DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: New Jersey Department of Human Services
Docket Nos. 78-106-NJ-HC (partial)
80-3-NJ-HC (ME-NJ 7602)
80-12-NJ-HC (ME-NJ 7601, ME-NJ 7801)
Decision No. 154

DATE: March 18, 1981

DECISION

These are cases that are being considered jointly because they involve some common issues in the Medicaid program. This decision disposes of all issues in 80-3-NJ-HC and 80-12-NJ-HC and the remainder of the issues in 78-106-NJ-HC (See also, Decisions Nos. 107, 137, and 148 which disposed of the other issues in 78-106-NJ-HC).

PROCEDURAL HISTORY

78-106-NJ-HC

The New Jersey Department of Human Services (State), by letter dated August 28, 1978, filed a request for reconsideration of the July 27, 1978 disallowances of Federal financial participation (FFP) by the Acting Assistant Director for Financial Management of the Health Care Financing Administration (HCFA, Agency). The State was advised in a letter dated October 27, 1978 that its appeal would be reviewed pursuant to 45 CFR Part 16 as amended. After being granted several extensions of time, the Agency filed a response to the appeal on May 24, 1979.

The costs disallowed are for Medical Assistance payments, and Medical Assistance State and Local Administration and Training, incurred during the quarter ended March 31, 1977. Under the category "Medical Assistance payments", the following costs were disallowed: (1) payments for skilled nursing and intermediate care facility services ($109,975); (2) payment for "special hospital expenditures" at Mount Carmel Guild ($874); (3) payments for medical care and services for residents in psychiatric hospitals and schools for the retarded ($81,244); and (4) payments for drugs - Vineland School ($33,895). Under the category" Medical Assistance State and Local Administration and Training", the following costs were disallowed: (1) payments for salaries and fringe benefits ($37,314); (2) salaries and fringe benefits claimed at 75% federal matching ($10,008); and (3) payments for inspection of nursing homes ($69,494).

The State advised the Board in its request for reconsideration that it was not contesting the disallowances for payments to Mount Carmel Guild ($874) and payments for inspection of nursing homes ($69,494). The total disallowances appealed therefore are $225,114 in Medical Assistance

payments and $47,322 in Medical Assistance State and Local Administration, a total of $272,436.

The skilled nursing and intermediate care facility services were provided in the following facilities:

	Facility	Amount
	Irvington Nursing Home	$31,381
	Bayview Nursing Home	26
1/	Springview Nursing Home	3,353
2/	Alps Manor Nursing Home	1,235
3/	Woodbine State School	68,076
4/	Emerson Convalescent Center	759
3/	McFarland Nursing Home	5,145

80-3-NJ-HC

On December 31, 1979, the Administrator of HCFA upheld a disallowance of $580,394 made by the Regional Commissioner of SRS (predecessor of HCFA), Region II. The disallowance was for FFP for payments for services rendered from October 1975 through December 1976 by the following facilities:

	Facility	Amount
	Irvington Nursing Home	$532,926
	Bayview Nursing Home	446,661
3/	Frank Langdon King Memorial Nursing Home	807

The State submitted an application for review on January 31, 1980 and requested that the appeal proceed under 45 CFR Part 16. After being granted an extension of time, the Agency filed its response to the appeal on April 7, 1980.

80-12-NJ-HC

On January 10, 1980, the Administrator of HCFA upheld a disallowance of $3,857,618 made by the Regional Commissioner of SRS, Region II. The disallowance was for FFP in payments for outpatient services expenditures for inmates of public institutions and the mentally retarded in public mental hospitals ($3,285,497), for the Vineland State School for the mentally retarded drug program ($306,770), and for salaries of State Medicaid staff in public institutions ($265,351).

1/ This disallowance was upheld in Decision No. 137, December 1, 1980.

2/ This disallowance was upheld in Decision No. 148, February 2, 1981.

3/ State withdrew appeal. See its Response to Board's December 15, 1980 Order.

