DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Pennsylvania Department of Public Welfare
Docket Nos. 85-224 and 86-131
Decision No. 811

DATE: November 19, 1986

DECISION

The Pennsylvania Department of Public Welfare (State), in Docket No. 85-224, appealed a determination by the Health Care Financing Administration (HCFA or Agency) disallowing $17,855,471 in federal financial participation for operation of the State's Medicaid program from July 1, 1981 through March 31, 1982 and from July 1, 1982 through June 30, 1983. The State, in Docket No. 86-131, subsequently appealed a determination by HCFA disallowing $10,556,111 in funding for the period July 1, 1983 through June 30, 1984. The parties agreed to consolidate the appeals since they concerned identical issues.

The basis for the disallowances was HCFA's determination that the State had not met the requirements of section 1903(s) of the Social Security Act (Act) and implementing regulations, which provided a one percent offset to reductions in Medicaid funding to states for fiscal years 1982 through 1984. Section 1903(s) of the Act provides for progressive percentage reductions in federal Medicaid funding for each of these years, which could nevertheless be offset by an amount equal to one percent of funding (the "one percent offset") if certain criteria were met.

The State here sought the one percent offset by virtue of having performed activities that allegedly met the regulatory criteria for the detection of fraud and abuse. The Agency determined that some categories of the State's activities would be countable towards the offset and that two major categories would not be. The categories found to be non-qualifying, both of which were here appealed by the State, were: (1) amounts which the State allegedly prevented from being paid to providers ("diverted") by virtue of the State's Concurrent Hospital Review system, and (2) amounts allegedly recovered from nursing homes as a result of certain onsite audits of the homes. In addition to arguing that the above categories should qualify for the offset, the State alleged that the Agency could not in any event effectuate the percentage reductions of Medicaid funding because it had failed to comply with certain statutory prerequisites.

As explained below, we uphold the disallowance in full. Our reasons can be summarized as follows:

- We conclude that the Agency met the applicable statutory prerequisites for implementing percentage reductions of funding. As required by section 1903(s), the Agency promulgated interim final regulations implementing certain other provisions of the Act by the first day of the first quarter of the fiscal year in which reductions of funding were taken. Contrary to the State's arguments, we find that section 1903(s) did not also require the Agency to amend these regulations at a later time to accommodate subsequent legislation, nor did it require the Agency to issue in final form the interim regulations which were promulgated in full satisfaction of the statutory prerequisite.

- We conclude that amounts that the State allegedly prevented from being paid to hospitals by virtue of its Concurrent Hospital Review System do not qualify for the offset because the State's system does not deny actual claims for payment through the use of screens in a claims processing system. The State's process reviews a hospital's requested length of stay for individual patients shortly before or after the patient has been admitted or shortly before a requested extension of stay. We find that the review does not come within the plain meaning of a "screen" in a "claims processing system" since it does not review a demand for payment from the hospital for services actually rendered. Indeed, if the requested stay is denied by the State under its process, the services quite possibly may never be provided and the hospital is in any event prohibited from billing for them. In addition to relying on the commonly accepted meaning of the regulatory language, we find that contrary to what the State alleged, the preamble to the final regulations does not support the State's position that its process would qualify. We also conclude that the Agency's position furthers a major statutory purpose in limiting diversions to what can be documented as actual, rather than estimated, savings.

- Finally, we conclude that amounts allegedly recovered from nursing homes as a result of onsite audits do not qualify for the offset. The State here failed to demonstrate that the audits in question were not routine and that they were undertaken under suspicion of fraud or abuse, as the regulation expressly required.

Statutory and regulatory background

Section 1903(s) of the Act provides for reductions in federal Medicaid funding of 3 percent for FY 1982, 4 percent for FY 1983, and 4.5 percent for FY 1984. Section 1903(s)(1)(A). The section further provides, however, that these percentages shall be "reduced . . . by one percentage point if the total amount of the State's third party and fraud and abuse recoveries for the previous quarter is equal to or exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State . . . for that previous quarter." Section 1903(s)(2)(C). "Third party and fraud and abuse recoveries" are defined as:

> the total amount that State demonstrates to the Secretary that it has recovered or diverted . . . in the quarter on the basis of (I) third-party payments . . . , (II) the operation of its State medicaid fraud control unit . . . , and (III) other fraud or abuse control activities . . . .

