DEPARTMENTAL GRANT APPEALS BOARD

Department of Health, Education, and Welfare

SUBJECT: Foundation Community Health Plan
(California State Department of Health)
Docket No. 78-49-CA-HC
Decision No. 89

DATE: March 24, 1980

Elisabeth C. Brandt, Deputy Attorney General, for the California State Department of Health. Robert P. Jaye, Deputy Assistant General Counsel, HEW Office of the General Counsel, Health Care Financing and Human Development Services Division, for the Health Care Financing Administration.

DECISION

This case involves a determination by the Regional Commissioner of the Social and Rehabilitation Service (SRS), Region IX, dated June 19, 1975, to disallow funds claimed by the California State Department of Health under Title XIX of the Social Security Act. The State Department of Health requested reconsideration of the Regional Commissioner's determination by the Administrator of SRS pursuant to 45 CFR 201.14 by letter dated July 17, 1975. On May 30, 1978, the Administrator of the Health Care Financing Administration (HCFA) affirmed the Regional Commissioner's determination. By letter dated June 29, 1978, the State Attorney General's office notified the Board on behalf of the State Department of Health of its election to proceed with review under 45 CFR Part 16, as permitted by the regulations transferring the reconsideration function to the Departmental Grant Appeals Board (43 FR 9264, March 6, 1978).

This decision is based on the reconsideration record made pursuant to 45 CFR 201.14 and on written submissions to the Board by the parties. We note here that the State requested that either a hearing or an informal conference be held in this case. The Panel has determined pursuant to 45 CFR 16.8(b) that there exists no dispute as to a material fact the resolution of which would be materially assisted by oral testimony, and accordingly denies the request for a hearing. Further, in the Panel's judgment, a decision can be made based on the parties' written briefing, which has been extensive, and would not be assisted by a discussion of the case at an informal conference.

The State receives reimbursement under Title XIX for a percentage of payments made for medical services provided to persons eligible for "Medi-Cal," the State's Medicaid program. Persons eligible for Medi-Cal may obtain services from providers on a "fee-for-service" (FFS) basis, in which case the State pays the providers for actual services rendered, or they may enroll in a "prepaid health plan" (PHP), in which

case the State pays the plan a fixed monthly amount for each person enrolled, regardless of actual services provided. In the instant case, the amount disallowed represents the Federal share of the amount by which payments to Foundation Community Health Plan (FCHP), a PHP, in calendar year 1974 exceeded FFS costs for Medi-Cal recipients who were not enrolled in the plan but resided in the same area served by FCHP. The disallowance is based on a Federal regulation, 45 CFR 250.30(b)(4), which both parties agree prohibits the State from making payments to a PHP exceeding the amount it would have cost to provide health care services to the individuals involved on a FFS basis. (Two State statutory provisions having the same effect were also cited in support of the disallowance.) 45 CFR 250.30(b)(4) provides that--

> The upper limit for payment for services provided on a prepaid capitation basis shall be established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The cost for providing a given scope of services to a given number of individuals under a capitation arrangement shall not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

The State appealed on the ground that certain categories of Medi-Cal recipients who enrolled in FCHP required both more care and more costly types of care than did persons in the same categories who remained under the FFS system. Therefore, the State argued, the fact that the payments to FCHP were in excess of those made for Medi-Cal recipients not enrolled in the plan did not mean that the payments to FCHP exceeded the amount that it would have cost to provide the services to the individuals enrolled in FCHP on a FFS basis. The Agency, however, did not accept the State's "adverse selection" argument, its position being that the State has not shown that the individuals enrolled in FCHP would have made the same use of health care services had they remained under the FFS system.

The Regional Commissioner's disallowance was based on a report issued by the State Auditor General in April 1975 which concluded, based on a study conducted by the Rates and Fees Section of the State Department of Health, that net excess payments of $1,604,775 for 1974 had been made to FCHP. The report specifically stated that it was beyond the scope of the audit to determine whether adverse selection existed as asserted by the State. The amount identified by the Auditor General as an overpayment included a setoff of $661,500 to account for the estimated administrative costs which the State Department of Health would have incurred for processing of claims if the services provided by FCHP had been provided on a FFS basis. The Regional Commissioner's disallowance determination requested the refund of the Federal share

(50 percent) of $2,266,275 ($1,604,775 plus $661,500), stating that the amount to be refunded could be reduced by the amount of adminstrative expenditures which would have been incurred had the services been provided on a FFS basis, but that the Auditor General's estimate of $661,500 appeared to be high.

