PRAKENESS HOSPITAL,
Petitioner,

v.
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES,
Respondent.

Decided December 3, 1981

Initial Decision

SYNOPSIS

Preakness Hospital challenged the attempt by the Division of Medical Assistance and Health Services (DMAHS) to recover over $50,000 against Medicaid billings for services provided from December 1, 1980 to December 3, 1980. The hospital was decertified as a Medicaid provider during that period of time and was therefore ineligible for Medicaid reimbursement. Arguing that the termination of its provider agreement was made without adequate and timely notice, the Hospital asserted that a new provider agreement signed between the parties on December 4, 1980 should be given retrospective effect to cover the period of December 1 through 3, 1980.

The administrative law judge found that on August 7, 1980, the Department of Health, which is designated by DMAHS to conduct compliance surveys of Medicaid providers, notified the acting superintendent of the Hospital that its dietetic services were not in compliance with federal health and safety requirements.

On August 18, 1980, the director of DMAHS sent a letter to the Hospital advising it that in the event the Health Department's recommendation stood, the Division would not make any Medicaid per diem reimbursement to the hospital beyond the 30th day after the date of termination of the provider agreement, i.e., November 30, 1980.

The judge found that on November 26, 1980, the Hospital was advised by DMAHS that it was unable to renew the Medicaid agreement, and thus, after November 30, 1980, per diem reimbursement would be terminated. The Hospital was also advised of its right to a hearing on the matter. Subsequently, the facility was recertified and entered into a new agreement with DMAHS on December 4, 1980.

The administrative law judge rejected the Hospital's argument that it was entitled to a hearing prior to a denial of reimbursement and concluded that the letters sent to the Hospital contained the elements
necessary for adequate notice. Since the Hospital's certification was properly revoked and since, pursuant to 42 C.F.R. 442.15 the effective date of a provider agreement may not precede the date on which the participating provider meets all federal requirements, the administrative law judge ordered the recovery of the improperly reimbursed Medicaid Funds.

Michael Glovin, Assistant County Counsel for Petitioner
Ivan J. Punchat, Deputy Attorney General for Respondent (James R. Zazzali, Attorney General of New Jersey, Attorney)

ROBBINS, ALJ:
This matter concerns petitioner's challenge to the demand for recovery of $50,977.87 against Medicaid billings for services provided from December 1, 1980 to December 3, 1980. The facility was decertified as a Medicaid provider during that period of time and therefore was ineligible for Medicaid reimbursement. The petitioner asserts that the termination of the provider agreement was made without adequate and timely notice and thus was invalid. The petitioner requests that the provider agreement signed between the parties on December 4, 1980 be extended to cover the period of December 1 through 3, 1980. The matter was transmitted to the Office of Administrative Law as a contested case pursuant to N.J.S.A. 52:14F-1 et seq.

Preakness Hospital is a county facility which has patients eligible for medical assistance (Medicaid) under Title XIX of the Social Security Act. The Division of Medical Assistance and Health Services (DMAHS) is required to designate a state authority which is responsible for establishing and maintaining eligibility standards for providers in the Medicaid program. 42 C.F.R. 431.610. The Division may not execute a provider agreement with a facility to provide intermediate or skilled nursing care services unless the designated survey has certified that the facility complies with all federal health and safety requirements. 42 C.F.R. 442.12. In the State of New Jersey the Department of Health is the designated survey agency.

The Department of Health conducted its 1980 annual survey of the facility on June 18, 19, and 20, 1980 and again on July 7, 1980. By letter of August 7, 1980, the Director of Licensing Certification and Standards of the Department of Health notified the acting superintendent of the facility that because of the dietetic services, the facility was not in compliance. On August 28, 1980, Mr. Russo, Director, DMAHS, sent a letter to Preakness Hospital advising that because of
the dietetic services deficiency, "the Health Department will not make a favorable recommendation of your facility for continuance of your Medicaid provider participation agreement for 1980-81." The letter further advised that:

in the event the State Department of Health recommendation to decertify your facility stands, this Division will not make any Medicaid per diem reimbursement to Preakness Hospital beyond the 30th day after the date of termination of the provider agreement. This is in compliance with 42 C.F.R. 441.11(b)(2) which states that Federal Financial Participation (FFP) cannot be continued for more than 30 days after the expiration date of the provider agreement. The termination date of the provider agreement is October 31, 1980; therefore, Medicaid per diem reimbursement will not be made to Preakness Hospital after November 30, 1980, unless in the interim the State Department of Health will recommend continuing Medicaid provider agreement beyond that date.

