DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: South Carolina Department of Social Services
Docket No. 79-78-SC-HC
Decision No. 177

DATE: May 27, 1981

DECISION

The South Carolina Department of Social Services (State) appealed from a penalty disallowance of $255,831 made by the Health Care Financing Administration (Agency) pursuant to Section 1903(g) of the Social Security Act (the Act) for the quarter ending June 30, 1978. The penalty disallowance was made after an Agency validation survey, as required by Section 1903(g)(2) of the Act, in which the Agency determined that the State violated Section 1903(g)(1)(D), requiring annual medical reviews in certain facilities. We conclude that the disallowance should be reversed because the State has met the technical failings exception of Section 1903(g)(4)(B).

The record in this appeal consists of the State's application for review, the Agency's response to the appeal, a supplemental memorandum filed by the Agency informing the Board of a Comptroller General's Opinion concerning this Section of the Act, 1/ and the parties' responses to the Board's Order to Show Cause, dated March 6, 1981. We have determined that there are no material facts in dispute which a hearing would help resolve, and that a conference or hearing would not assist the development of the issues.

Pertinent Statutes and Regulations

Section 1903(g) of the Act requires that the State agency responsible for the administration of the State's Medicaid plan under Title XIX of the Act show to the satisfaction of the Secretary that there is an "effective program of control over utilization of" long-term inpatient services in certain facilities, including "hospitals for mental diseases." This showing must be made for each quarter that the federal medical assistance percentage (FMAP) is requested with respect to amounts paid for such services for patients who have received care for 90 days in "hospitals for mental diseases," or the FMAP will be decreased according to the formula set out in Section 1903(g)(5). The satisfactory showing must include evidence that the State has an effective program of medical review (MR) of the care of patients in mental hospitals (Section 1903(g)(1)(D)). Independent professional

1/ The Comptroller General's Opinion referred to the question of whether the Secretary had the discretion to waive the penalty for violations regarding only a few patients. This question is not an issue in this decision.

review teams must review and evaluate the professional management of each case "at least annually," including the care provided to the patient, the adequacy of available services, the necessity and desirability of the patient's continued placement in the hospital, and the feasibility of meeting the patient's health care needs through alternative services. The teams' findings and recommendations are to be put in full reports (Sections 1903(g)(1)(D) and 1902(a)(26)).

The implementing regulations in effect during the quarter in question were 42 CFR 450.18(a)(4) and 450.20(b), which required that the medical reviews of the care of patients in mental hospitals meet the requirements of §450.23. 42 CFR 450.23(a)(3)(iii) stated that a State plan must provide for methods and procedures assuring that a medical review is made in each "institution for mental diseases ... not less often than annually." 2/ Section 450.23(a)(3)(v) required that the review include personal contact with and observation of each patient under 21 receiving assistance under the plan in such an institution and that review for patients 65 years or older include review of their medical records, or personal contact if the records are unavailable or inadequate. 42 CFR 450.23(a)(4)(i) provided that the medical review report must include observations, conclusions, and recommendations on the adequacy and quality of all patient services in the institution and specific findings for individual patients.

Section 1903(g)(4)(B), discussed later in this decision, provides an exception to the requirement of Section 1903(g)(1)(D).

Statement of the Facts

The hospital invòlved here, one of two mental hospitals in the State, entered the Medicaid program on July 1, 1968 (State Response to Order to Show Cause, April 22, 1981). Annual medical reviews of the hospital were conducted in July 1976 and June 1977 (Letter from Virgil L. Conrad, State Commissioner to Agency Regional Medicaid Director, August 30, 1978). Medical reviews conducted at the hospital in April, May, and June, 1978 did not include one of the hospital's fifteen buildings. On August 29, 1978, soon after the State discovered this omission, it conducted a review of that building (State Response to Order to Show Cause, April 22, 1981). Federal reviewers conducted a validation survey at the State Agency during August 1978 to determine whether timely medical reviews had been performed for all patients for