Section 1903(s)(5)(A)(i).

"Diverted" funds from "fraud and abuse control activities" are not defined in the statute. Regulations implementing section 1903(s), however, provide:

> . . . Definitions.
>
> For purposes of this subpart--"Abuse" means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
>
> "Diverted funds" means program funds not spent because claims were denied or reduced in amount as a result of the following:
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> * * *
>
> (3) Use in claims processing systems of prepayment screens that are--
>
> * * *
>
> (ii) Specifically designed to detect fraud or abuse and applied to all claims submitted by all providers or by a general category of providers.

42 CFR 433.203 (1982). 1/

The section in the fraud and abuse offset regulations pertaining to audits provides that fraud and abuse recoveries:

* * *

(2) May include . . . funds recovered as a result of

* * *

(ii) Audit activities that are initiated as a result of suspicion or complaint of fraud or abuse (. . . but not including . . . fraud and abuse uncovered through routine audits). . . .

42 CFR 433.213(b).

I. The Statutory Prerequisites for the Reductions

The State argued that, before examining whether the State was entitled to the one percent offset, the Board should find that the Agency was precluded from initially reducing Medicaid payments to the State because it failed to meet certain

1/ Regulations implementing section 1903(s) were first published on September 30, 1981 in interim final form, which provided for a comment period. The Agency subsequently published a final rule on September 30, 1982. 47 Fed. Reg. 43340. The preamble to the final rule implied that the final rule would apply to the FY 1982 period by stating that "it is essential that these regulations be finalized in order to complete actions necessary on the FY '82 reductions." 47 Fed. Reg. at 43348 (September 30, 1982).

The parties assumed throughout the appeal that the final regulations published on September 30, 1982 would apply for the entire period in dispute, even though part of the disallowance pertained to three quarters of FY 1982. The changes between the 1981 and 1982 versions of the regulations that are relevant for our purposes had the effect of liberalizing the Agency's policy as to whether a state would be eligible for the fraud and abuse offset, by "expanding" the definition of diverted funds. 47 Fed. Reg. at 43344 (September 30, 1982). Therefore, we find the 1982 regulations to be the applicable authority for the entire period of the disallowances. Unless noted otherwise, the regulations cited in the decision refer to the final rule published on September 30, 1982.

prerequisites provided in section 1903(s) of the Act. The State argued that the Agency failed to comply with the following provision:

> (1)(B) No reduction may be made under subparagraph (A) for a quarter unless, as of the first day of the quarter, the Secretary has promulgated and has in effect final regulations (on an interim or other basis) implementing paragraphs (10)(C) and (13)(A) of section 1902(a) (as amended by the Medicare and Medicaid Amendments of 1981).

Section 1903(s)(1)(B). The State argued that HCFA should be precluded from taking the reductions under subparagraph (A) because HCFA did not properly promulgate final regulations implementing these other provisions of the Act. State's Opening Brief, pp. 12-13.

The State presented two arguments as to why HCFA did not fulfill the statutory requirement that regulations be promulgated to implement paragraphs (10)(C) and (13)(A) of section 1902(a) of the Act. 2/ First, the State maintained that, although regulations were promulgated in interim final form at the proper time to implement these two provisions, these regulations "were in conflict with" section 1902(a)(10)(C), because of subsequent legislation which made changes in this section of the Act. Second, the State maintained that the Agency violated the intent of the statutory requirement by not finalizing its interim regulations which implemented section 1902(a)(10)(C).

The State's first argument that regulations "were in conflict with" the statutory provisions was based upon subsequent amendments of the Act in 1982 which, as explained by the State, in effect rendered obsolete the regulations implementing section 1902(a)(10)(C) and therefore "statutorily overruled" the regulations. State's Opening Brief, pp. 5-6. The State further noted that the later legislation, the Tax Equity and Fiscal Responsibility Act (TEFRA), provided that it "shall be effective as if it had been originally included as a part of" the original enactment of section 1902(a)(10)(C) of the Act. Section 137(d)(2) of TEFRA, Pub. L. 97-248.

2/ These two paragraphs of the Act have no substantive connection to funding reductions under section 1903(s), but rather provide other rules pertaining to the Medicaid program, including rules relating to eligibility requirements for the payment of Medicaid benefits to certain individuals.