On September 2, 1980, the acting superintendent of Preakness Hospital requested clarification of the existing deficiencies so that action could be taken to expedite a plan of correction. On September 12, 1980, the hospital requested an extension of time in which to submit its plan of correction. Mr. Russo's response to the hospital's letters, dated October 3, 1980, advised the hospital that any extension in time must be obtained from the Health Department. In accordance with 42 C.F.R. 441.11(b)(2), the Division extended reimbursement for an additional 30 days to November 30, 1980.

On November 26, 1980, a letter was sent to the hospital stating that the State Department of Health had advised DMAHS that the condition of dietetic services remained unmet. The Health Department continued to recommend decertification based on its revisit to the hospital on November 21, 1980. The hospital was informed that since the Division was unable to renew the Preakness Hospital Medicaid participation agreement for 1980-81, per diem reimbursement for services provided after November 30, 1980 would be terminated. This letter contained notification of the entitlement to a hearing as follows:

If you wish to contest the termination of the Preakness Hospital’s Medicaid provider agreement, you may request a hearing on the matter. The hearing request must be made within twenty (20) days from the date of the mailing of this letter.

Subsequently, the facility was recertified by the Department of Health and the provider entered into a new agreement with the Division of Medical Assistance and Health Services, effective December 4, 1980. The Department of Health recommended certification from
December 4, 1980 through June 30, 1981. Since Preakness Hospital was not an approved and authorized provider of health services under the Medicaid program until December 4, 1980, the State is requesting recovery in the amount of $50,977.87 against Medicaid billings for services for the period December 1, 1980 to December 3, 1980.

Counsel for petitioner argues that regulations require timely and adequate notice prior to any termination of benefits. He cites N.J.A.C.10:49-5.4, which specifies that timely notice means notice that is received at least ten days before the action is to be taken and adequate notice means written notice “that includes details of reasons for the proposed departmental action, explanation of the recipient’s right to a conference, his right to request a fair hearing and the circumstances under which assistance is continued if a fair hearing is requested.” It is counsel’s position that although the hospital was advised of the possibility of decertification, the letter of August 28, 1980 did not constitute notice under the Department’s own rules and guidelines as there was no reference in the letter to the “right to a hearing on this matter prior to the decertification of the facility.” The letter of November 19, 1980 again emphasized the deficiencies and possible decertification, but made no mention of a hearing. This letter was considered as a warning to the hospital rather than the notice required by the regulations. It is further the position of the petitioner that the hospital was relying on a follow-up inspection and was attempting to rectify the dietary deficiencies noted.

Counsel for petitioner argued that the first official notice from the Division advising the hospital that Medicaid funding was to be terminated effective November 30, 1980 was issued November 16, 1980. This letter contained the necessary elements to qualify as adequate notice under N.J.A.C. 10:49-5.5. Counsel argued that the notice was not issued ten days prior to the termination as required and therefore was not timely. He further asserted that if the required adequate notice, including information regarding a hearing, had been issued in a timely manner, the hospital would have requested a hearing and assistance would have been continued unreduced. Because of the foregoing, counsel for petitioner argues that as the hospital never received notice pursuant to N.J.A.C. 10:49-5.5, termination of medical payments was inappropriate. He requests that the provider agreement signed between the DMAHS and the hospital be extended to cover the period of December 1, 1980 through December 3, 1980.

