DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: New York Department of Social Services
Docket No. 80-108-NY-HC
Decision No. 151

DATE: February 26, 1981

DECISION

On June 13, 1980, the New York Department of Social Services (State) appealed the May 15, 1980 disallowance by the Health Care Financing Administration (Agency) of $148,312,578 in federal financial participation (FFP) for expenditures for public intermediate care facilities for the mentally retarded (ICF/MRs) for the period April 1, 1974 through September 30, 1979. The issue before the Board is whether the State was precluded in 1979 from promulgating upward adjustments in the daily rates applicable from 1974 to 1979 for services in its ICF/MRs by the provision in the New York State Plan for Medical Assistance for reimbursement of ICFs on a fee schedule basis.1/ According to the Agency (Hearing Transcript, p. 12), as of April 1, 1979, for costs incurred during that quarter, the State ceased making fee schedule adjustments retroactively. The Agency has therefore withdrawn the portion of the disallowance for the period April 1, 1979 through September 30, 1979 -- $24,482,244 -- leaving $123,830,334 the amount in dispute before this Board. At a hearing before the Board on December 8, 1980, the Agency stated that whether the State had failed to reimburse its ICF/MR facilities on a reasonable cost-related basis since July 1, 1976 (and the subsidiary issue of whether publicly-operated facilities were being reimbursed differently from privately-operated

1/ In its post-hearing brief, the State argues that the issue remaining in dispute was not raised in the notification of disallowance, either expressly or by implication. The State may be technically correct that the notification of disallowance does not discuss whether the State should be bound by its original and duly promulgated fee schedules for April 1974 through September 1979 and only briefly mentions that the adjusted rates for the fee schedule were not developed according to the usual means, but the Board does not believe that this alone should result in a reversal of the disallowance. The notification of disallowance put the State on notice that the fee schedule was at issue. Nowhere has the State argued that it has not had the opportunity to present its arguments in full on the relevant issue as the proceedings have progressed before this Board. Furthermore, the issues and arguments on both sides were developed and refined during the appeals process, so that the Board will not find against HCFA on this basis.

facilities) is a compliance issue and not a proper basis for the disallowance (Transcript, p. 11). The Agency, accordingly, withdrew this as the basis for the disallowance.

Our decision is based on the State's application for review and extensive documentary supplements, a compilation of documents provided by the Agency, the Agency's response to the appeal, both parties' pre-hearing submissions, the transcript of the hearing, and both parties' post-hearing briefs.2/ We find that the Agency has submitted no convincing evidence or argument which would support, in this case, a conclusion that New York is precluded from retroactively amending its fee schedule, and we therefore hold that the disallowance should be reversed. However, we recognize that the Agency still may examine the claimed costs to determine their allowability.

Statutory and Regulatory Background

Title XIX of the Social Security Act, 42 U.S.C. §1396, et seq., provides for the establishment of cooperative federal-state programs, commonly called "Medicaid," to provide payments for "necessary medical services" rendered to certain "needy individuals whose income and resources are insufficient to meet the cost of these services." 42 U.S.C. §1396. States are not required to institute a Medicaid program, but if they choose to do so, they must submit to the Secretary a satisfactory "State plan" which fulfills all requirements of the Act. 42 U.S.C. §1396a. The Secretary must approve a plan which meets all requirements of the statute and implementing regulations. 42 U.S.C. §1396(b). The state thereupon becomes entitled to grants of federal funds in reimbursement for a portion of the expenditures which it has made in providing specific types of medical assistance (including intermediate care services) to eligible individuals under the plan and in accordance with federal conditions. 42 U.S.C. §1396b.

Development of the New York Fee Schedule and the State's Arguments

Pursuant to the New York Mental Hygiene Law, the Office of Mental Retardation and Developmental Disabilities within the Department of Mental Hygiene was responsible for the operation of public ICF/MRs, which were providers for Medicaid purposes. The New York State Plan for Medical Assistance (the State Plan), attachment 4.19-B, stipulated that the method of reimbursement for ICFs would be a "fee schedule." The fee schedule was revised annually by the State but was not part of the State Plan. FFP had been provided for ICF/MRs under the Plan since attachment 4.19-B was approved by the Agency effective April 1, 1974. The Department of Mental Hygiene, under its cooperative agreement with the single State

2/ Although both parties have titled their final submissions "Post-Trial" briefs, a hearing was held in this case, so that citations to these documents in this decision therefore will be to the "post-hearing" briefs.

agency (the Department of Social Services), billed the Department of Social Services for "actual and necessary care and services to patients" (Cooperative Agreement, pp. 85-86, Section III of the second of two volumes of documentation submitted by the State to the Region after the State's claims were deferred).