We reject the State's argument here that the interim regulations did not meet the requirement of section 1903(s) by implementing section 1902(a)(10)(C). The statutory prerequisite provided in section 1903(s) was precisely and narrowly defined: the Secretary must have promulgated regulations implementing the two provisions of the Act by the first day of the quarter in which reductions would be taken. The State admitted that the Secretary in fact did this. Nowhere does the Act provide that such regulations must then be subsequently amended based on later legislation. If Congress had intended such a result, it could easily have so required in section 1903(s) or in other legislation.

Indeed, section 1903(s)(1)(B) is not silent on the issue of the possible effect of later legislation, but specifically refers to the implementation of section 1902(a), "as amended by the Medicare and Medicaid Amendments of 1981." (The 1981 amendments of the Act were those that created section 1903(s).) Since the statutory language specifically limits the relevant amendments to those made in 1981, it seems to us an unreasonable interpretation that the statute also intended to consider later amendments, as well.

The State argued that, since the TEFRA amendments of 1982 related back to earlier versions of the Act, Congress had "legislatively blocked implementation of the reductions" authorized by section 1903(s). State's Opening Brief, p. 7. As noted by the Agency, this position leads to the absurd result of nullifying the major purpose of 1903(s) in allowing reductions in Medicaid funding. If Congress had indeed intended to nullify section 1903(s), it seems reasonable that it would have instead explicitly repealed section 1903(s) or altered the period for which reductions could be taken.

We also see no merit in the State's argument that the Agency's regulations were not properly promulgated since they were only issued in "interim" form and not finalized. The State cited the Conference Report on the legislation including section 1903(s) of the Act, which indicated that Congress expected any interim regulations implementing sections 1902(a)(10)(C) and 1902(a)(13)(A) to be eventually issued in final form. See H.R. Rep. No. 208, 97th Cong., 1st Sess., Vol. II., p. 960 (1981). Nevertheless, these comments do not alter the plain language of section 1903(s), which allows the promulgation of regulations "on an interim or other basis" in order to take the reductions in Medicaid funding.

We therefore conclude that the Agency complied with the prerequisite of section 1903(s) that final regulations be promulgated to implement paragraphs (10)(C) and (13)(A) of section 1902(a) of the Act.

II. Diversions from Operation of the Concurrent Hospital Review (CHR) System

A. The basis for the disallowance

The Agency's primary basis for the disallowance of funds allegedly diverted by the CHR system was that CHR was not a "claims processing system," as required by the fraud and abuse offset regulations. The regulations defined the phrase "diverted funds" to mean "program funds not spent because claims were denied or reduced in amount as a result of . . . [u]se in claims processing systems of prepayment screens that are--. . . [s]pecifically designed to detect fraud or abuse. . . ." 42 CFR 433.203 (definition of "Diverted funds"). The Agency interpreted a "claims processing system" to encompass only the processing of the hospital's "invoice," or bill for services, that is submitted to the State Medicaid agency for reimbursement. Since the State's CHR system examined the provision of services before the patient's discharge and thus before the hospital submitted an invoice for the services provided, the Agency concluded that any diversions from operation of the system were ineligible.

B. The CHR system

The State's CHR system involves a review of a patient's status by both the hospital and the State either before or shortly after admission to evaluate the medical necessity of the assigned length of hospitalization. Upon admission, the hospital assigns an initial length of stay (LOS) to the patient based upon a schedule of expected lengths of stay for the patient's medical condition and other characteristics of the patient. The hospital then completes a State form MA-87 based on this information and sends the form to the State Bureau of Utilization Review (BUR). The State BUR reviews the form, making its own determination of an appropriate LOS. If the State's determination is that the patient's admission was unnecessary or that a shorter LOS was appropriate, this would serve as a "denial" of those days of hospitalization and would be used to calculate the amount of diverted funds. Where the patient's attending physician recommends some additional period of hospitalization (an "extension" of the initial LOS) following a further review by the hospital of the patient's medical status, the State again makes its own review of the need for an extension and may again deny days, which would also be calculated as diverted funds. See State's Appeal File, p. 51a. 3/

3/ The State's offset claim was also based on diversions from
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C. Analysis