The deputy attorney general argues that N.J.A.C. 10:49-5.4 is intended to protect the rights of the eligible recipients and not the rights of the participating providers. Since the intended beneficiaries
of Medicaid are the recipients. *N.J. Fed. of Physicians and Dentists v. Klein*, 144 *N.J. Super.* 467, 471-472 (App. Div. 1976). As such, the governing federal regulations mandate certain procedures for providing fair hearings to applicants and recipients when the Medicaid agency takes action to suspend, terminate, or reduce services. 42 *C.F.R.* 431.200 *et seq.* This requires that notice be mailed at least ten days prior to the intended action and include an explanation of the individual’s right to a hearing. *N.J.A.C.* 10:49-5.4 mirrors the federal regulations concerning the recipients’ rights to a hearing and adequate advance notice, specifically noting the application of the regulation to “recipients” in (a)(2) and (b)(2).

The deputy attorney general contends that in contradistinction to the expansive rights afforded program beneficiaries, the federal Medicaid governing rules and regulations do not establish any hearing rights for providers. Rather, any right to a hearing for a participating provider of medical or health services is based upon *N.J.S.A.* 30:4D-7(f), which allows for providers to be afforded the opportunity for an administrative hearing within a reasonable time on any valid complaint arising out of the claims payment process. *N.J.A.C.* 10:49-5.3(a)(2) requires that such requests for a hearing be made within twenty (20) days of the agency action giving rise to said complaint or issue. There are no provisions regarding any advance notice of intended agency action with regard to providers, nor any right to a hearing prior to agency action. *Monmouth Medical Center v. State*, 80 *N.J.* 299, 314 (1979). With regard to the aforementioned provisions governing hearings, the court expressly rejected the provider’s contention that it was constitutionally entitled to a hearing prior to a denial of reimbursement. While hospitals have both the constitutional right and a statutory right under *N.J.S.A.* 300:40-7(f) to a fair hearing within a reasonable time, such hearing need not be in advance of the termination of benefits.

Based on the foregoing, I FIND the following undisputed facts:

1. The Department of Health, in a 1980 annual survey of the facility, recommended decertification based on deficiencies in the dietary program.

2. Since the provider was not recertified, no new provider agreement could be entered into between the provider and the Division of Medical Assistance and Health Services at the expiration of the provider agreement on October 31, 1980.

3. In accordance with regulations, the Division continued providing reimbursement for the additional 30 days until November 30, 1980.
4. The provider was recertified effective December 4, 1980 and a new agreement with the DMAHS was completed. Based upon the foregoing, I CONCLUDE that a certification of the provider's compliance with all federal health and safety requirements is a precondition for a provider agreement with the DMAHS. The hospital was not certified as in compliance until December 4, 1980. As the hospital was not an approved and authorized provider of health services under the Medicaid program between the period from December 1, 1980 to December 4, 1980, a provider agreement could not be in effect during that period of time. The effective date of the provider agreement may not precede the date upon which the participating provider meets all federal health and safety requirements based upon the survey conducted by the survey agency. 42 C.F.R. 442.15. Since Preakness Hospital was not an approved and authorized provider of health services under Medicaid from December 1, 1980 to December 4, 1980, it was not entitled to any reimbursement for services rendered during that time. Therefore, the demand for recovery is AFFIRMED.

After reviewing this Initial Decision, the Division of Medical Assistance and Health Services on January 21, 1982 issued the following Final Decision:

The Director, Division of Medical Assistance and Health Services has reviewed and considered the entire record in this matter, including the initial decision of the administrative law judge.

Based upon his full review of the record, the Director hereby adopts the findings and conclusions of the administrative law judge in their entirety and incorporates the same herein by reference.

Therefore, it is on this 21st day of January, 1982 ORDERED:

That the Bureau of Claims and Accounts take all necessary action to recover the amount of $50,997.87, which amount constitutes the Petitioner’s Medicaid billings from December 1, 1980 to December 3, 1980, the time period during which the petitioner was not an approved provider of services under the Medicaid Program.