DEPARTMENTAL GRANT APPEALS BOARD

Department of Health, Education, and Welfare

SUBJECT: California State Department of Health
Docket No. 78-69-CA-HC
Decision No. 55

DATE: MAY 14, 1979

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CHAIRMAN'S DECISION

I. Procedural Background.

This case arises under Title XIX of the Social Security Act. Section 1116(d) of the Act entitles a State to receive upon request reconsideration of a disallowance made under that title. This decision is the final step in the reconsideration process provided in Section 201.14 of Title 45 of the Code of Federal Regulations. Charles W. Goady, then Regional Commissioner, Social and Rehabilitation Service (SRS), issued a disallowance determination on June 19, 1975, in the amount of $1,176,150 for payments found to have been made by the State of California during the month of March 1974 for services rendered during January 1974 to persons then ineligible for Medi-Cal, the State's Medicaid program. Mr. Goady's determination was reviewed under the reconsideration process and the disallowance was reduced to $74,544 by the Administrator of the Health Care Financing Administration (HCFA) in a determination issued June 26, 1978.

The State requested further reconsideration by the Chairman of the Departmental Grant Appeals Board on July 24, 1978. Although the State was entitled under 45 CFR 201.14(a), as amended March 6, 1978 (43 FR 9266), to exercise an option to have the matter considered by the Board under 45 CFR Part 16, it expressly chose not to do so but to be governed by the Section 201.14 procedure with the Chairman substituted for the Administrator, SRS, in accordance with the transfer of functions of March 6, 1978 (43 FR 9266-7).

Since the State had, prior to March 6, 1978, requested a conference with the Administrator of SRS, it was entitled under the transfer of functions to a conference with the Chairman and indicated that it desired such a conference. Accordingly, by a Notice of Conference dated November 28, 1978, I gave notice that such a conference would be held, invited the parties to suggest agenda items for the conference, and directed them to come prepared to discuss

certain questions present in the case and also the correctness of the preliminary analysis of facts and issues set forth in the Notice. The conference was held on January 15, 1979. A transcript was made at the State's expense in accordance with Section 201.14(d)(7) and is part of the file. Both parties have been afforded an opportunity to review and propose corrections to the transcript. At the conference the parties were afforded an opportunity to discuss the questions that had been placed on the agenda as well as others that arose for discussion in the course of the conference and were invited and afforded an opportunity to file post-conference submissions which have since been received.

II. Facts.

California, for the purposes of its own effort to upgrade its performance, performed an audit of Medi-Cal. It identified roughly 1,600,000 claims filed for services rendered in January 1974 which were paid in March 1974. No claims for services rendered in January and paid in January or February or April or later were considered and no claims paid in March for services rendered in March or February or December or earlier were considered. (Transcript, pp. 58-59.) In this survey of a limited segment of claims, the State found, on an initial review, 84,537 claims (representing a total of $2,352,300) involving some 27,000 beneficiaries who were not listed in the State's computer file of January 1974 Medi-Cal eligibles. Based on this survey by the State, which was not required by federal regulation (Transcript, pp. 11-12), and apparently not based on any specific sampling technique (cf. Transcript, pp. 9-12, 57-58; cf. Reconsideration record, Tab 1, p. 61), the Regional Commissioner, SRS, disallowed federal financial participation (FFP) in the amount of $1,176,150. (Reconsideration record, Tab 2.)

The Regional Commissioner stated that an adjustment in the amount of the disallowance could be made for paid claims for services rendered to medically indigent adults eligible for Medi-Cal but not covered by the Title XIX plan. According to the Regional Commissioner, such claims were excluded from the paid claims for which the State originally claimed FFP, but were included among the roughly 85,000 claims paid for beneficiaries not appearing on the State's computer file of Medi-Cal eligibles. Since the State never claimed or received FFP for payments involving medically indigent adults, it was not required to account to HEW for errors in those payments. The Regional Commissioner left the determination of the proper amount of the adjustment to the State. The State later identified this amount as 8 percent of Medi-Cal service costs, which it stated was based on an historical average. (Reconsideration record, Tab 6.)

