DEPARTMENTAL GRANT APPEALS BOARD

Department of Health, Education, and Welfare

SUBJECT: Delaware Department of Health and Social Services
Docket No. 78-108-DE-HC
Decision No. 87

DATE: February 29, 1980

Matthew J. Lynch, Jr., Deputy Attorney General, Department of Justice, for the Delaware Department of Health and Social Services. Robert A. Dublin, HEW Office of the General Counsel, Health Care Financing and Human Development Services Division, for the Health Care Financing Administration.

DECISION

I. Procedural Background

This decision is the final step in the reconsideration process provided in Section 201.14 of Title 45 of the Code of Federal Regulations, implementing Section 1116(d) of the Social Security Act. Section 1116(d) entitles a State to receive upon request reconsideration of disallowances under certain titles of the Social Security Act including Title XIX. This case arises from disallowances issued on December 20, 1976 ($2,158) and March 1, 1977 ($5,002) by the Regional Commissioner of the Social and Rehabilitation Service (SRS) and July 13, 1977 ($810) and September 15, 1977 ($245) by the Acting Assistant Director for Financial Management, Health Care Financing Administration (HCFA) - a total sum of $8,215 in Federal financial participation (FFP) claimed by the State under Title XIX. On July 14, 1978, the Administrator, Health Care Financing Administration issued a decision upholding the disallowances.

By letters dated August 16, 1978, addressed to the Administrator, and November 20, 1978, addressed to the Executive Secretary of the Departmental Grant Appeals Board, the State requested further reconsideration by the Chairman of the Board. Although the State was entitled under 45 CFR 201.14, as amended March 6, 1978 (43 FR 9266), to exercise an option to have the matter considered by the Board under 45 CFR Part 16, it expressly chose not to do so but to be governed by the Section 201.14 procedure with the Chairman substituted for the Administrator, SRS, in accordance with the transfer of functions of March 6, 1978 (43 FR 9266-7). A new Chairman was appointed February 25, 1980, just prior to the issuance of this decision. To remove any doubt as to my authority to decide this matter, the new Chairman, as authorized in the transfer of functions, has made a confirmatory delegation to me of that responsibility.

Although it had not asked for a conference prior to March 6, 1978, the State indicated that it desired to have a conference with the Board Chairman. The Agency also indicated that it desired a conference, and I determined that one would be helpful in resolving the issues. By Notice of Conference dated August 22, 1979, I informed the parties that such a conference would be held and directed them to come prepared to discuss certain questions present in the case and also the correctness of the preliminary analysis of facts and issues set forth in the Notice. Other States with cases before the Board posing questions similar to those present in this case were invited to brief and discuss at the conference the issue of whether FFP should be continued if a state is compelled by court order, contractual agreement or state law to continue Medicaid payments to a provider after expiration of the provider agreement. The purpose of this was to assure that a decision on the Delaware case would not be reached without awareness of the range of issues, and so that a precedent not be developed improvidently without awareness of how it might affect other cases on related but not identical facts. The conference was held on October 9, 1979. In addition to Delaware, eight states sent legal representatives. Because of a lack of an appropriation, we were unable to have a professional reporter and had to rely on amateur recording equipment and transcription. A transcript was made however and is part of the file. Corrections will be received and filed with the record. This decision is based on the written record and on what I heard at the conference.

There is no good solution to the dilemma which the parties, Delaware and HCFA, 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 me consistent with the Medicaid regulations and not in conflict with current case law.

II. Statement of the Case

On April 6, 1976, the Delaware Department of Health and Social Services entered into a written agreement (a "provider agreement") with the Scott Nursing Home for intermediate care facility participation in the Medicaid program. In the printed terms of the agreement, paragraph B on page 6 provides:

> "B. That the term of this Agreement shall be for a period of 12 months, or until the Federal and/or State Government cease to participate in the program, or by mutual consent of the Department and the Intermediate Care Facility or, if not by such mutual consent, either party to this Agreement may consider it cancelled by giving notice in writing to the other party. If the Intermediate Care Facility wishes to continue its participation in the program, it shall file a reapplication at least 60 days before the expiration date."

Paragraph H, on page 7 provides:

> "H. This Agreement shall be effective from 3/1/76 to 6/30/76, but is subject to cancellation if such action is recommended by the certification agency." (The dates are typed in the blanks provided.)

