sufficent personnel on duty to perform an evacuation of the building. This cannot be condoned by Federal financial participation. This would remain true no matter what the outcome of the hearing conducted by the State on the license revocation. The health and safety of patients will always be a concern of the Board in a controversy involving the Department's obligation to provide FFP when a state has terminated a facility from the Medicaid program. To require the Department to continue payments when a facility does not meet minimal statutory and regulatory requirements would disarm the Department of its main weapon, the denial of FFP, to ensure that quality care is received.

On February 15, 1979, the Agency promulgated regulations (44 FR 9749) requiring states to make appeals proceedings available to facilities whose participation in the Medicaid program is being denied, terminated, or not renewed. In the preamble, the Agency states that one of the primary goals of the Notice of Proposed Rulemaking was --

> to clarify the point at which Federal funding of Medicaid payments would cease for a facility that had been terminated from the Medicaid program. Included ... were rules providing retroactive payments for terminated facilities which were determined after administrative or judicial appeal to have been qualified to participate and certain provisions relating to the coterminous nature of Medicare and Medicaid provider agreements. (42 FR 3665)
>
> It was our intention to raise in that Notice the question whether Federal financial participation in payments to facilities should be continued throughout the hearing process, and, more specifically, what effect State laws and court injunctions against States which continued State payments to facilities or extended their provider agreements throughout the hearing process should have on Federal Medicaid payments. We now believe, however, that these issues were not adequately addressed in the Notice. We have,

> therefore, decided not to issue final rules on the Federal financial participation question contained in the Notice at this time. We intend to address those issues specifically in a new Notice of Proposed Rulemaking.

Although it has been almost one-and-a-half years since that regulation was published, there has been no new Notice of Proposed Rulemaking dealing with the issues set out in the part of the preamble quoted above. Accordingly, the Board will deal with this admittedly difficult problem on a case-by-case basis and attempt to provide some guidance to the states until the Agency issues comprehensive rules.

Conclusion

Based on our analysis that N.R.S. 71-2023 and court decisions cited by the State are not applicable to this appeal and that 42 CFR 449.10 (b)(15)(vi)(A) is applicable to this factual situation, we conclude that the payments by the State to the Warren Hospital Annex during the period from September 1, 1977 through November 30, 1977 are not eligible for FFP because the provider agreement entered into by the facility and the State was not valid under Federal regulations. This decision constitutes the final administrative action on this matter.

/s/ Donald G. Przybylinski

/s/ Robert R. Woodruff

/s/ Frank L. Dell'Acqua, Panel Chairman