2/ Section 1903(g) refers to "hospital[s] for mental diseases" and "mental hospitals." These terms are used by the Agency as references to levels of care (SRS-AT-76-88, June 3, 1976, page 1). While we do not decide here whether the term "institution for mental diseases," as used by the Agency, can include more than mental hospitals, it seems clear that the term does include mental hospital level of care and, therefore, 42 CFR 450.23 applies to the facility involved here.

the facilities in which reviews were required for the quarter ending June 30, 1978. They determined that a timely medical review was not performed in one building (Notice of Disallowance, March 30, 1979, page 1).

Discussion

The issues in this appeal are whether the required medical review of each patient was conducted in a timely manner and, if not, whether the State may be excused under the exception provided in Section 1903(g)(4)(B).

A. Timeliness of the Review

The State (Response to the Order to Show Cause April 22, 1981, pages 2-3) alleged that, under Action Transmittal HCFA-AT-77-106, a medical review is timely if conducted by the end of the anniversary quarter of a facility's entry into the Medicaid program. The State argued that because the hospital entered the Medicaid program on July 1, 1968, the 1978 review was not due until the end of the anniversary quarter for the facility's entry into the program ten years earlier, i.e., by September 30, 1978. The Agency argued that the review was due by the end of the anniversary quarter of the last prior review of the facility, i.e., by June 30, 1978.

The statutory and regulatory provisions require that reviews such as these be made "annually." In order to understand the statement made in HCFA-AT-77-106, it is necessary to consider it in the context of the development of the Agency's written policy. The Agency first set out its interpretation of the "annual" requirement in May, 1976.

> [A] complete inspection by an MR team must be made in each SNF and MH within the first 12 months of a facility's certification as a Title XIX provider and that each subsequent inspection by the team must be completed within 12 months of the last prior inspection. (Action Transmittal SRS-AT-76-79, May 14, 1976, addressed to State Administrators and other interested agencies and organizations, pages 2-3.)

The Agency amplified its definition of "annual" in June, 1976.

> [I]t logically follows from our definition that an inspection in a facility (by either an MR or an IPR team) which is completed more than 12 months after the last prior inspection in that facility is not in accordance with Federal timeliness standards. (Action Transmittal SRS-AT-76-88, June 3, 1976, addressed to State agencies administering medical assistance programs)

SRS-AT-76-88 provided the following example:

> Example 1: A facility becomes a certified Title XIX provider of SNF services on July 1, 1976. The first inspection by an MR team must be completed on or before June 30, 1977. If the first inspection is completed on April 1, 1977, the next inspection must be completed on or before March 31, 1978.

Note that the due date of the second review is keyed according to the date of the previous review rather than the date of the facility's entry into the Medicaid system.

The Agency added a "clarification" of the two previous Action Transmittals December, 1976 (Action Transmittal SRS-AT-76-176, December 8, 1976, addressed to State agencies administering medical assistance programs). This Transmittal stated that the determinant of the due date should be the calendar month, rather than the particular day the review occurred. Thus, in the example provided above (using the clarification set forth in SRS-AT-76-176), the first inspection would be due by July 31, 1977. If the first inspection were completed on April 1, 1977, the next inspection would need to be completed on or before April 30, 1978.

Finally, Action Transmittal HCFA-AT-77-106, November 11, 1977, addressed to State agencies administering medical assistance programs, summarized the provisions of P. L. 95-142, enacted October 25, 1977. It stated, at page 3, that the enactment of P. L. 95-142 effected a change in Agency policy. The requirement of a review no later than the end of the anniversary month was relaxed so that, "[u]nder 1903(g) as modified by P.L. 95-142, effective with quarters beginning on or after January 1, 1977, a MR or IPR will be timely if it is conducted by the end of the anniversary quarter of the facility's entry into the program or of the last prior review." 3/ It is this statement that the State relies upon for its position.