At the outset, it is important to understand precisely what the State's CHR process accomplishes. CHR is a review of a hospital's requested lengths of stay for its admissions. The hospital's requests are made either before or immediately following admission (or before the "extension" of a length of stay) and thus are routinely made before the hospital has provided the full length of stay requested. Following a denial by the CHR process of a requested LOS, the hospital presumably would be deterred from providing denied days of services because the denial effectively precludes the hospital from billing the State for the services and from receiving Medicaid reimbursement. The alleged diversion under CHR, therefore, results from denials of requested, not actual, days of service. The diversions as computed by the State are thus estimates of what the denied length of stay at the hospital would have cost if the services had been provided and the hospital had eventually sought Medicaid reimbursement for those services.

The fraud and abuse offset regulations define "diversions" as program funds not spent because of denials of claims through the use in claims processing systems of prepayment screens designed to detect fraud and abuse. 42 CFR 433.203. We find that the State's CHR system does not meet the basic requirements for a diversion under the regulations because it is not a prepayment screen occurring as part of a "claims processing system" and leading to the actual denial of a claim. The regulations clearly contemplate the existence of a "claim" from the hospital and the provision by the State of a "screen" in its "claims processing system" to determine whether that claim is abusive. Consistent with the Agency's position, we find that a "claim" is a demand for payment for services rendered, as in the case of an invoice which the hospital presents to the State Medicaid Agency. (Webster's Third New International Dictionary defines a "claim" to be "a demand for compensation.") This, in our view, is the only reasonable interpretation of the provision at issue and is consistent with the definition of "claim" in Medicaid regulations as a

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a predecessor system called a Pre-Discharge Utilization Review system (PDUR). The State alleged that CHR and PDUR systems worked similarly (State's Opening Brief, p. 13), and the parties agreed that any differences between the systems were not relevant to the Board's consideration. Accordingly, the Board's analysis of the CHR system in this decision would apply equally to alleged diversions under the PDUR system.

whole. For example, although in a different context, program regulations elsewhere specifically define a "claim" to be a "bill for services." 42 CFR 447.45(b). We thus find that the State was on notice that its CHR system would not be eligible for the offset since it was not a part of the State's "claims processing system." 5/

The State in this appeal never attempted to explain how the language referring to denial of a "claim" by means of a prepayment screen in a "claims processing system" could reasonably be interpreted to include denials of requested lengths of stay under its CHR process. Nor did the State specifically allege that it relied on any such interpretation in attempting to use the CHR system as a means of qualifying for the offset. 6/ Instead, as primary support for its

5/ In addition to the actual language of the regulations and the preambles (which we discuss at length in the text below), the State's hearing exhibits suggest that the State may have had notice of the Agency's position by being privy to correspondence between the Agency and officials from other states. See State's Hearing Exs. A and B; Agency's Hearing Exs. 1 and 2. The Agency's response in March 1983 to questions raised by states concerning the effect of the regulations demonstrates a contemporaneous position on the Agency's part that is consistent with the Agency's position in this appeal.

6/ The State did argue during the hearing in this appeal that CHR as one form of a prior authorization process was a part of the State's Medicaid Management Information System (MMIS), and hence would qualify as part of the State's claims processing system. Tr. pp. 26-29. (As we discuss in the text below, prior authorization processes require approval prior to delivery of certain services.) The Agency, however, clarified that no Agency instruction had ever included the actual prior authorization process itself as part of an MMIS. Agency's letter to Board of July 23, 1986, pp. 3-4. Rather, the MMIS included only processing that occurred before the prior approval process and processing that introduced approved authorization requests into the system. The Agency argued, and we agree, that this definition of MMIS is confirmed by relevant provisions of the State Medicaid Manual and the State's own description of CHR. See Agency's Ex. 3 to its July 23, 1986 letter and State's Appeal File 51a.
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position, the State relied on a discussion of qualifying screens in the preambles to the interim and final regulations implementing the offset. See 46 Fed. Reg. at 47999 (September 30, 1981) (preamble to interim regulations), 47 Fed. Reg. at 43344 (September 30, 1982) (preamble to final regulations). The State noted that prior authorization processes, of which CHR is an example, were listed as non-qualifying screens in the preamble to the interim regulations, but were not listed as non-qualifying in the preamble to the final regulations. (A prior authorization process is one that requires approval from the State prior to delivery of the service as a prerequisite for reimbursement. State Medicaid Manual, Agency's Ex. 10.) The State argued that since prior authorization processes were no longer specifically excluded from qualifying in the preamble to the final rule, they should be thought to qualify even in the absence of any express evidence in the preamble discussion of the final rule.