The State Agency also agreed (paragraph G on page 5):

> "G. To provide a fair hearing to the Intermediate Care Facility in the event the Department suspends or cancels the Intermediate Care Facility's participation in the Title XIX program;"

The State continued to make payments to the Scott Nursing Home for a period after June 30, 1976, although the Delaware Office of Health Facilities, Licensing, and Certification determined that the nursing home did not meet the intermediate care facility (ICF) certification standards. A hearing was held on August 11, 1976. According to the State, a decision by the State's Hearing Officer was rendered four months later, and the facility was terminated from the Medicaid program. The Agency disallowed FFP to the State for the post-June 30 payments making, however, an allowance for an additional 30 day period pursuant to 45 CFR 449.10(b)(15)(v), because the Agency contended that the provider agreement expired on June 30, 1976.

In a letter dated December 24, 1975, the Regional Attorney (Region III) had advised the State that:

> It is the present policy of the Department of HEW to continue Federal financial participation to Title XIX-only skilled nursing facilities which are terminated from continued participation in the medicaid program during the period of appeal of the termination action if "State law provides for the continued validity of the provider agreement pending appeal, or if the facility is upheld on appeal and State law provides for retroactive reinstatement of the agreement..." MSA-PRG-11, 12/30/71.

In a letter to the Regional Attorney (Region III) dated March 9, 1979, an Assistant Attorney General of the State of Delaware stated that he could find no statutory or case references which would provide for the continued validity of the provider agreement pending appeal.

III. Threshold Question

An initial question must be answered as to whether the facility's provider agreement had expired on June 30, 1976 (Paragraph G on page 5 of the agreement) or continued to run for twelve months (Paragraph B on page 6 of the agreement).

The State has argued that the agreement remained in effect until the hearing decided the facility's status. It has asserted that the conduct of the parties leads to this conclusion. The facility continued to provide services to Medicaid patients and bill the State, the State continued to accept the bills and reimbursed the facility until the results of the hearing were obtained and the facility's participation in the Medicaid program was terminated. The State has also contended that if the contract was no longer in effect after June 30, 1976, then there would be no contractual obligation on the part of the State to give the facility a fair hearing.

The wording of Paragraph C on page 5, however, does not indicate that certification was to continue pending a decision after a hearing. The paragraph states simply that if the State suspends or cancels, then the facility receives a fair hearing. (It is not clear that the State was obligated to provide a hearing in this case under the terms of the agreement since it did not "cancel" or "suspend" but refused to recertify; this issue was not explored in detail in the record, and I am assuming that the State in good faith intended the provision to apply to the situation in this case.) Part of the

contract is printed, and part is typed. It is the latter which prevails. See, e.g. Williston On Contracts, Section 622 (3d Ed., 1961). The June 30, 1976 date specifically typed into the agreement is the controlling termination date of the agreement as against the 12 month period of the printed form. At no time prior to the State's Reply to the Response of HCFA did the State dispute the fact that the agreement terminated on June 30, 1976. For example, the State included a letter in its Reply from the Nursing Home Coordinator, Division of Social Services, State of Delaware, to the Associate Regional Commissioner, Medical Services, HEW, which states:

> The Scott Nursing Home...has not been recertified to Title XIX by the Certification Agency; their Provider Agreement expired on June 30, 1976...

The attorney for the Delaware Department also has stated in a letter dated August 8, 1978 to the Director, Division of Business Administration and General Services, State of Delaware, that this was a case of nonrenewal. It appears that both the survey and the single State agencies considered the provider agreement ended on June 30, 1976.

Thus, the specific issue in this case is the effect that an administrative hearing process afforded by the State under an ICF provider agreement has on the availability of FFP, otherwise precluded because the provider agreement has expired and certification has not been renewed.