4/ This disallowance was upheld in Decision No. 104, June 9, 1980.

The Board received the State's application for review on February 22, 1980; the application requested that the appeal proceed under 45 CFR Part 16. After being granted an extension of time, the Agency filed its response to the appeal on June 18, 1980.

On December 15, 1980, the Board issued an Order to Show Cause and an Order to Develop the Record which analyzed the issues in all three cases. The Agency responded on January 12, 1981 and February 11, 1981. The State also responded on February 11, 1981.

SKILLED NURSING AND INTERMEDIATE CARE FACILITIES (78-106-NJ-HC, 80-3-NJ-HC)

Irvington and Bayview

The chronologies of events leading to the disallowances were described in detail in the appendix to the Board's December 15, 1980 Order to Show Cause and are incorporated by reference herein. In brief, the issue common to both facilities is whether a day-to-day provider agreement is valid if it has not been preceded by certification.

Regulations and Discussion

The Medicaid regulations have been recodified several times in recent years, but have not changed substantively since March 1975, the beginning of the periods in question. For convenience, citations will be to 45 CFR Part 249 (1975), "Services and Payment in Medicaid Assistance Programs." FFP in payments to a facility providing skilled nursing and intermediate care services is available only if the facility is certified as having met all the requirements for participation in the Medicaid program as evidenced by an agreement (provider agreement) between the single state agency and the facility. (§249.10(b)(4)(i)(C) for skilled nursing services, §249.10(b)(15)(i)(E) for intermediate care services.) The execution of the provider agreement is contingent upon certification of the facility by an agency designated as responsible for licensing health institutions in the state (state survey agency). §249.33(a)(6). The survey agency is required to certify that the facility is in compliance with each condition of participation. §249.33(a)(4)(i). In order for the State to obtain FFP the execution of the provider agreement must be in accordance with the federal regulations. §249.33(a)(6). Ordinarily, a provider agreement between the state agency and a facility is a sufficient basis to claim FFP. The provider agreement may be determined invalid if the Secretary establishes that any of the five provisions listed in §249.10(b)(4)(i)(C)(1)-(5) for a skilled nursing facility or in §249.10(b)(15)(vi)(A)-(E) for an intermediate care facility were violated in the certification of the facility. A facility which does not qualify under §249.33 is not recognized as a skilled nursing facility or an intermediate care facility for purposes of payment under the Medicaid program. §249.33(a)(10).

The State has argued that an understanding, expressed in an April 1, 1975 letter from the Director of the Regional Office of Long Term Care (OLTC), existed between the Agency and the single State agency that permitted the issuance of a day-to-day provider agreement under extenuating circumstances. That letter, apparently a review of discussions on several matters between the Agency and the State, details how in circumstances where a two-month extension of a provider agreement (permitted under §249.33 (a)(6)) has been insufficient to complete the certification process, a day-to-day provider agreement may be issued if the reason for the delay is well-documented and appropriate action is in progress; once a new provider agreement is issued, it would be retroactive to the expiration date of the two month administrative extension. The State has claimed that on the basis of this letter, the State issued a day-to-day provider agreement to Irvington as the November 21, 1975 letter from Irvington indicated that the deficiencies had been corrected or were in the process of being corrected and to Bayview by letter dated December 16, 1975 "for record purposes." The Agency is now estopped, the State has argued, from issuing disallowances.

As was discussed in Decision No. 148, in which the Alps Manor factual situation is similar, we do not believe it is necessary to examine the theory of whether estoppel can be asserted against the federal government to dispose of this argument by the State. The April 1, 1975 letter states that a day-to-day provider agreement may be executed only after the two month administrative extension proves insufficient to allow certification action. There is nothing in the records to indicate that two month extensions were ever recommended by the State survey agency or granted by the single State agency. Indeed the Certification and Transmittal Form (C & T) signed November 25, 1975 by the survey agency for Bayview states that "lack of correction of the deficiencies...could affect the health and safety of patients in this facility", and the C & T signed November 3, 1975 by the survey agency for Irvington states that "conditions are not met and the plan of correction is not acceptable for these areas." As the procedure set forth in the OLTC Director's letter for the issuance of a day-to-day provider agreement was never followed by the State, the State cannot now assert reliance upon that letter as a defense against the disallowances.

