DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Massachusetts Department of Public Welfare
Docket No. 79-243-MA-HC
Decision No. 155

DATE: March 20, 1981

DECISION

By letter dated December 21, 1979, the Massachusetts Department of Public Welfare (Massachusetts) appealed a November 21, 1979 disallowance by the Director, Bureau of Program Operations, Health Care Financing Administration (HCFA) of $157,972 in Federal financial participation (FFP). The amount disallowed by HCFA was estimated by a statistical sample of payments to providers of physician services for aged and disabled Medicaid recipients during the period from February through November 1976. This decision is based on the appeal, HCFA's response, responses by Massachusetts to the Board's questions and to an Order to Show Cause, and the Order itself.

## Background

Under the federal Medicaid regulations and the Massachusetts State Plan FFP is available for physician services paid according to the fee schedule set by the Massachusetts Rate Setting Commission. This dispute arises as a result of claims by Massachusetts for payment of physician fees at 100 percent of the rate established by the Commission (prior to January 1976) after the Massachusetts legislature passed a law (in January 1976) requiring a 30 percent reduction in physician fees paid by the Department of Public Welfare. The Rate Setting Commission issued regulations in January 1976 to implement the cut immediately, but the Department of Public Welfare directed Blue Cross-Blue Shield, the fiscal agent for the processing of claims on behalf of aged and disabled recipients, not to apply the reduction. HCFA Response, Exhibit H.

Only after the (then) Department of Health, Education, and Welfare Audit Agency began an audit did Massachusetts instruct Blue Cross-Blue Shield to apply the 30 percent reduction. HCFA Response, Exhibit A., pp. 5, 11. The primary objective of the audit was to determine whether Medicare liability was identified and applied prior to Medicaid payments on behalf of aged and disabled patients.

On December 29, 1976, shortly after being advised by the auditors that physicians had been overpaid, Massachusetts informed the auditors that the State would perform its own audit of 100 per cent of the claims. Upon learning such an audit would cost $20,000, the State decided against it. HCFA Response, p. 3; Exhibits C, G.

The HEW auditors drew a sample of physician claims when they discovered that available fiscal agent payment reports, on which reimbursement was based, did not separately identify physician payments based on the Medicaid Fee Schedule. As a result, they were unable to determine readily the exact amount of these payments during any given period of time. However, they did estimate the amount of these payments and test whether the thirty percent fee reduction was applied for the period February through November 1976. HCFA Exhibit A, pp. 11-12.

Blue Cross-Blue Shield groups claims in batches for its own processing purposes as they are received. The number of claims in the chosen batches ranged from 8 to 50. The auditors randomly selected one batch of claims from each of the ten months (the physician fee reduction commenced in February 1976 under State law and the sample frame consisted of all batches processed through the payment system from February through November 1976 by the fiscal agent). Each line item on each claim in each selected batch was reviewed to see if the service date of the line item was before or after February 1, 1976. The auditors then calculated the average dollar amount of claims in each selected batch and the percentage of line items after February 2, 1976. HCFA Response, p. 4.

A two-part calculation was necessary because some claims were filed on State forms whereas others were filed on Medicare forms, but then determined to be reimbursable as State Medicaid claims. The auditors took the State form dollar average and applied it to the claims filed on State forms; then they took the Medicare form item dollar average and applied it to the items filed on Medicare forms. Ibid.

## Discussion

Massachusetts argues that HCFA's estimate of the amount overpaid is invalid because HEW auditors used a defective sample and improper statistical methodology. In support of its assertion that the statistical sampling and methodology employed was contrary to HHS policy, Massachusetts submitted a letter from the Assistant Inspector General for Auditing, HHS, which states: "it is essential that a valid statistical sample (every item has an equal or known chance of selection) be selected for examination and that valid statistical methods be used in projecting the results of the examination." Response to Order to Show Cause, Exhibit 10.

HCFA admits that the amount of the overpayment is not precise and that there are defects in the procedures used by the auditors, but contends that the data was generated on a random selection basis and is representative of the universe of claims in question. It uses this same data to demonstrate that the amount disallowed should have been greater, not less, and suggests that the Board consider revising it upward. HCFA Response, pp. 5,9-11.

Massachusetts has requested that the Board direct HCFA to answer six questions posed by the State on the subject of the reliability of the statistical sample and methodology used by the HHS auditors and to conduct a hearing to consider the testimony of a statistician employed by the Department of Public Welfare on this same subject. We deny these requests because our resolution of this dispute does not depend on a finding that the HCFA estimate is based on a 100 percent valid sample and methodology. We do hold that in the narrow circumstances of this case, Massachusetts is bound to pay the amount of the disallowance because it has not demonstrated the allowability of its claim.

