DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: California Department of Health Services
San Franciscan Center
Docket Nos. 79-49-CA-HC
79-55-CA-HC
Decision No. 203

DATE: July 31, 1981

DECISION

By letters dated February 5 and 8, 1979, the Health Care Financing Administration (HCFA, Agency) disallowed $88,041 and $42,238, respectively, in Federal financial participation (FFP) in payments for skilled nursing facility (SNF) services provided at the San Franciscan Center (formerly Post Street Convalescent Hospital), claimed by California (State) on its quarterly expenditure reports for the quarters ended June 30, and September 30, 1978. The disallowances were based on the grounds that the facility did not have a valid provider agreement in effect after March 2, 1978 as required by Title XIX of the Social Security Act. The Board docketed the State's appeal of the February 5 disallowance as 79-49-CA-HC and of the February 8 disallowance as 79-55-CA-HC.

This decision is based on the State's appeals and the Agency's responses, this Board's March 17, 1981 Order to Show Cause and the parties' responses to that Order, a June 3, 1981 conference call, and briefs submitted by the parties in response to questions raised during that conference call.

Facts

On November 6-18, 1977 and January 4-6, 1978, the State inspected the San Franciscan Center and documented numerous deficiencies. (See Agency's May 16, 1979 response to the State's appeal, hereafter referred to as "Agency Response", Exhibit A.) Based on those surveys the State, by letter dated February 6, 1978, notified the facility's operator, Quality Care Convalescent Hospital Centers, Inc. (Quality Care), that since the facility had been found to be out of compliance with Medicare and Medicaid conditions, the facility's provider agreement was not renewed when it expired on January 31, 1978. That letter also stated that the agreement would be extended to March 2, 1978 in order to allow time for proper notice to the facility and the public, and that Medi-Cal payments (payments under the State's Medicaid program) to the facility would not be available after April 1, 1978. (See Agency Response, Exhibit B.)

On or about March 2, 1978, Public Advocates, Inc. filed suit in the United States District Court for the Northern District of California, on behalf of patients in the facility, against the Director of the California Department of Health (now the California Department of Health Services), to compel the State "to operate the San Franciscan Center at the expense of the State ... until such time as an acceptable plan has been implemented either to continue operation of the facility or to transfer the residents in an orderly and humane manner to an approved facility in San Francisco." (See Agency Response, Exhibit C, p. 16.) Subsequently, on March 29, 1978, the Court in Bracco v. Lackner, 462 F.Supp. 436, 459 (1978), issued a preliminary injunction enjoining the State:

1. From removing any residents or patients from said Center until after notice and opportunity for hearing has been given to them in compliance with 45 CFR §205.10 and its subsections and with the requirements of due process ...;

2. From failing to maintain the Center and to provide for all residents and patients there substantially the same quantity and quality of services as they were provided immediately prior to the filing of this lawsuit, including payment or effective provision for payment of the actual cost thereof.

While the preliminary injunction was still in effect and prior to any hearing, the Public Advocates and the State entered into settlement negotiations. At the request of the parties, the Court on May 12, 1978 issued an order requiring the State to pay certain amounts consisting of Medi-Cal payments plus certain legislatively authorized supplements. The May 12 order also stated that the legislatively authorized supplements would be provided for the period from May 5 through June 20, 1978, and that funding would be at the standard Medi-Cal rate for the period June 21 through June 27, 1978. The order also provided that by June 27 all patients would be transfered to other SNFs, that on June 27 the San Franciscan would be closed, and that, no later than July 1, 1978, the preliminary injunction in Bracco v. Lackner would be vacated and the court action dismissed.

On June 6, 1978, Quality Care filed a motion in the District Court for enforcement of the language in the preliminary injunction calling for payment of "actual costs" for the period from March 29 through May 5, 1978. Quality Care maintained that during that period the State paid only the Medicaid rate of $27.77 per patient per day while the actual cost based on occupancy by 145 patients was $43.53 per day. The District Court denied the facility's motion by order dated June 15, 1978.

In accordance with provisions of the May 12 settlement agreement, the State moved all patients from the facility by June 27, 1978. By order dated July 16, 1978, the Court dismissed the March 29 preliminary injunction in Bracco v. Lackner.

Subsequently, the State submitted claims for FFP in payments for services provided at the facility after March 2, 1978. Finding that efforts had been made to move patients to other facilities during the 30 days following the expiration of the provider agreement on March 2, 1978, the Agency in accordance with 42 CFR 441.11, allowed the State's claim for FFP for services provided during the period March 2, 1978 through April 1, 1978. (See Agency disallowance letter dated December 5, 1979.) Finding that no provider agreement was in effect, the Agency disallowed the State's claims for services provided during the period April 1, 1978 through June 27, 1978. (See Agency disallowance letters dated September 5 and 8, 1975.) 1/

Issue

The issues in dispute are (1) whether the Agency must provide FFP to the State on grounds that, although the facility's provider agreement had expired, a Federal district court order required the State to continue making payments to the facility; and (2) whether a subsequent court approved settlement agreement which altered certain terms of the court order operated to preclude such payments.