Furthermore, the State's reliance on Irvington's own November 21, 1975 assertion that the deficiencies were corrected is an action without basis in the regulations. Mere assertions by a facility that it has corrected deficiencies cannot be accepted as evidence that certification standards have been met without actual substantiation by the State survey agency. The Medicaid regulations require that a certification be based on on-site surveys, not unsupported assertions by a facility. In the case of Irvington, the on-site survey did not occur until January 6, 1976, and deficiencies were found.

The facts set out above indicate that Irvington and Bayview were not recertified. Their previous provider agreements expired, and since there were no recertifications, there were no valid provider agreements for the purposes of providing FFP after those expirations.

The State has argued that the amount of the disallowances is significantly out of proportion to the deficiencies that may have existed at both facilities. This argument was discussed and rejected in Decision No. 148, pages 5-6.

MEDICAL CARE AND SERVICES FOR RESIDENTS IN PSYCHIATRIC HOSPITALS AND SCHOOLS FOR THE RETARDED; DRUG PROGRAM-VINELAND STATE SCHOOL (78-106-NJ-HC, 80-12-NJ-HC)

The issue is whether FFP is available in Medicaid claims for outpatient services for inmates of public institutions for the mentally retarded and public mental hospitals.

Section 1905(a) of the Social Security Act defines "medical assistance" for purposes of Medicaid. At the end of the definition, the section provides that "such term" does not include:

> (17)(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or
>
> (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. 5/

By amendment effective January 1, 1973, inpatient psychiatric hospital services for individuals "under the age of 21" could also be covered. The age limit is further interpreted to include services to some individuals until the age of 22. Section 1903(h)(1).

Regulations implementing this provision provide in 45 CFR 248.60(a)(1975) as follows:

> (a) Federal financial participation.
> (1) Federal financial participation under Title XIX of the Social Security Act is not available in medical assistance for any individual who is an inmate of a public institution except as a patient in a medical institution or as a resident of an intermediate care facility.

5/ The Supreme Court has recently noted that "[t]he Medicaid limitation was based on Congress' assumption that the care of persons in public mental institutions was properly a responsibility of the States...." Schweiker v. Wilson, 49 U.S.L.W. 4207, 4211 n. 19 (U.S. March 4, 1981).

> (2) Federal financial participation under Title XIX of the Social Security Act is not available in medical assistance for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases, except for an individual under age 22 who is receiving inpatient psychiatric hospital services pursuant to Section 249.10(b)(16) of this Chapter.

45 CFR 249.10(c)(1)(1975) provides:

> (c) Limitations.
> (1) Federal financial participation in expenditures for medical and remedial care and services listed in paragraph (b) of this section is not available with respect to any individual who is an inmate of a public institution (except as a patient in a medical institution or as a resident in an intermediate care facility), or any individual who is a patient in an institution for tuberculosis or mental diseases.

Thus, it is clear that inmates of public institutions, under-65 patients in tuberculosis facilities, and patients between ages 22 and 65 in psychiatric facilities are generally excluded from receipt of medical assistance benefits under Title XIX. The only exception to this exclusion is that such an inmate may receive Title XIX benefits if he is a "patient in a medical institution."

"Patient" is defined in the regulations as an individual in need of and receiving professional services directed by a licensed practitioner toward maintenance or improvement or protection of health or alleviation of illness or pain. §248.60(b)(8). "In an institution" is defined in the regulations as referring to an individual who is admitted to participate in the living arrangements and to receive treatment or services provided there as appropriate to the individual's needs. §248.60(b)(2).