Although the State has not challenged the use of a sample per se, we note here that this method of calculating the amount of a disallowance has been upheld in court and before the Board. In Georgia v. Califano, 446 F. Supp. 404, 409 (N.D. Ga. 1977), upholding a disallowance of excess physician fees based on a statistical sample, the Court found the statistical method to be "reliable and acceptable" but pointed out that this "is not to say that the statistical model will always be conclusive." Noting that "the state is ultimately charged with the duty of proving the allowability of deferred claims," the Court held that it was not arbitrary and capricious to determine the amount of overpayment by use of a sample, particularly where the state did not challenge the sample during the disallowance reconsideration. In California State Department of Health, Decision No. 55, May 14, 1979, the Board extended the Georgia v. Califano rule on the state's duty to claims that are directly disallowed without being preliminarily deferred.

This does not mean that in general the Board would uphold a disallowance based on a statistical sample or statistical sampling methods that are not shown to be valid. The principle which would govern in most cases is that set out in University of California — General Purpose Equipment, Decision No. 118, September 30, 1980, at p. 5:

> If an agency disallows an amount determined through use of this audit technique [statistical sampling], however, that agency must accept responsibility for explaining the technique and defending its validity as used in a particular case.

The appeal before us now is not the usual case where a disallowance results from errors in processing a large number of claims: payments may be made for ineligible recipients; providers may be overpaid through careless processing of their bills; or duplicate payments may be made for the same service. Such errors are bound to creep in where large numbers of claims are processed. The situation in this appeal is entirely different. Here the State made a conscious and deliberate choice not to apply the 30 per cent reduction.

In a letter dated December 27, 1976, to the Manager of Blue Shield Medex/Medicaid Department, the Project Director of the State makes it clear that failure to apply the reduction was deliberate (HCFA Exhibit H):

> As you know, I had told you not to apply this reduction in February when it was first announced...

The resulting disallowance by HCFA was clearly within the scope of that agency's responsibility to pay FFP only for valid claims.

Even though the State could have and should have developed its own figures instead of continuing to highlight the problems with HCFA's, this decision provides the State yet another and final opportunity to submit a more accurate basis for the disallowance. Whether the State produces its estimate by correcting the alleged defects in HCFA's sample and methodology, or by some other acceptable means (such as the promised 100 per cent review), HCFA should use the new figure. If the State again fails to come forward, then it cannot complain that the reimbursement is based on HCFA's estimate.

Massachusetts also argues that:

1) HCFA failed to join the physicians as necessary parties to the disallowance; and

2) HCFA is estopped from making this disallowance because HCFA encouraged the Department of Public Welfare not to implement the reduction and did not alert Massachusetts to the possibility of disallowance prior to the letter of November 21, 1979.

We agree with HCFA that Massachusetts lacks standing to argue that HCFA should have provided notice and a hearing to the physicians, and that HCFA's relationship is with Massachusetts, not the physicians.

We also note that despite its announced concern, Massachusetts apparently has not undertaken to advise the physicians of the pendency of this matter. If it did, none of the physicians were interested enough to attempt to intervene or even file an amicus brief. See 45 CFR §16.58.

The estoppel argument also is without merit. HCFA did not advise Massachusetts that FFP would be available if the State failed to enforce the 30 percent reduction. HCFA merely called to the State's attention that if the reduction caused a shortage of physicians -- mostly pediatricians -- to screen and test children, the State might be liable for a penalty under the program for the Early and Periodic Screening, Diagnosis, and Treatment of persons up to age 21. The State does not explain how its failure to reduce fees paid to physician providers serving the elderly was done to ensure the continued services of pediatricians. The State was aware of the requirement that the reduced fee schedule had to be followed and it has not established that its failure to impose the reduction was due solely to the threatened penalty. Moreover, it did implement the fee reduction generally, failing to do so only with respect to claims on behalf of the elderly and disabled.

We do not agree with the implication in the May 1, 1980 "Further Response" by Massachusetts that the audit report does not contain a recommendation that the State reimburse the federal government for its matching share of the overpayments. The auditors did find that "claims for Medicaid recipients ... should be subjected to the thirty percent fee reduction." HCFA Exhibit A, p. 11. The decision to disallow is HCFA's.

## Conclusion

Although we uphold the disallowance, the effect of this decision is suspended for sixty days to permit Massachusetts to provide HCFA with a more acceptable basis for calculating the amount properly disallowed as a result of the State's failure to implement the required 30 percent fee reduction. Should Massachusetts choose to submit an alternate calculation of the disallowed amount with supporting rationale, the effect of this decision will remain suspended until HCFA accepts or rejects it. If HCFA does not accept the State's proposed disallowance amount, HCFA must be prepared to show why the HEW audit estimate is better. Should HCFA decide to reject the State's proposed disallowance amount, Massachusetts may appeal that decision to this Board.

/s/ Cecilia Sparks Ford

/s/ Alexander G. Teitz

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