Discussion

This case is one in a series of cases the Board has considered involving the question of the availability of FFP pending a court ordered hearing on the termination or non-renewal of a provider agreement. In Ohio Department of Public Welfare, Decision No. 173, April 30, 1981, the Board held that pursuant to MSA-PRG-11 and 45 CFR §205.10(b)(3), FFP is available in the cost of covered services to Medicaid recipients in nursing homes with provider agreements that have been terminated or not renewed, where a facility appeals the adverse determination and a State or Federal court orders the State to continue payments because of that appeal, thereby effectively continuing the provider agreement. Subsequently, in New York Department of Social Services, Decision No. 181, May 29, 1981, the Board extended Ohio to appeals brought by

1/ The State noted in its June 23, 1981 brief that although claims were submitted as late as the quarter ending September 30, 1978, the claims were for services rendered during the period April 1 through June 27, 1978.

recipients. The Board based this extension on an analysis of Section 205.10(b)(3) alone, finding that MSA-PRG-11 applied only to provider appeals. Section 205.10(b)(3) makes FFP available for:

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

During a telephone conference on June 3, 1981, the Board requested that both parties show cause in writing why, based on the Board's analysis of Section 205.10(b)(3) in Ohio and New York, the Board should not find in favor of the State in this case.

March 29 - May 5

The Agency argued in response that Section 205.10(b)(3) does not apply to this case since the March 29, 1978, preliminary injunction cannot reasonably be construed as ordering payments of assistance "within the scope" of the Medicaid program. The Agency argued that this is so both because the preliminary injunction makes no mention of the Medicaid program and because the preliminary injunction ordered the State to pay on an "actual cost" basis rather than the "reasonable cost basis" of the Medicaid program.

The Board concludes that the absence per se of a reference to Medicaid in the court order is not dispositive of whether payments were "within the scope" of the Medicaid program. The use or lack of the word Medicaid would not alone be sufficient to either include or exclude payments from "within the scope." What is important in determining scope is not so much the language of the court order as the effect. (See generally, Ohio and New York.) The effect here was to continue the status quo at the facility.

The Board is also not persuaded by the Agency's argument that language in the injunction calling for payment of "actual costs" removes payments pursuant to the order from the scope of the program. Section 205.10(b)(3) states that FFP is available in payments "within the scope ... in accordance with a court order." Payments until May 5, 1978 were made pursuant to court order and though the order may have called for payments of actual cost, the State's payments until May 5 were "within the scope" since they were made at the Medicaid rate of $27.77. (See State's brief dated June 23, 1981, p.3, and attachment B.) Moreover, the Court never enforced the "actual cost" language and, in fact, on July 16, 1978, dismissed Quality Care's motion calling for enforcement of the "actual cost" provision of the March 29 preliminary injunction.

It is apparent that the Court's use of the term "actual cost" was not intended by the Court as the only method by which the State could fulfill the gravamen of the March 29 injunction--maintaining the Center and providing substantially the same services until a future event. Accordingly, it would not be reasonable to interpret the "actual cost" language here as removing payments made until May 5 from "the scope" of the Medicaid program, such that FFP would not be available for payments which were made at the Medicaid rate.

May 5 - June 27

The Agency argues that even if the Federal court order of March 29 is construed as ordering payments "within the scope" of the Medicaid program, the order was superceded by the court-approved settlement agreement of May 12, 1978 which required payment of a legislatively-approved lump sum from May 5 through June 20, 1978 and the Medi-cal rate for the period June 21 through June 27. The Agency argues that Section 205.10(b)(3) does not apply because the payments from May 5 through June 27 were pursuant to voluntary settlement rather than court order.

The March 29 preliminary injunction in effect required the State to continue the status quo by funding the facility until the patients were provided with notice and the opportunity for a hearing. The May 12 settlement agreement provided that:

> [a]ll prior orders of the court, including injunctive orders, shall remain in effect until plaintiffs dismiss this action, except as such orders are expressly modified by this order.

The May 12 settlement modified the March 29 preliminary injunction by changing the payment requirement from "actual cost" to the Medicaid rate plus, for a portion of the period, a special legislatively appropriated lump sum. The May 12 settlement also changed the period in which payments must continue from "payments pending a hearing" to payments until a specific date on which all patients would be removed from the facility. The preliminary injunction was unchanged, however, in its requirement that the State continue the status quo at the facility until a future date upon which the preliminary injunction would be vacated. It is in this sense that the case is parallel to Ohio and New York and it is for this reason that the Ohio and New York holdings must be applied here as well. Were this agreement clearly a voluntary agreement of the parties unassociated with continuation of Court oversight, we would agree with the Agency's argument; but here, the

preliminary injunction was continued in full force and effect except for certain modifications which the Court allowed, as evidenced by its approval of the agreement. While it is a close question, on balance we find the evidence more indicative of a continuing obligation imposed by the Court, accompanied by some agreement of the parties, than of an agreement of the parties alone.

The Agency also argues that payments pursuant to the lump sum funding scheme were "outside the scope" of the Medicaid program. The regulation allows FFP for payments "within the scope ... in accordance with a court order." As discussed above, the payments after May 5 were pursuant to the March 29 preliminary injunction, although the amount was agreed to by the parties; the payments are "within the scope" since the State claimed FFP only for that portion attributable to the Medicaid rate. It would not be reasonable to read Section 205.10(b)(3) as meaning that payment by a State in excess of the Medicaid rate precludes FFP for the portion of the payment which is in accordance with reasonable cost levels. In addition, under the Ohio and New York rationale, had the State not engaged in the May 12 settlement FFP would have been available for the entire period in question. Thus, this result gives the State no more than it might have received absent the settlement.

Conclusion

Based on the foregoing analysis, the Board concludes that the State should receive FFP for payments made to the facility at the applicable Medicaid reimbursement rate during the period April 2, 1978 through June 27, 1978.

/s/ Norval D. (John) Settle

/s/ Donald F. Garrett

/s/ Cecilia Sparks Ford, Panel Chair