"Inmate of a public institution" is defined at §248.60(b)(4) as a person who is living in a public institution. However, an individual is not an inmate if in a public, educational or vocational training institution for purposes of securing education or vocational training or when in a public institution for a temporary emergency period pending other arrangements appropriate to his needs. "Medical institution" is defined at §248.60(b)(5) to include an institution which "is organized to provide medical care...." The regulations, however, fail to offer a definition for the phrase "patient in a medical institution." The Agency asserts that in order to ascertain the meaning of this phrase, the definitions in §248.60 of "patient," "in an institution" and "medical institution" must be synthesized. The resultant definition is "an individual in need of and receiving professional medical services from a licensed practitioner while admitted to participate in

the living arrangements and to receive treatment or services provided in an institution organized to provide medical care." (Emphasis added.)

The State's arguments can be summarized under three topics:

(1) The Agency is required to provide advice and guidance to a state. It failed to do so here either by remaining silent when it should have spoken or by misleading the State to its detriment, resulting in expenditures which were disallowed.

(2) The Agency has not met its burden of proof of establishing the factual basis for its determination that FFP has been claimed for ineligible inmates.

(3) The State disagrees with the Agency's reading of the Social Security Act and the regulations that an inmate is eligible for medical assistance as a patient only when "physically housed" in or admitted to a qualifying medical institution.

These arguments will be discussed in the order mentioned above.

(1) On February 22, 1971, the Commissioner of the New Jersey Department of Institutions and Agencies requested clarification of the Medicaid eligibility status for certain children and for needy disabled persons between the ages of 18 and 65 who had been placed in or who resided in State institutions (Record for Reconsideration, Item 1). In a reply dated May 6, 1971, the Regional Commissioner, SRS, cited Section 1905(a) of the Social Security Act and stated that inmates in public institutions could qualify for all medical care services set forth in the New Jersey title XIX plan provided they lacked "inmate" status or were patients in a medical institution. The Regional Commissioner stated that one could qualify as a patient for any period of time in which he was physically housed in a distinct institution (or part thereof) classified and accredited as a medical facility (Record for Reconsideration, Item 3).

In February 1971, the State submitted to the Regional Commissioner copies of the service agreement between the State's Division of Mental Health and Hospitals and the State's Division of Medical Assistance and Health Service. On August 25, 1971, Region II replied, taking only minor objection to the agreement and no objection to subparagraph E.1.(c), which indicated that the division of medical assistance and health services would reimburse the institutions for outpatients. (Record for Reconsideration, Item 4).

In 1974, after learning that the State's Title XIX program was reimbursing for outpatient and other services, the Regional Office advised the State that the "physically housed" requirement referred to by Mr. Smith in his 1971 letter was synonymous with inpatient status (Record for Reconsideration, Item 5). The Regional Commissioner notified the State in April 1975 that the Title XIX Medicaid claims for outpatient services for inmates of public institutions for the mentally retarded and public mental hospitals had been incorrectly claimed (Record for Reconsideration, Item 12).

The State contends that the submission of the 1971 agreement between two state agencies and the failure to comment on the provision evidences approval of all of the provisions in the agreement. The record shows that since 1971, the State was apprised of the federal requirements for reimbursement for medical expenses of inmates of public institutions. The State has not presented any convincing arguments why this agreement between two State agencies should be made binding on HHS or that HHS was put on notice that the State intended to seek FFP in the cost of outpatient services.

(2) The Agency asserts that:

> The State of New Jersey has quite accurately pointed out that many habitual residents of public, non-medical institutions may fall within the language of the exceptions and, thus, not be considered inmates under the regulations. Nevertheless, the fact that such person <u>are</u> habitual residents of public, non-medical institutions is sufficient to justify the presumption by the Federal Government that those individuals are, in fact, inmates in a public institution. Such presumption is rebuttable on a sufficient showing by the State, either that an admitted inmate was, for a demonstrated period of time, simultaneously housed as an inpatient in an acknowledged medical institution or that the individual housed in a public, non-medical institution is not within the definition of "inmate" contained in the regulations (for whatever reason).... It is appropriate that the State thus bear the burden of proof: the State is in sole possession of any data which justifies excluding an individual from inmate status. (Notification of Disallowance, p.9, 80-12-NJ-HC.)