IV. Regulations

The provider agreement between Scott Nursing Home and the State's Division of Social Services was for intermediate care facility (ICF) participation in the Title XIX program. Part 449 of 42 CFR outlines the "services and payment in medical assistance programs." Although the time period in question includes part of 1976, we cite, for convenience, the 1977 edition of the Code of Federal Regulations, which recodifies but does not appear to make any material change in substance in the regulations effective during the period in question. 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 applicable here, require that prior to the execution of the provider agreement and the making of payments, the agency designated pursuant to §450.100(c) (the "survey agency") must certify that the facility meets the statutory definition in 1861(j) of the Social Security Act and is in full compliance with standards prescribed in the regulations (See 42 CFR 449.33(a)(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. §449.33(a)(6). Facilities which are determined to have deficiencies requiring decertification or termination may enter into a plan of correction with the State agency pursuant to 42 CFR 449.33(a)(4). This agreement may be for 60 days (449.33(a)(4)(iii)(A)) or a conditional term of 12 full months, subject to an automatic cancellation clause that the certification will expire at the close of a predetermined date unless the corrections have been satisfactorily completed or the facility has made substantial progress in correcting the deficiencies (449.33(a)(4)(iii)(B)). A two-month extension is also permitted by 42 CFR 449.33(a)(6) when the State survey agency notifies the State agency in writing prior to the expiration of the provider agreement that certain conditions noted below exist within the facility. The regulations permit the State to continue to claim FFP for 30 days after the expiration of its provider agreement if the individuals in the facility were admitted before the date of expiration and the State agency makes a showing satisfactory to the Secretary that it has made reasonable efforts to facilitate the orderly transfer of the individuals to another facility. (See 42 CFR 449.10(b)(4)(i)(C) and 42 CFR 449.10(b)(15)(v)). As indicated above, the 30 day extension of FFP was granted to the State.

V. Discussion

There is no provision in the Social Security Act or Federal regulations authorizing HEW to make payments to a State because it has bound itself to make payments to a facility during a fair hearing process that extends beyond the expiration of a valid agreement. The applicable regulation states that FFP is only available when the facility in question meets all the requirements of certification as evidenced by a valid provider agreement; the provider agreement in this case expired on June 30, 1976 and was not renewed. Only the 30 day extension discussed in Section IV above is applicable and was utilized to extend FFP through July 30, 1976.

The State has argued that HCFA is estopped from claiming that Delaware cannot receive FFP for the period after June 30, 1976. The State asserts that advice, given by the HEW Regional Office on July 27, 1976 in response to a letter from the State on July 16, 1976, that FFP could only be claimed until July 31, 1976 was inaccurate and misleading because extensions of the provider agreement were possible under the regulations. The advice from the Regional Office was correct, however. The letter from the State was dated subsequent to the expiration date of the provider agreement and itself stated that the agreement had expired. The only extension available at that point, in 42 CFR 449.10(b)(15)(v),

was given to the State. The exception set forth in 42 CFR 449.33(a)(2) requires that a written plan of correction be accepted by the survey agency; no plan of correction was submitted by the facility in this case. The two month extension available pursuant to 42 CFR 449.33(a)(6) requires that the survey agency notify the single State agency in writing prior to the expiration of the provider agreement that the health and safety of the patients will not be jeopardized and that the extension is necessary to prevent irreparable harm to the facility or hardship to the residents. The Delaware survey agency did not notify the single State agency of such facts before the expiration of the agreement. There was, therefore, no valid provider agreement in effect after June 30, 1976, and HEW, under its regulations, could not reimburse the State for its payments for services provided by the facility after July 30, 1976.

Throughout the reconsideration process, the State has asserted that constitutional due process mandates that a hearing must be provided before a provider agreement is terminated and that HEW is therefore bound to continue FFP throughout the course of the hearing. As authority, it has cited Klein v. Matthews, 430 F. Supp. 1005 (D.N.J. 1977), aff'd sub nom, Klein v. Califano, 586 F.2d 250 (3rd Cir. 1978) and Hathaway v. Matthews, 546 F.2d 227 (7th Cir. 1976). HEW has argued that whether or not a State has to afford such a hearing, HEW, under its regulations, can not continue FFP during that period.

In Hathaway, the facility had been licensed and certified by the State of Indiana. After receiving complaints, an HEW inspection team determined that the facility should not have been certified and notified the State that it would cease FFP for the facility. The State then decertified the facility, and the owner/operator went into court to enjoin HEW from cutting off payments before notice and a hearing were given. The court discussed the fact that Hathaway had not been given notice of what specific areas of the facility were allegedly out of compliance; the argument for requiring a pre-termination hearing was thus stronger than in other situations in which a facility has been given notice and an opportunity for a meeting with HEW officials. In light of these facts, the court held (p. 232) that HEW could not terminate payments until it had first given the owner notice of the charges and conducted a hearing. In the Delaware situation, the State acknowledged at the conference that it had been working with the facility for a considerable time to bring it into compliance (Conference Transcript, p. 69); the facility would, therefore, have been aware of the areas of deficiencies, a factual difference from the situation in the Hathaway case.