In the course of a reconsideration proceeding started before the SRS Administrator and transferred to the Administrator of HCFA, the State made further study of a sampling of the roughly 85,000 claims initially not shown to be eligible. This sampling was taken by making a search of every 85th claim

among the almost 85,000, resulting in a sample of 994 claims. In this sample, on further research, 931 were found to be eligible, 18 were found to be ineligible, and 45 claims were for persons for whom records were not found and who were thus not shown either to be clearly eligible or clearly ineligible. The Administrator of HCFA, acting upon the recommendation made by the Regional Commissioner, SRS, to the SRS Administrator, reduced the amount of the disallowance to $74,544, treating the 45 cases in which no records were found, as well as the 18 cases in which ineligibility was clearly shown, as having involved payments to ineligibles. The Administrator's determination, without explanation, made no adjustment for claims paid for medically indigent adults.

III. Issues.

A. One issue in this case is whether the 45 cases should be treated as ineligible as HCFA claims or as divided between eligibles and ineligibles in the same proportion as those for whom a direct eligibility determination could be made, that is to say eligible in the ratio of 931 to 949 as the State contends.

If the 45 cases are treated as eligible in the ratio of 931 to 949, then the number of ineligible cases in the sample of 994 would be 19 (rounded off), and the amount of the disallowance, which is based on a projection of the number of ineligible cases in the 994 sampled to the roughly 85,000 claims involving beneficiaries not in the State's computer file of January 1974 eligibles, would be substantially reduced.

B. A second issue is whether the disallowance was appropriate in view of the fact that the number of payments in the sample which involved ineligibles, even counting as ineligible all of the no-record cases, was small, and the error rate for the universe of 1,600,000 claims paid in March 1974 for services rendered in January 1974 negligible.

If 19 of the 994 claims in the sample, or roughly 1.9 percent, are treated as ineligible, then, assuming the sampled universe to be in the same proportion, approximately 1.9 percent of the roughly 85,000 claims initially found not supported by documentation of eligibility would appear to be ineligible. It is to be noted that the 85,000 include all the questionable cases, it being assumed that all the rest of the 1,600,000 claims, which were matched to individuals in the State's computer file of Medi-Cal eligibles, are eligible, that is to say, 94.7 percent are initially shown to be eligible. Of the remaining 5.3 percent, roughly 98.1 percent are shown to be eligible, and the ineligibles amount at most to 1.9 percent of 5.3 percent, or barely more than one-tenth of one percent. On the other hand, assuming the alternative least favorable to the State, the 45 cases for which records have not been found will be treated as ineligible and in that case instead of 19, there will be 63 ineligibles in the sample, and the State's error rate

for the 1,600,000 claims would then appear to be at most something like 6.3 percent of 5.3 percent, or three-tenths of a percent.

C. A third issue is what adjustment is to be made in the amount of the disallowance, if there is to be a disallowance, for paid claims for services rendered to medically indigent adults. There is no dispute between the parties as to the propriety of such an adjustment, but questions have been raised both as to the percentage of paid claims involving beneficiaries in that category and as to the manner in which that percentage is to be applied to the costs in question.

III. Discussion.

A. The State argues that the 45 beneficiaries for whom eligibility records were not found should be treated as eligible in the same proportion (931 out of 949) as those for whom a clear-cut eligibility determination could be made, or roughly 44 eligible and 1 ineligible. (Application for review, dated 7/24/78, p. 4; Letter to Board's Executive Secretary, dated 1/23/79, pp. 9-11; Transcript, pp. 21-22.) This position is unacceptable.

Federal statute and regulations impose on the State the ultimate burden of establishing and documenting eligibility. Section 1903(a)(1) of the Social Security Act authorizes payment of the federal medical assistance percentage of the total amount expended during each quarter under the State plan. Regulations at 45 CFR 249.81 (now 42 CFR 449.81(a)), provided for FFP, provided the beneficiary "was found eligible for medical assistance for the month during which the medical care and services were rendered..." Similarly, 45 CFR 206.10(a)(5) directs that "... medical... services... shall be furnished promptly to eligible individuals...." Furthermore, the State is required by regulation to maintain the pertinent records for a period of three years or until the resolution of any disputed audit findings. (45 CFR 74.20.)