The development of the fee schedule was tied to the State's budgetary process. A preliminary budget request for State-operated ICF/MRs (which included a number of direct and indirect cost components) was reviewed through various administrative levels before becoming part of the Governor's budget request to the State legislature. Once the State legislature determined the amount it would allocate to operate State-run ICF/MRs, the State-wide per diem rate was determined based generally upon the budget allotment, divided by the projected number of patient days for ICF/MR care anticipated by all facilities. Each facility received the flat per diem rate for each day of patient care. The rate-setting process remained the same throughout the years in question. Once determined, the rate was then promulgated in duly published State regulations as part of the fee schedule (14 NYCRR, Chapter III, Section 60.1 (1974-1978), 14 NYCRR, Chapter III, Section 62.1 (1979)). The upward adjustments to the rates in question here were promulgated in an amended regulation on June 27, 1979.

For the first 2 1/2 years involved in this appeal, up to October 1, 1976, §43.01(a) of the New York Mental Hygiene Law stated that the Department of Mental Hygiene had the authority to charge fees for its services to patients and in (b) stated:

> The commissioner, by regulation, shall establish fee schedules which may include part or all of the costs of services, care, treatment, maintenance, overhead and administration.

Effective October 1, 1976, §43.01(b) read:

> The commissioner, by regulation, shall establish fee schedules annually for inpatient and noninpatient services which shall be based on the costs of services, care, treatment, maintenance, overhead, and administration....

In 1979, §43.01(b) remained as cited above, but further amendment of §43.01 added, inter alia, paragraph (c) which states in part:

> Notwithstanding the foregoing, the commissioner may establish, at least annually, schedules of rates for inpatient services that reflect the costs of services, care, treatment, maintenance, overhead, and administration which assure maximum recovery of such costs....

According to the Principal Budget Examiner in the Mental Hygiene and Substance Abuse Unit, New York State Division of the Budget, who testified at the hearing:

> It has also been long a matter of state policy that in the establishment of fees associated for state services that such fees are related to the cost of the service being provided and that they do insure a maximum recovery, a maximum allowable recovery. (Transcript, p. 24)

In 1978, the State determined that its per diem rates used in claiming FFP from April, 1974 resulted in systematic underclaiming. The State undertook an extensive study and determined that the rates per patient day should have been higher than those originally utilized. Alexander Grant & Company, a national accounting firm, was employed by the State to determine the reimbursable inpatient costs during 1974-1978 and to assist State staff in determining the costs for 1979. The process of recalculation was finished in mid-1979. In June 1979, the State submitted its Quarterly Estimate of Expenditures for the quarter ended September 30, 1979. The statement included an adjustment to prior claims for ICF/MR services.

The amount in dispute is $123,830,334. The State has asserted that it expended $600 million annually in the ICF/MR program (Transcript, p. 74). Therefore, the claim represents approximately three percent of the total amount expended in the program during the period in question.

The State asserts, and the Agency has not refuted, that the underclaiming involved two major cost areas. The first has been called "the six month lag." Billing was based on rates reflecting the budgeted costs for each State fiscal year which ran from April 1 to March 31. For the period in question, however, the rates were not implemented until October 1, the midpoint of the fiscal year, and were in effect until September 30 of the following fiscal year. Therefore, the rates in effect during the period April 1 to September 30 of any year were based on the lower budgeted costs for the prior fiscal year. For example, if there had been a seven percent salary increase for State employees which went into effect at the beginning of the fiscal year, that increase would not have been reflected in the federal reimbursement rate for another six months (Transcript, pp. 75-76). Since the rates were never adjusted to account for this six-month delay in application, the original Medicaid claims did not accurately reflect the costs incurred. In response to a question at the hearing, the Deputy Commissioner for Administration of the Department of Social Services admitted:

> I don't think there is any other way around it than to say that we simply overlooked this six month time lag a lot longer than we wish we had. I don't know that we could really say a lot more about it except it was a classic goof by the state. (Transcript, p. 160)

The other major cost area was unclaimed items which the State asserts were reimbursable. Some expenses, such as certain asset depreciation, bond interest, Facilities Development Commission management fees, aborted project costs, costs of certain education services, costs of dentistry services, and patient clothing costs, had either been underclaimed or inadvertently omitted in the development of the original rates. The process used to find and claim these costs is described in detail in the May 25, 1979 report done by Alexander Grant & Company, Section II, which was included in the first of two volumes of documentation submitted by the State to the Region after the State's claims were deferred.