The fundamental problem with the State's argument is that the reference to "prior authorization" in the regulatory preamble was not a reference to the prior authorization process itself, but rather to a prepayment billing screen that denies claims because of the prior authorization process. Such screens review claims for compensation from providers to see if services claimed had received prior authorization. Claims lacking prior authorization would be denied. Thus, while an argument could be made that this type of prepayment billing screen might now be a qualifying screen because it had not been designated as non-qualifying by the preamble to the final regulations, there is absolutely no indication anywhere in the preamble to the final regulations that the prior authorization review itself could constitute a prepayment screen for the detection of abuse in a claims processing system. While we agree with the State that the final regulations were expanded to include manual screens to uncover overutilization or lack of medical necessity, those screens must take place as part of a claims processing system after the services have been provided and a claim for the services actually made. Contrary to the State's general assertion that the preamble intended to accept "pre-invoice" systems, the preamble is consistent throughout in indicating that screens in claims processing must review claims for reimbursement for

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Moreover, even if the actual prior authorization process itself could be viewed as part of the MMIS, that would not necessarily mean that the process could be viewed as part of the State's claims processing system since the MMIS serves functions other than purely claims processing. 42 CFR 433.111.

services actually provided. Indeed, the term "prepayment screen" connotes a screen that is performed just prior to payment in response to a demand for payment for services rendered. It does not reasonably refer to a screen performed shortly after a patient's admission to the facility in response to the facility's requested length of stay.

Finally, if the regulations had been amended to include prior authorization reviews, such a significant change would certainly have warranted some form of Agency comment in the preamble and, indeed, explicit recognition in the actual language of the regulation. The State here conceded that CHR denials would not qualify as offset amounts under the interim final regulations. We find no basis for concluding that they could qualify under the preamble or language of the final regulations.

We further find that the Agency's position should be upheld because it furthers a major statutory purpose. The Agency noted that Congress intended diversions to be limited to what can be actually documented as having been fraudulent and abusive. The House Report on the legislation which included section 1903(s) stated:

> Generally, the intent of the Committee is that recoveries must be documented; claims of reduced expenditures because fraud and abuse has been 'discouraged' would be considered too subjective to establish the right to a smaller reduction to Federal fundings.

H.R. Rep. No. 158, 97th Cong., 1st Sess., Vol. II, p. 290 (1981).

The Agency noted that, prior to this appeal, it had never specifically assessed the efficacy of the State's methodology for computing diversions under CHR, since the State's system could not in any event qualify under the regulations as a "claims processing system." 7/ Nonetheless, the Agency questioned whether CHR denials could ever accurately reflect the detection of program abuse. The Agency submitted that the use of a methodology which only estimated possible abuse would

7/ The Agency stipulated as a general proposition that under the CHR process a claim would have resulted but for a CHR denial. See Agency's letter to Board of March 30, 1986. However, this cannot be viewed as a concession by the Agency that the anticipated claim in every instance would have been equal to what was computed as the CHR diversion. For the reasons explained above, the amount of the CHR diversion in many cases would be entirely speculative.

raise serious questions whether the alleged diversions under CHR had actually been documented. Agency's letter of July 23, 1986, pp. 1-2. Moreover, the Agency specifically identified examples of situations under CHR which could result in an inaccurate measure of unnecessary days of service where the hospital requests an "extension" of the initial LOS. Id., p. 2.

The Agency also questioned whether the type of review that takes place in CHR might "involve disagreements in professional judgment which cannot be simply assumed to involve fraud or abuse" (Agency's letter of July 23, 1986, p. 7) or might include matters such as coverage of services which the preamble to the final regulations specifically excluded as a qualifying screen. 47 Fed. Reg. 43344; State's Appeal file, p. 44a.