While reconsideration proceedings were pending before the Administrator of SRS, the State applied for and received a grant from HEW under Section 222 of Pub. L. 92-603 (as amended by Section 107 of Pub. L. 94-182), a specific objective of which was to determine if FCHP had in fact suffered adverse selection. SRS consented to delay reconsideration proceedings pending the results of the "Prepaid Health Research, Evaluation and Demonstration" (PHRED) project funded by the grant, which it agreed would have a bearing on the reconsideration decision. The PHRED report concluded that there was some adverse selection with respect to two of the four categories of Medi-Cal recipients enrolled in FCHP and that, taking into account the State Auditor General's estimate of savings to the State in claims processing costs for FCHP enrollees, there was no net overpayment to FCHP.

The basic methodology used by the PHRED project was to determine the actual FFS per capita cost for each of two major categories of Medi-Cal recipients (those receiving Aid to Families with Dependent Children, and those receiving Aid to the Totally Disabled) and to then adjust it to match the FCHP "utilization pattern," that is, the quantities and types of health care services actually used. According to the PHRED report, this yielded the cost that would have been incurred under the FFS system to provide the same services as were actually provided to the FCHP enrollees. To the extent that this figure was higher than the cost of services provided to persons remaining under the FFS system, the PHRED report concluded that FCHP had suffered adverse selection. The crucial assumption on which this conclusion rested was that "for both FCHP and FFS the relationship between 'need' and 'utilization'" was approximately the same. (PHRED project report, Tab 18, reconsideration record, p. 6.)

Another approach which the PHRED project took to determine whether there was adverse selection was suggested by the fact that all of the FCHP enrollees returned to the FFS system when FCHP cancelled its contract with the State in 1976. The PHRED project found that there was a change in the FFS utilization pattern after that time which reflected the utilization pattern experienced by FCHP.

The HCFA Administrator nevertheless affirmed the Regional Commissioner's disallowance, allowing, however, the $661,500 setoff for administrative costs suggested by the State Auditor General. This new determination relied on an evaluation of the PHRED report by the General Accounting Office (GAO) which challenged the PHRED report's assumption that utili-

zation reflected the need for medical services on the ground that "differences in utilization can be due to very subtle differences in utilization control and reimbursement methods for health practitioners [rather than to differences in need]." (Tab 20, reconsideration record.) GAO's evaluation did not, however, specify in what respects the utilization controls or reimbursement methods were different for FCHP and the FFS system.

An Order to Develop Record was issued in this case by the Board Chairman on October 2, 1979. The Order sought development of the record in three areas. One area was whether the disallowance was based in part on the State's failure to have a proper rate-setting methodology in effect when the per capita rates for FCHP were set. Although the State had sought reconsideration on the ground that, regardless of the methods used to set the rates, there was in fact no overpayment to FCHP, the HCFA Administrator's determination seemed to imply that the lack of proper methods was one of the grounds for the disallowance. In response to the Order, however, the Agency stated that this was not a basis for the disallowance.

The second area of inquiry was the extent to which, if any, the grant award or the grant application for the PHRED project described the methodology to be used to determine whether FCHP had suffered adverse selection. If those documents indicated that the PHRED study would assume that utilization reflected need, it would seem arguable that there was some element of unfairness in HEW's challenging that assumption only after the PHRED report was completed. In response to this portion of the Order, the State submitted documents which clearly indicate the intent of the project to evaluate the State's adverse selection argument. Rather than identify the specific methodology to be used in such an evaluation, however, the documents give as one of the goals of the project "[t]o develop a methodology for the detection and measurement of baised enrollment selection (either adverse or favorable)...." (Revised Project Narrative, p. 10.)