In general, the State's position is as follows:

> An agency may come to the realization that it has set rates that do not reimburse the reasonable allowable costs of facility operation until some time has elapsed after the expenditures have actually been made. Neither the statute nor the regulations bar the submission of claims for such amounts. Here, the claims were developed on the basis of improved information as to items that were claimable at the outset. A systemic error due to a lag in application of the annual fee schedule described in the State Plan has been identified and corrected. The resulting inputs have been recast into revised rates based not on budgeted costs and projected eligible patient days, but on actual allowable costs and actual patient days. The result is a reimbursement request that better describes the items of expense which the State has incurred, and, to date, met from its own funds. (Application for Review, p. 29)

The State admits that because facility rates were set in advance, based upon the budget, there was the possibility that the actual expenditures would differ from the projected expenditures upon which the rates were based but argues that the retroactive claim was not directed at this built-in imprecision (Grantee's Response to Board Questions, page 24). The State asserts that the retroactive claim involved no change from prior methodology. However, the State also admits that the recalculation of the claims was based on actual costs and actual patient days because those actual figures were then available. So, technically, while the methodology might have been the same for the calculation of both the

original and the adjusted rates, the figures used to compute the adjusted rates were not those that would have been used had the original rates been calculated to account for the unclaimed items and applied as of the beginning of the State's fiscal year. Therefore, the recalculations included not only omitted costs and readjustment for the six month lag but also reflected actual instead of estimated costs.

Agency's Position

The Agency's position is that a fee schedule is non-adjustable. "There is a predetermined flat rate applicable to all providers of services that remains fixed with no adjustments for any given cost year" (Response to Appeal, p. 13). "What the State casually passes off as a ...'fine tuning' ...and 'technical improvement'...cannot be seriously anything less than a massive readjustment to fees originally fixed and codified by state regulation" (Response to Appeal, p. 14). The State proposed and the Agency approved a plan that specified that reimbursement for ICF/MR services would be made on the basis of a fee schedule. The retroactive adjustments were not computed according to the methodology which HCFA claims was agreed upon by the parties and did not represent expenditures for "medical assistance under the state plan." 3/

At the hearing and in its post-hearing brief, the Agency argued that a fee schedule is a common reimbursement methodology used in all avenues of commerce and it is a "stated price for a service known in advance by both provider and receiver of the services and constitutes payment in full for the service rendered" (Agency's Post-Hearing brief, p. 2). "To retroactively adjust a fee schedule would be to negate its primary character" (Post-Hearing brief, p. 3).

Discussion

It is clear from the federal Medicaid statutory scheme that when a state plan is approved, a state becomes entitled to FFP in reimbursement for a percentage of the costs of the state medical assistance program. The court in State of Ga. Dept. of Human Resources v. Califano, 446 F. Supp. 404 (N.D. Ga. 1977) at 405 stated:

3/ The Agency has not argued that the State's claim is improper because the State is retroactively claiming for costs incurred up to five years before (See, e.g., Transcript, p. 149). The State argues that no law or regulation barred such action and asserts that retroactive claims are commonplace in the Medicaid program and, in addition, cites examples of the retroactive amendment or application of a rate or fee schedule (See, e.g., State's Post-Hearing brief, pp. 19-25). We therefore need not rule on whether retroactivity per se bars this claim. Rather, our decision is concerned with whether a fee schedule can be adjusted retroactively.

> Pursuant to Title XIX, any state which administers a medical assistance (Medicaid) plan that has been approved by the Secretary of HEW pursuant to the provisions of 42 USC 1396a is entitled to federal financial participation in its Medicaid program. This federal financial participation is in the form of a reimbursement for a percentage of the total amounts spent by the state for medical assistance pursuant to the approved state plan.

There has been no argument in this case that FFP would not have been available had the State taken into consideration the six month lag and the previously unclaimed items, assuming their allowability, when calculating and applying its initial rates.

The relevant section of the State Mental Hygiene Law, under which the fee schedules were developed and then adjusted, required that the fee schedule reflect the costs of ICF/MR services. During the period of the claim, the mandate had changed from a pre-1976 statement that the schedule "may include part or all of" costs to a 1976 statement that the schedule "shall be based on" costs to the language added in 1979 that the schedule "reflect the costs...which assure maximum recovery of such costs."

The State has asserted, and the Agency has not contested, that the fee schedule was set originally to capture the actual costs incurred. This assertion is supported by the testimony of the Principal Budget Examiner cited on page 4 of this decision and bolstered by the terms of the agreement between the single State agency and the Department of Mental Health noted on page 3 of this decision. In addition, given the State statutory requirements, it would be illogical to assume that the State would deliberately set up a reimbursement methodology that would not capture all possible allowable costs. The description of how the State originally set the fee schedule rate shows that, given the constraint of having to determine an amount before the costs were actually incurred, the State attempted to project its actual costs based on past indicators.