At the conference, the representative of the State conceded that if there were such a provision for records retention, the State could not prevail because it has not produced all of the records for the claims in question. (Transcript, p. 51.) The State argues that it is not worth the cost of digging out and examining the records for the 45 cases if they exist. (Application for review, dated 7/24/78, p. 2.) That of course is a decision the State may make, but if it finds that a further search for those records is not cost-effective, it must accept the disallowance, which it has deemed to be the lesser cost. It is not permitted to claim the benefits of valid documentation and simultaneously to argue that it should not have to produce the records to support a conclusion of valid documentation on the ground that that is an excessive cost.

duty of proving the allowability of deferred claims. 43 CFR 201.15(c)(7)." 446 F.Supp. at 409. The same logic that requires that the State carry the burden of proof regarding the allowability of deferred claims appears to extend in principle to claims that are directly disallowed without being preliminarily deferred.

B. The second principal issue in this case is whether the disallowance is inappropriate given the low rate of payments to ineligibles for the 1,600,000 claims paid in March 1974 for services rendered in January 1974, as contended by the State. (Letter to Board's Executive Secretary, dated 7/27/78, p. 4; Letter to Board's Executive Secretary, dated 1/23/79, pp. 13-15; Transcript, pp. 22, 38-40.) This issue is best understood if viewed in a larger context.

HEW has had to deal with a serious problem of erroneous public assistance payments made by States and charged in part to the federal government under the Aid to Families with Dependent Children program (AFDC) and under the Medicaid program involved here. Although the details are complicated, some of the facts may be stated without distortion in a simplified form.

In an early effort to deal with the problem of erroneous payments in the AFDC program, SRS set as a target a 3 percent error rate for payments to ineligibles and a 5 percent error rate for overpayments to eligibles, providing that States would be held accountable for errors in excess of these targets. Error rates were to be determined based on a quality control sample, the results of which would be projected to the universe of all AFDC payments within each State for a given period. 45 CFR 205.41, 40 FR 32954 (August 5, 1975). This regulation was found to be invalid by the United States District Court for the Northern District of Georgia in Maryland v. Mathews, 415 F.Supp. 1206 (1976), on the ground that an empirical basis for the setting of target rates had not been established. The implications of the opinion appear to be that perfect performance was not to be expected, that a tolerance level at some reasonable minimum was appropriate, and that the proposed target rates were defective because they had no empirical basis and were if anything too low.

No regulation setting tolerance levels had been promulgated for the Medicaid program up to that point. Regulations requiring States to implement a quality control (QC) program to measure eligibility errors were in effect for both AFDC and Medicaid prior to April 1973. (Cf. Mashaw, Report in Support of Recommendation 73-3, Quality Assurance Systems in the Adjudication of Claims of Entitlement to Benefits or Compensation, 3 Rec. and Rep. of the Administrative Conference of the United States 160, 184-186.) It is stated, however, in a Notice of Proposed Rulemaking published on March 13, 1975, that HEW discontinued the Medicaid QC program on April 6, 1973, on the ground that it was "relatively unsophisticated in terms of providing statistically reliable error and payment data...." 40 FR 11735 (March 13, 1975). A Medicaid QC program based on the AFDC QC program was reinstituted effective July 1, 1975. 40 FR 27222 (June 27, 1975).

After the decision in Mathews v. Maryland, the Department made empirical studies and proposed new regulations (43 FR 29311 (July 7, 1978)) applicable to both the AFDC and Medicaid programs. The proposed new regulations set as an ultimate goal an error rate of 4 percent for both payments to ineligibles and overpayments to eligibles. The Department received and considered over a long period of time comments on these proposed regulations. Ultimately, final regulations were adopted for each program which provide that, to avoid a disallowance, a State must either not exceed the national weighted mean payment error rate calculated for a prior specified base period or must meet a prescribed rate of reduction in the percent of payments in error. 45 CFR 205.41 (AFDC) and 42 CFR 431.801 (Medicaid), 44 FR 12578, 12579, 12585 (March 7, 1979). The national mean for AFDC for the period July-December 1977 was 8.7 percent. 44 FR 12580 (March 7, 1979). The record does not show the national mean for Medicaid, although the fact that the same goal of 4 percent was proposed for both programs may be an indication that it was roughly comparable. (SRS in 1975 stated that the ineligibility rate for Medicaid recipients might be significantly higher than for AFDC recipients. 40 FR 11735 (March 13, 1975).) The 4 percent target error rate was omitted from the final regulations, however, in response to States' comments that it was too low. 44 FR 12581, 12588 (March 7, 1979).