In the Klein cases, both the State of New Jersey and the patients in a facility sought to block the termination of FFP; as in Hathaway, HEW had determined that the facility was not a qualified provider and terminated FFP in a situation in which the State and its surveyors disagreed with HEW's findings. The lower court did determine that the patients must receive a pre-termination evidentiary hearing and that FFP must continue during the hearing period. The Court of Appeals upheld the lower court's decision that FFP must continue until the residents were given an opportunity to participate in the decision to decertify the facility. The lower court emphasized a distinction between the factual situation with which it was dealing and the one present in Hathaway - that the patients' direct assertion of their interest not only undermined the governmment's interest in a a pre-hearing termination but was a more compelling interest in postponing termination than that asserted by the nursing home in Hathaway (p. 1012).

Numerous other cases presenting many different factual patterns were cited at the conference and in briefs by other States having similar appeals before the Board. Some of the courts have ordered the state to continue providing funds to a facility until a hearing had been held, but specifically stated that a state's obligation to provide medical assistance is independent of Federal law and regulations with respect to FFP; in these cases, HEW was not a party. Gardner v. Parry, 386 N.Y.S. 2d 322, 88 Misc. 2d 154 (1976); Kane v. Parry, 371 N.Y.S. 2d 605, 82 Misc. 2d 1019 (1975). Another enjoined HEW, as one of the defendants, from terminating FFP before the process of administrative and judicial review was completed, based on state law and MSA-PRG-11 (See page 4), both of which are not applicable in this appeal. Maxwell v. Wyman, 478 F.2d 1326 (2nd Cir. 1973). Others, in which HEW was a defendant, involved serious deficiencies in both Medicare and Medicaid standards, and the courts based their decisions on Medicare review procedures. Town Court Nursing Ctr., Inc. v. Beal, 586 F.2d 266 (3rd Cir. 1978); Case v. Weinberger, 523 F.2d 602 (2nd Cir. 1975). One, in light of serious Life Safety Code deficiencies, stated that no pre-termination hearing was necessary and that:

> Presumably, should the plaintiff be successful in enjoining the state termination of its status, the federal funds would again be channelled to Caton Ridge. And without such a result, HEW cannot be ordered to resume payments to beneficiaries residing in Caton Ridge. As such, there is no relief which is or can be sought from Califano.

Caton Ridge Nursing Home, Inc., v. Califano, 447 F. Supp. 1222, 1227 (D. Md. 1978), aff'd 596 F.2d 608 (4th Cir. 1979). These citations, while not exhaustive, are typical.

In light of the legal principles enunciated in the cases dealing with the rights of patients and providers to some sort of "process" before a facility's Medicaid participation is canceled or terminated, it can be seen that the State of Delaware may have in good faith inserted a hearing provision in its provider agreements in order for its Title XIX program to comport with what it perceived to be the requirements of due process.

On the other hand, the cases relied on by the State and by some of the other states present factual situations different from the specific situation in Delaware. There is no basis in this situation to require HEW to continue to pay FFP for an unlimited amount of time while a facility wends its way through an administrative appeals process that might take years to complete, particularly when HEW's commitment to participate in payments would continue past the expiration date of the provider agreement. The purpose of the Medicaid program is to ensure that qualified recipients receive health care in facilities which comply with Federal and state standards. Its main tool of enforcement is to deny FFP for facilities which are substandard, whether they are found to be so by the state or by HEW itself. FFP is not available for a facility with an expired provider agreement.

VI. Conclusion

As noted above, the statute and the regulations and the tensions inherent in the fact situation create a no-win problem. No easy solution is available, and it may be that HEW will have to give serious consideration to its regulations and possibly even seek a legislative solution better accommodating the problem. Meanwhile, under the present regulations, with full consciousness of the difficulties, I conclude in favor of the disallowance.

Although this decision has been reached with awareness of the arguments made in the related appeals in other states, no conclusion is here expressed as to the result to be reached in those appeals.

For the reasons stated above, I hereby uphold the disallowance of $8,215. This decision constitutes the final administrative action on this matter.

/s/ Malcolm S. Mason