The Agency's interpretation of the annual review requirement, as expressed in its regulation implementing P.L. 95-142, was also consistent with its policy as expressed in Action Transmittals 76-79 and 76-88. The regulation says:

> An on-site review is required in a facility by the end of a quarter if the facility entered the Medicaid program during the same calendar quarter 1 year earlier or has not been reviewed since the same calendar quarter 1 year earlier. (emphasis supplied) (42 CFR 456.652(b)(2))

3/ The Agency based this change on the language in Section 1903(g)(4)(B), added by P.L. 95-142, which says, "... if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter ...."

The Action Transmittals 76-79 and 76-88 clearly established that once a facility has been in the program for over a year and at least one review has been conducted, the anniversary for the next review is calculated based on the prior review rather than the date of entry into the program. Action Transmittal 76-176 merely clarified that the reviews were due within the anniversary month rather than on the anniversary day. Action Transmittal 77-106 modified this policy only with regard to the fact that reviews were due in the anniversary quarter rather than the anniversary month (43 FR 50924, November 1, 1978). Although the statement in 77-106 quoted above is susceptible of more than one interpretation when read alone, the Board concludes that it was not intended to be a statement of a new policy. A construction of the policy statement in HCFA-AT-77-106 that would allow a State to use either the facility's entry into the Medicaid program or the date of the last prior review as the anniversary date for the next review would be inconsistent, in the context of the Agency's expressed interpretation of "annual" prior to HCFA-AT-77-106 and the subsequently promulgated regulation. Furthermore, the Agency's interpretation implements the underlying statutory policy that medical reviews be conducted regularly in all facilities during a 12 month period (H. Rep. 95-673, at 102, October 11, 1977). To construe the word "annual" as once each calendar year, or to permit a choice of either the date of a facility's entry into the program or the date of the last prior review as the basis for calculating the next review date, would allow a State to establish an irregular review pattern and would be a contravention of the basic statutory policy. Thus, we conclude that a review would have had to be completed by June 30, 1978 in order to be timely.

B. Adequacy of the Reviews

Although the State's application for review focused on the Agency's statement in the notice of disallowance that adequate medical reviews had not been done in one building of a fifteen-building facility, there appears to be general agreement by the parties that the issue is not whether a particular physical component of an institution has been reviewed (Agency Response to Order to Show Cause, page 7; State Response to Order to Show Cause, pages 1 and 2). The adequacy of a medical review is determined by whether the regulatory requirements set forth at 42 CFR 450.23 have been met. These include observation of and reporting on the adequacy and quality of all services in the facility (450.23(a)(3)(v)(A) through (F)), as well as specific findings about all individual patients (Section 1903(g)(1)(D) and 42 CFR 450.23(a)(4)(i)) 4/, although personal contact with patients 65 years or older is not necessary unless their medical records do not contain adequate reports of periodic assessment of the patients (450.23(a)(3)(v)). Thus, the issue is whether the review met these requirements.

4/ Section 1903(g)(1)(D) refers to review and evaluation of the "care" and "professional management of each case."

The record shows that there were 43 Medicaid patients residing in the building which was not timely reviewed (Application for Review, April 25, 1979, page 2; State's Response to Order to Show Cause, April 22, 1981, Appendix A). All of these patients were 65 years or over. The Board's Order to Show Cause, March 6, 1981, asked whether these patients were reviewed, whether their records had been reviewed, and whether it was possible for the review team to report on the adequacy and quality of facility services to patients if the building was not reviewed. The State responded that the building was "basically a housing unit with treatment and even meals being provided in other buildings," and that, therefore, it would be possible for the review team to report on the adequacy and quality of facility services without physically inspecting the building (State Response to Order to Show Cause, Appendix A). The record does not reflect, however, any timely reports or specific findings with regard to the 43 patients; in fact, the record shows that the State admits that it did not complete medical reviews for the patients in the building until August 29, 1978 (Letter to Regional Medicaid Director from State Commissioner of Social Services, August 30, 1978; State's Response to Order to Show Cause, April 22, 1981, pages 3 and 4). Thus, we conclude that the State did not conduct adequate and timely medical reviews as required by Section 1903(g)(1)(D) and 42 CFR 450.23 for the 43 patients residing in one building of the mental hospital.