During the period in question in this appeal, when there was no Medicaid quality control program and no regulation setting tolerance levels for FFP in erroneous Medicaid payments, SRS apparently applied a standard under which all payments for services rendered to Medicaid ineligibles which were identified would be subject to penalty with no tolerance permitted (a system characterized by the State's representative as "catch as catch can," Transcript, p. 59). Taken literally, this rule violated the intention of Maryland v. Mathews where the court pointed out that SRS itself had recognized, in promulgating the AFDC tolerance levels, that perfect performance in the administration of a public assistance program was not to be expected and should not be required. 415 F.Supp. 1206, 1212. (See, also, HCFA's later statement at 44 FR 12586 (March 7, 1979) that "it is not feasible for the States to administer an absolutely error-free program.")

The fact that no tolerance level was expressly recognized, however, was palliated by certain countervailing facts. SRS did not systematically test all Medicaid payments or systematically sample them on a reasonable sampling system, but took such information as it had regarding specific paid claims and, without extrapolation to the entire universe of Medicaid cases in a State, based disallowances only on the erroneous payments actually identified. Since only a small segment of all payments made by the State was examined and the disallowance was limited to erroneous payments found in that segment, there was in effect a built-in tolerance level in that the State had the benefit of all payments not examined being treated as made without any error whatsoever.

This approach did not produce a rational control and was erratic in its effect, although on the average it might have been roughly fair. In some cases, this approach might have led to a smaller disallowance than if the State's error rate had been determined based on an unbiased sample with results projected to the universe of all Medicaid payments and only payments in excess of an empirically based tolerance level had been disallowed. In other cases, it might have led to a larger disallowance.

As already noted, California's error rate for payments made in March 1974 for Medi-Cal services rendered in January 1974 was roughly three-tenths of one percent. The error rate for all remaining payments made that year for Medi-Cal services would have had to be drastically higher in order for the State to have reached an overall error rate of even three percent, the rate which the court in Maryland v. Mathews found was not supported as a tolerance level for AFDC payments for ineligibles. The error rate for the remaining payments would most likely have had to be higher still to exceed the standard set for Medicaid by the recently promulgated regulation. Thus, it seems as though California is possibly being penalized in this instance for a performance enormously better than the Department or the court has ever deemed it reasonable to expect.

It must be recognized, however, that there has been no showing that California performed as well with respect to the remaining payments made in 1974, or that a sampling of payments made in March 1974 for services rendered in January 1974 can be used to accurately estimate the error rate for the remaining payments. The State's own audit report, on which the disallowance was based, stated that, "[c]onsidered as a whole, the data on service provided and eligibility are not indicative of good program control." (Reconsideration record, Tab 1, p. 76.) HCFA, although it initially took the position that there was no authority to apply a tolerance level in the absence of a regulation providing for one (Pre-Conference Memorandum, dated 12/28/78, p. 2; Transcript, pp. 56, 61; Post-Conference Memorandum, dated 2/16/79, p. 5), later stated that if the State "had established an error rate so low as to approach perfection, Respondent would probably not have taken a disallowance, although it would not have been precluded from doing so." (Respondent's Response to the Request for Corrections of the Transcript and for Additional Information, dated 3/14/79, p. 2.) HCFA argued, however, that the sample of 994 claims was taken only to determine eligibility within the initial no-record population and was not designed to determine the State's error rate for a larger number of claims. (Transcript, pp. 57-58, 64-67; Post-Conference Memorandum, pp. 4-5; and Respondent's Response to the Request for Corrections of the Transcript and for Additional Information, p. 2.) It may be that the harsh treatment accorded to California in this instance balances other instances in which SRS procedures resulted in exceptionally soft results for California. I have, however, no information one way or the other as to the overall fairness of the results of the approach SRS took.

It is clear that SRS had an important and difficult administrative task to perform to ascertain whether federal funds were being properly used. During the period in question, there was no Medicaid quality control program through which the States' error rates could be reliably ascertained as a basis for setting tolerance levels. Thus, it may not have been unreasonable for SRS to disallow all those payments for services to ineligibles which were actually identified in one way or another, without estimating an overall error rate.