The third area of inquiry was GAO's specific objections to the PHRED report which caused it to reject the report's conclusion that FCHP had in fact suffered some adverse selection and that there was thus no overpayment to FCHP. In response to the Order, the Agency forwarded a copy of a letter from GAO to HCFA dated November 19, 1979 which identified the use of "Medi labels" in the FFS system as a form of utilization control not present in FCHP which could have accounted for the difference in their respective utilization rates. According to GAO, during the time period in question in this case, Medi-Cal recipients who used the FFS system were given each month by the State two "Medi labels" which had to be affixed by providers of outpatient services to claim forms in order to obtain payment for services rendered. After a recipient

used the two labels, a provider had to obtain a treatment authorization from a State Medi-Cal consultant before a service was provided in order to receive payment. A similar system applied to the dispensing of drugs. GAO noted that the data included in the PHRED report showed that almost all of the difference in utilization between FCHP and the FFS system was for services which were covered by the "Medi label" or "drug label" limit. Based on this fact, it argued that the label restrictions rather than differences in need were responsible for the differences in utilization, thus calling into question the PHRED report's analysis. The GAO letter did not discuss the differences in the reimbursement methods for providers which were referred to in GAO's earlier criticism of the PHRED report.

The State in its reply to the Agency's response to the Order acknowledged that the Medi label system should have been discussed in the PHRED report. It denied, however, that this factor changed the report's conclusion that there had been no overpayment to FCHP. The State relied on a study done by the State Department of Health's Center for Health Statistics in August 1977 on the effect of the removal in July 1975 of most of the label restrictions.

That study found that from October 1, 1975 to April 30, 1977, there was in the area of physician outpatient visits a 6.7 percent increase (from 1.5 to 1.6) in the ratio of visits per user. The study stated that the removal of the Medi label restrictions "may have been responsible" for this increase since the visits per user ratio had remained practically unchanged from 1974 until the removal of label restrictions in July of 1975. The State argued that since the study did not find that the Medi label requirement "clearly had an inhibiting effect upon utilization," it should be concluded that Medi labels were not a form of utilization control. The State contended, moreover, that even if one assumed that Medi labels did inhibit utilization of physician's services by 6.7 percent and the figures in the PHRED report were revised accordingly, the cost of providing medical services to Medi-Cal recipients enrolled in FCHP would have been only 1.84 percent more than if they had been served under the FFS system, resulting in an overpayment of only $297,000 instead of the $802,388 disallowed by the HCFA Administrator. The State further contended, relying on a statement by the former director of the PHRED project, that since this amount ($297,000) represented less than 2 percent of the total amount paid to FCHP during 1974, it was statistically insignificant and the reasonable conclusion would be that there was no overpayment to FCHP. The project director did not indicate the basis for attributing this degree of measurement error to the PHRED study, however.

The one issue remaining in dispute is thus whether the use of labels for outpatient physician services and drug prescriptions in the FFS system had a significant effect upon utilization and renders invalid

the PHRED report's comparison of utilization data for FCHP and the FFS system. It is unlikely that conclusive evidence can be produced on this issue, just as the broader question posed in this case, whether the payments to FCHP exceeded the amount that it would have cost to provide services to the individuals enrolled in FCHP on a FFS basis, is essentially a hypothetical one. The study by the State Department of Health's Center for Health Statistics introduced by the State, however, involved a careful examination of the effect of Medi labels on utilization, undertaken without any view to its use in this proceeding, which we think may justifiably be relied upon in reaching a final determination in this matter. Although the study concluded only that the removal of the Medi label restrictions "may have been responsible" for the subsequent increase in utilization, that statement is no more speculative than any of the findings of the PHRED report on which the State relies. The State's own computations then show that a revision of the PHRED report to take into account the effect of Medi labels on utilization posited by the Center for Health Statistics study would result in an overpayment to FCHP of $297,000. The State asserts that this amount is statistically insignificant, but provides no support for this assertion.

DECISION

We therefore conclude that the payments to FCHP exceeded the amount it would have cost to provide health care services to the FCHP enrollees on a FFS basis by $297,000 rather than $802,388 as determined by the Administrator of HCFA, and, accordingly, reverse in part his disallowance. This is the final administrative decision in this matter. (45 CFR 16.91(b)).

/s/ Bernard E. Kelly

/s/ George Putnam

/s/ Frank Dell'Acqua, Panel Chairman