The Agency has not cited any federal statute or regulation which expressly defines what a fee schedule is. In the absence of an express rule, the evidence presented by the Agency does not support the conclusion that New York's fee schedule could not be adjusted retroactively. The Agency's position is that a fee schedule has no unique or special meaning within the context of the Medicaid program but is a concept known "to anyone who has ever been to a doctor's office, a dentist's office, or a lawyer's office" (Agency's Post-Hearing brief, p. 2). HCFA has emphasized the testimony of the Director of the Division of Alternative Reimbursement for HCFA who stated that he had never heard of a fee schedule that was retroactively adjusted (Transcript, p. 96). Yet this witness admitted that he had never read Article 43 of the New York Mental Hygiene Law and that no one had ever explained to him the provisions of that statute

regarding the use of costs in generation of the fee schedule (Transcript, p. 103). Examples given by the Agency to support its argument include that of a midwife who charges a chicken to assist the birth of a baby (Transcript, p. 100) and a podiatrist who bills a Medicaid-eligible patient for a footmold and then subsequently renders another bill which is based on a higher fee since the original billing failed to cover all the podiatrist's costs (Transcript, p. 50). As the State points out, the first example is not analogous to the situation in this appeal since the fee of a chicken is a market price. The department administering the ICF/MRs in New York was not functioning in a marketplace since it was operating the ICF/MRs and, under State law, was to set cost-related rates.4/ In the second example, a situation in which an individual provider is billing for service to an individual client in a noninstitutional setting, there was no state law requiring that the outpatient fee be cost-related (Transcript, pp. 52, 54). In addition, the State has indicated that its requirement that such fees represent "full and final payment" implemented 42 CFR 447.15 which requires that "[a] State plan must provide that the medicaid agency must limit participation in the medicaid program to providers who accept as payments in full, the amounts paid by the Agency" (State's Post-Hearing brief, p. 23).

We might have found the Agency's argument persuasive if the positions of the State and the Agency were analogous to a vendor and purchaser engaged in a marketplace transaction. There, principles of consideration and notice would support the conclusion that a fee charged for a particular service completes the transaction between the parties. It is clear, however, that the State and Agency were not a vendor and purchaser engaged in a marketplace transaction. The Agency was under a statutory mandate to participate in costs incurred under the New York State Plan, and the State was in essence purchasing services from itself through its ICF/MRs and not only had to bear the costs associated with operating these facilities but also had a statutory mandate to set fees which reflected those costs.

As the State indicates, the term "fee schedule" has various meanings. It can be a minimum fee schedule (See Goldfarb v. State Bar of Virginia, 421 U.S. 773 (1975)), a maximum fee schedule (as in New York's compendium of "Fee and Rate Schedules" for services rendered in noninstitutional settings), and an advisory fee schedule (See U.S. v. American Society of Anesthesiologists, Inc., 473 F. Supp. 147 (S.D. N.Y. 1979)).

Testimony at the hearing by a partner in Alexander Grant and Company indicated that his examination of other states' plans showed that

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4/ Although the record does not clearly show that all ICF/MRs during the whole period in question were State-run, the State has asserted that "the category of ICF/MRs through much of the claim period consisted entirely of OMRDD's facilities" (Grantee's Responses to Board Questions, p. 6).

"the term [fee schedule]...modified and unmodified is used for a numerous array of services" (Transcript, p. 34). The same accountant also testified that his examination of the "basic pronouncements concerning generally accepted accounting principles" did not reveal any standard on how to construct a fee schedule and whether fee schedules may be corrected (Transcript, pp. 33-35). In its Response to Board Questions, the State gives (pp. 10-13) a number of illustrations taken from different approved state plans showing a great variety of phrases incorporating the words "fee" or "rate" and "schedule."

There is nothing in the Social Security Act, in any applicable guidance or regulation, or in the evidence in this case, indicating that the term "fee schedule" as used here must exclude the possibility of retroactive adjustments. Since the New York State Plan does not elaborate on its use of the term, it is appropriate to look to relevant State law and practices as support for the reasonableness of the State's actions. Particularly in view of the entitlement nature of the Medicaid program, an examination of all elements of this case leads to the conclusion that nothing precluded New York from claiming FFP based on its adjusted fee schedule rates for ICF/MRs, and that New York did not act unreasonably in doing so.

Conclusion

For the reasons stated above, we find, given the facts of this case, that New York is not precluded from retroactively adjusting its fee schedule for ICF/MR services. While this disallowance is therefore reversed, we recognize that this decision may not ultimately be dispositive of the issue of New York's entitlement to payment of the $123,830,334 in dispute here. This decision does not address the allowability of the costs claimed by means of the adjusted fee schedule. If the Agency subsequently issues another disallowance on the basis of unallowability, it would be subject to review by this Board if appealed. Also, this decision does not limit the Agency's authority to initiate a compliance proceeding if the Agency deems it appropriate.

/s/ Cecilia Sparks Ford

/s/ Thomas E. Malone

/s/ Norval D. (John) Settle, Panel Chair