C. Exception to the Section 1903(g)(1)(D) Requirement, as provided by Section 1903(g)(4)(B)

Section 1903(g)(4)(B) says:

> The Secretary shall find a showing of a State with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraph (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter --
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> > (i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and
> > (ii) in every such hospital or facility which has 200 or more beds,
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> and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the

> satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only. 5/

There are only two mental hospitals in the State; if one hospital is out of compliance because there was no medical review for some of its patients, the State cannot meet the 98% requirement for that level of care. 6/ Furthermore, since there were 792 Medicaid patients in the facility (State's Response, to Order to Show Cause, April 22, 1981, Appendix A), the hospital would be considered a facility with 200 or more certified Medicaid beds and must be reviewed. Therefore, the State would not meet either of the numerical requirements necessary to qualify for the good faith and due diligence exception.

On the other hand, the State's action does fall within the "technical failings" exception. Previous decisions of this Board have interpreted the provision so that a State need not meet the 98%, 200-bed requirement in order to be excused by a technical failing (Ohio Department of Public Welfare, Decision No. 66, October 10, 1979, and Utah Department of Health, Decision No. 168, April 30, 1981). The Agency's statement of the exception, as expressed in the preamble to its final regulation, 7/

5/ The Agency published its final regulation implementing this provision at 44 FR 56338, October 1, 1979. The regulation became effective December 31, 1979 and is codified at 42 CFR 456.653.

6/ The Agency's policy generally is to survey one level of care and take a penalty based only on that level of care. The numerical standard in Section 1903(g)(4)(B) is also calculated on the basis of only the level of care being surveyed (SRS-AT-76-88, June 3, 1976, page 1).

7/ 42 CFR 456.653 says:

> The Administrator will find an agency's showing satisfactory, even if it failed to meet the annual review requirements of §456.652(a)(4), if --
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> (a) The agency demonstrates that --
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> (1) It completed reviews by the end of the quarter in at least 98 percent of all facilities requiring review by the end of the quarter;
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> (2) It completed reviews by the end of the quarter in all facilities with 200 or more certified Medicaid beds requiring review by the end of the quarter;
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> and
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> (3) With respect to all unreviewed facilities, the agency exercised good faith and due diligence by attempting to review those facilities and would have succeeded but for events beyond its control which it could not have reasonably anticipated; or

published at 44 FR 56336, October 1, 1979, also interpreted the provision in this way, although the regulation and its explanation in the preamble confined the statutory provision further by requiring that, in order for a failure to meet the 98%, 200-bed standard within the quarter to be excused, the 98%, 200-bed requirement must still be met within 30 days after the close of the quarter.

The regulation was not effective during the quarter in question here. 8/ We conclude that it would be possible for the State to make a satisfactory showing if it were excused by a technical failing, even though the reviews were made later than 30 days after the end of the quarter.

Neither party has pointed to a precise definition of technical failings. Action Transmittal HCFA-AT-77-106 cited the only pertinent legislative history, which stated that technical noncompliance would include instances where a State reviewed patients in most facilities on time with the remaining facilities reviewed "several weeks after the deadline for completion of all reviews" (S. Rep. 95-453, September 26, 1977, page 41). The Action Transmittal also said:

> This provision thus gives the Secretary some limited discretion to find satisfactory a showing that indicates that all facilities have been reviewed since the beginning of the annual period ending on the last date of the showing quarter, although some facilities were not reviewed until after the end of the showing quarter. (page 9)