In addition to these specific objections to CHR that were explained by the Agency, we note that the State's CHR may be an inaccurate reflection of actual program abuse in other respects. It is unclear from the record how the State's computation of diversions under CHR could take into account instances where the patients would have transferred out of the facility during their denied length of stay or where their medical condition might have improved (or where the patients might have died) during a denied length of stay. It is also possible that the hospital could have changed its requested treatment plans and lowered the anticipated lengths of stay through the hospital's own re-evaluations. It is also possible that facilities might feel inclined to request inflated or overly long extensions of lengths of stays if they know they still will have time to modify their treatment plans if the extension request is denied and no reimbursement would be lost as a consequence. The need to adequately document diversions and to avoid speculation and subjectivity regarding the amounts diverted supports the Agency's position that the diversions can result only from reductions or denials of actual claims for services rendered. 8/

In conclusion, while the State's CHR process may have been commendable in that it performed valuable utilization control functions for the program and may even have prevented the

8/ Other types of prior authorization systems such as those identified in State Hearing Exhibits A and B (prior authorization systems for admission or continued stay in a skilled nursing facility or an intermediate care facility) might be even more problematic in terms of computing amounts of actual program abuse.

actual provision of unnecessary services, such a system is simply not what the offset regulations authorize. 9/

III. Onsite Audits of Nursing Homes

The State argued that amounts recovered from certain onsite audits of nursing homes should be considered as "recovered" funds to count toward the fraud and abuse offset. The State maintained that the audits resulted in countable recoveries, since they fulfilled the purpose of the fraud and abuse regulations. There were two reasons cited by the State for this. First, the State annually audited approximately one third of all nursing homes, an amount in excess of a 15 percent level which federal regulations had once required states to audit. Second, the State alleged that its auditing of the homes was conducted under a "generalized suspicion of abuse" and that one factor used in determining whether a particular home should be audited was whether it was classified as a "problem home." State's Opening Brief, p. 18, n. 9; State's letter to Board of May 12, 1986.

The fraud and abuse offset regulations require that funds recovered as a result of audit activities must be "initiated as a result of suspicion or complaint of fraud or abuse." 42 CFR 433.213(b). The regulations further specifically

9/ Our decision ultimately rests on the type of process at issue and not specifically on the technical fact that the CHR process occurs prior to the hospital's submission of an invoice. In a companion decision, which we also issue today, we conclude that a medical necessity review that occurs after the hospital renders the services and following discharge may qualify as a prepayment screen under the regulations even though the review takes place prior to the actual submission of an invoice. See Maryland Department of Health and Mental Hygiene, Decision No. 812, November 19, 1986. We found in Maryland that the facts clearly showed that the review in question, just as the invoice, was an essential part of the processing of a hospital's demand for compensation for days of services actually rendered, and as such, fits within the commonly accepted or plain meaning of "claim" and "claims processing." In addition to finding the State's position consistent with the language of the regulations and the preambles, we noted that there was no question that Maryland's review furthered legislative purposes of particular concern to the Agency since, under Maryland's process, the State would only receive credit for documented actual savings to the program.

exclude fraud and abuse uncovered "through routine audits." Id. We conclude that the State's onsite audits of nursing homes were "routine," as the term is used in the regulation, and in any event were not "initiated as a result of suspicion or complaint of fraud or abuse." 10/

The State's policy of auditing one third of all nursing homes annually does not demonstrate to us that the audits were any more than "routine" and does not demonstrate that they were undertaken "as a result of suspicion or complaint of fraud or abuse." The federal requirement that 15 percent of providers

10/ The State made the point that audit activities need not actually be "initiated as a result of suspicion or complaint of fraud or abuse," since the regulation only listed such audit activities as an example of what fraud and abuse recoveries "may include. . . ." (Emphasis added). The State thus maintained that "[t]he regulations are silent as to whether other audit related recoveries can be counted." State's Opening Brief, p. 18. Alternatively, the State argued that, even if the regulation were to be interpreted as requiring that audits be initiated because of suspicion or complaint of fraud or abuse, the State here fulfilled such a requirement, since the large number of audits which the State undertook implied that such audits were "conducted under a generalized suspicion of abuse." Id., p. 18, n. 9.