In particular, with regard to the Vineland School, the Agency asserts that the School has only 125 certified skilled nursing facility beds (which would qualify as a "medical institution" which is a distinct part of the public institution). Yet 1600 residents were having their drugs reimbursed under Title XIX. No evidence has been produced by the State to show that part of the disallowed amount was payment made for residents while inpatients of the SNF. It appears that if the State could have produced evidence of inpatient status at Vineland or inpatient status in a section of any other facility that might be involved in these appeals, the Agency would have considered those costs eligible for FFP, provided the expenditures had not been previously billed to Medicaid and payments made. The State has provided no such evidence.

(3) The State argues that Section 1905(a) of the Social Security Act was intended to preclude Medicaid payments for institutional custodial care, but not necessarily for medical care. It argues that no definitions preclude payments for "outpatient care rendered to an 'inmate' who is a 'patient,'" and that inmates need not be physically housed at a medical

institution in order for the State to receive FFP. (Application for Review, p.9.) These conclusory statements do not appear to correctly describe the law and regulations.

The State is correct that the Medicaid program does not necessarily preclude payments for medical care; indeed, the purpose of Medicaid is to permit federal matching for medical care and services provided to eligible individuals, which might include outpatient services such as dental, clinic, and home health services. The problem is that the individuals for whom the State has requested reimbursement are inmates of public institutions who do not qualify for Medicaid coverage and do not fall within the exception for inmates who are "patients in a medical institution." In the absence of a definition for the latter phrase, the Agency's procedure of amalgamating three separate definitions ("patient," "in an institution," and "medical institution") appears reasonable. Therefore, only if a public psychiatric institution or institution for the mentally retarded has distinct sections which are separately certified as a hospital, SNF, or ICF may there be FFP for Medicaid eligible patients physically housed in these sections. For residents of the other non-medical parts of these public institutions there can be no FFP.

SALARIES OF STATE STAFF IN PUBLIC INSTITUTIONS (78-106-NJ-HC, 80-12-NJ-HC)

The Agency argues that since the population of the public institutions is ineligible for Medicaid, personnel cannot be performing Medicaid functions. The State merely argues that HCFA has made no demonstration of a factual basis for the conclusion that staff at public institutions perform no valid Medicaid function. However, as was noted in the discussion above, the burden is placed on the State, which has access to the records, to demonstrate the eligibility of recipients so that a proportional amount of salaries could be claimed. No such evidence has been provided.

SALARIES AND FRINGE BENEFITS CLAIMED AT 75% FEDERAL MATCHING (78-106-NJ-HC, 80-12-NJ-HC)

The State, in its response to the Board's December 15, 1980 Orders, stated that the appeal pertaining to this issue was "withdrawn previously". It is not clear from its statement whether it meant that the appeal pertaining to this particular amount disallowed was withdrawn. The Board had noted in its Order that two other earlier appeals involving this issue had been closed because the State had accepted the Agency's determinations. We therefore find that the State is here once again accepting the Agency's determination.

CONCLUSION

Based on the discussion above, we find the following:

(1) The appeals pertaining to Irvington Hursing Home and Bayview Nursing Home are rejected;

(2) The appeals pertaining to outpatient services to inmates in public institutions for the mentally retarded and public mental hospitals are rejected;

(3) The appeal pertaining to salaries of State staff in public institutions is rejected; and

(4) The appeal pertaining to salaries and fringe benefits claimed at 75% federal matching has been withdrawn by the State.

/s/ Donald F. Garrett

/s/ Alexander G. Teitz

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