In this case the State performed reviews in the facility within the anniversary quarter. As soon as the State discovered that the patients in one building had not been reviewed, it reviewed them. This could be viewed as a mere technical failing. Furthermore, the record shows that the review process was hampered by the fact that the institution transferred patients from building to building and closed and reopened wards because of heat, thus confusing the reviewers (Letter to Regional Medicaid Director from State Commissioner of Social Services, August 30, 1978, Exhibit 2 of State's Application for Review; Letter from the State reviewer to the Department of Social Services, December 14, 1978,

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7/ Cont' (b) The agency demonstrates that it failed to meet the standard in paragraph (a)(1) and (2) of this section by the close of the quarter for technical reasons, but met the standard within 30 days after the close of the quarter. Technical reasons are circumstances within the agency's control.

8/ The Agency admits that the regulation is not binding for purposes of this case (Agency's Response to Order to Show Cause, April 24, 1981, page 11).

Exhibit 7 of State's Application for Review). The Agency has not refuted this evidence. We conclude that a failure to review one building under such circumstances can be considered "technical."

The Agency invokes its regulation, 42 CFR 456.653(b), which provides that where a state does not meet the 98%, 200-bed standard within the quarter due to technical failings, its showing will be considered satisfactory if it meets the standard "within 30 days after the close of the quarter." This regulation did not become effective until December 31, 1979, however, and did not apply during the quarter for which the reduction was made. The applicable Agency policy during the quarter involved here was stated in HCFA-AT-77-106, which simply said, "For example, the Secretary could find satisfactory a showing for the quarter ending December 31, 1977 which showed that all facilities had been reviewed since January 1, 1977, although some reviews had not been completed until January 1978." This statement is, by its own words, merely exemplary. It can hardly be taken as a statement of the maximum amount of time allowable to complete a missed or unsuccessful review under the exception. The NPRM containing §456.653 (43 FR 50925, November 1, 1978) phrased the proposed policy in terms of future application. Thus, there is no evidence that the 30-day limit was other than a proposal of future policy until finally promulgated. There is no basis for concluding that such a restriction would be effective prior to final promulgation of the rule, particularly because the statutory language does not mention a time limit by which the 98% standard must be met. The preambles to both the NPRM and the Notice of a Final Regulation (44 FR 56335, October 1, 1979) quote the legislative history's phrase "several weeks." The word "several" is, of course, indefinite. Webster's Third New International Dictionary defines it as "being more than two but fewer than many." This does not mean, of course, that the State could meet the "technical failings" exception by completing a review any time it wished. Clearly it was bound to a reasonable standard. In the absence of an effective regulation or other definitive statement by the Agency of <u>currently applicable</u> policy, this Board will look to Congressional intent and reason to determine the standard. The State conducted a review within the quarter but was technically unsuccessful in its attempt to complete the requirements. Completion of a satisfactory review of the hospital as soon as the discrepancy was discovered, within several weeks of the end of the anniversary quarter, should be deemed a compliance with the statute, in the absence of a promulgated regulation or other requirement binding on the State during the period in question. Thus, we conclude that the State has met the requirements of the technical failings exception, as provided in Section 1903(g)(4)(B).

D. Calculation of the Penalty Section 1903(g)(5)

Although the State raised several issues pertaining to the Agency's calculation of the penalty, we do not address these since we have concluded that the disallowance should be reversed and, therefore, no penalty should be imposed.

Conclusion

The State was required to complete an adequate and timely medical review of all patients in the facility on or before June 30, 1978. We conclude that the State did not conduct an adequate and timely review in one of two mental hospitals in the State since it did not complete the reviews by June 30, 1978. We also conclude that, although the State did not meet the 98%, 200-bed requirement necessary to qualify for the statute's good faith and due diligence exception, the State did meet the technical failings exception by completing the required reviews in August 1978. Therefore, we conclude that the disallowance should be reversed.

/s/ Donald F. Garrett

/s/ Alexander G. Teitz

/s/ Cecilia Sparks Ford, Panel Chair