We disagree with the State's argument that, under the regulations, audit recoveries need not be "initiated as a result of suspicion or complaint of fraud or abuse." The regulation indicated merely that fraud and abuse recoveries may include diverted funds or funds recovered under three specified circumstances, including audit recoveries. While the regulations use the term "may" in describing acceptable recoveries, we do not necessarily conclude that they intended to authorize further unlisted circumstances which might qualify as recoveries. The better reading is that the State is limited to methods specifically identified and merely has the option to choose among them. Moreover, the regulation is clear that if a state specifically chooses to count the recovery of funds from audit activities toward the one percent offset, only one type of audit activities is countable, those "initiated as a result of suspicion or complaint of fraud or abuse." Thus, even if the listing of "audit activities" as one type of recovery could somehow be read as non-exclusive, the stated requirement of what particular audit recoveries might qualify is clearly mandatory.

participating in the Medicaid program be audited, 42 CFR 447.293(a) (1980), was no longer in effect for the period in dispute, so the State clearly was not exceeding any existing requirements. Even if the regulation had remained in effect, however, the rule by its own terms was meant to be a minimal auditing requirement, not a definition of a "routine" effort. Furthermore, the fact that the State audited some larger percentage of homes than once required by regulation does not make such audits other than routine. The record indicates and the State did not dispute that its regular practice was to audit one third of the nursing homes. State's Appeal File, p. 6a (Agency's Final Report). While the percentage audited may have been greater than in some other states (a point not substantiated in the record), this particular quantity of audits was clearly the State's "routine" which was followed year by year. Id.; State's Opening Brief, p. 18.

The State argued that the practice of auditing one-third of the nursing homes fulfilled the requirement that they be undertaken as a "result of suspicion or complaint of fraud or abuse," since the audits were "conducted under a generalized suspicion of abuse." State's Opening Brief, p. 18, n. 9. The State presented no documentary or other evidence to support this statement. As argued by the Agency, to accept for purposes of the offset audits which were conducted under a "generalized suspicion of abuse" would render meaningless the regulation's requirements. Any and all audits could be described as being undertaken under a "generalized" suspicion of abuse, since one purpose of any audit would be to identify the "abuse" that might exist in any program.

The State's argument that a "problem home" factor is used in deciding which nursing homes should be audited also does not demonstrate to us that the State's audits of nursing homes met the regulatory requirements. In a memorandum prepared for this appeal, the State's Chief of Medical Assistance Nursing Home Audits stated that during the period October 1, 1981 through September 30, 1983 (corresponding to most of the time in dispute), "too many field audits were selected" by the State's usual method for determining which of the State's nursing homes should be field audited or "desk audited." Attachment to State's May 12, 1986 letter to Board. Since there were "not enough staff resources to cover all field audits selected," the writer of the memorandum explained that his agency "randomly determined" which homes that were initially intended for field audit were instead only desk

audited, based upon "criteria such as problem homes, timing, the regional location of the facility, or the reporting period last field audited." 11/

In response to specific questions by the Board as to the significance of the problem home factor, the State's counsel at the hearing estimated that five or ten percent of homes subject to field audits were selected because of the problem home factor. Tr., p. 38. Even if we accepted this undocumented estimate, it is apparent that the State could not use the problem home factor as a basis for viewing all of the homes audited as meeting the regulatory requirements. Moreover, even for those audits which the State might have documented as having actually involved problem homes, the State did not present enough information about the "problem home" criterion and how it was applied to enable us to determine whether the audit of such homes could qualify as being initiated as a result of suspicion or complaint of fraud or abuse. The State, for example, did not even explain specifically how it defined a "problem home."

Accordingly, on the basis of the foregoing, we conclude that amounts recovered from certain onsite audits of nursing homes do not qualify as "recovered funds" for purposes of the fraud and abuse offset.

11/ The State appeared to maintain that the determination here to field audit less nursing homes than initially expected did not cause the State to audit less than the usual one-third level of homes. See Tr., p. 34. While no evidence was presented by the State on this issue, we note that this conclusion is difficult to understand, since, as explained by the State, whether a facility was a "problem home" was one of several factors examined in reducing the number of homes initially selected for field audit. The memorandum presented by the State clearly indicated that the number of homes originally selected for field audit was based upon the State's usual practice (which was presumably to audit one-third of homes) and the State needed to reduce this number of field audits during the specified period because of a shortage of resources.

Conclusion

For the reasons discussed above, we uphold the Agency's disallowance in full.

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