It should be noted that, while the State made a de minimis argument with respect to its error rate, that argument extends as well to the State's cost. (Transcript, pp. 41-42.) That the case has, in context, relatively little dollar importance cuts both ways, however. On the one hand, it would not be a significant burden for the State to absorb the cost of this case. On the other hand, since this is a problem which involves a small amount of funds and which will not recur for periods after the new regulations were promulgated, it would seem that a decision not to disallow would not have significantly damaged HCFA's ultimate goal of encouraging good performance.

Insofar as the issue turns not on the Administrator's correctness in determination of fact or in interpretation of the statute, but on the wisdom of the practice adopted, there is some presumption in favor of the agency's determination in that area and an appropriate reluctance on my part sitting as successor to the Administrator, SRS, to overrule, in the absence of a clear and strong showing, an administrative practice that appears to be permissible. The State in this case has neither made, nor presented any persuasive argument that it could make, a showing that its overall error rate was significantly below the tolerance level invalidated in Maryland v. Mathews, and on these facts, I rule in favor of the agency on this issue. It does not necessarily follow from this decision that the same presumption in favor of the agency's action will be applied in all other cases since a case may turn on issues of fact, law, or policy, or mixed issues, as to which different standards of review may well be appropriate.

C. The parties agree that any disallowance should reflect an adjustment for paid claims for services rendered to medically indigent adults. (Transcript, pp. 13-14, 41.) Persons in that category were eligible for Medi-Cal, but the State was not entitled to and did not claim FFP in its payments involving such persons. Since the audit on which the disallowance was based was conducted for the State's own purposes, however, claims for services rendered to medically indigent adults were included in the roughly 85,000 claims not initially shown to be eligible. Therefore, before a disallowance can be calculated, the amount of claims pertaining to medically indigent adults must be deducted from the value of the 85,000 claims.

The State indicated that 8 percent of its Medi-Cal service costs were for services rendered to persons in that category. Rather than deduct from the value of the 85,000 claims 8 percent of that amount, however, the State took

8 percent of the value of the 85,000 claims and deducted it from 50 percent (the rate of FFP) of the value of 85,000 claims. (Reconsideration record, Tab 6; Letter to Executive Secretary, Departmental Grant Appeals Board, dated 1/23/79, p. 2; Transcript, pp. 13, 41.) In order for the adjustment indicated by the State to be warranted, payments to medically indigent adults would have had to be 16 percent of all Medi-Cal service costs, not 8 percent as claimed by the State.

HCFA pointed out the State's error in its post-conference memorandum (Respondent's Post-Conference Memorandum, dated 2/16/79, p. 1). The State did not contend in either of two submissions filed significantly after the date of service on it of HCFA's post-conference memorandum that an error had not been made.

HCFA in its post-conference memorandum also intimated that the 8 percent figure itself might not be correct, and requested that the case be remanded to it for an accounting of the proper adjustment once the disallowance was sustained. The case has had a long history and there has been ample opportunity to challenge the accuracy of the 8 percent adjustment. HCFA did not, however, indicate on what ground the 8 percent figure might be subject to question and, in view of that fact, I am not inclined to question the accuracy of that figure.

The file indicates that at one time there was a proposal for a settlement of final State liability in this case at $32,000. (Reconsideration record, Tab 16.) Both parties are agreed that that attempted settlement was not binding and has no present effect. (Transcript, pp. 40-41.)

IV. Conclusion.

I therefore conclude that the 45 no-record cases in the sample of 994 cases examined were properly regarded by HCFA as cases of ineligible beneficiaries, making a total of 63 ineligibles out of 994. This ratio may properly be projected to the 84,537 claims initially not shown to be eligible. The projection is made on the basis of number of claims rather than dollar amount of claims, as agreed by both parties (Transcript, pp. 19-20), and is applied to the entire dollar value of the 84,537 claims, less an 8 percent adjustment for claims pertaining to medically indigent adults. This results in a disallowance of 50% (rate of FFP) x 63/994 x [$2,352,300 (value of the 84,537 claims) - $188,184 (8 percent of the value of the 84,537 claims)], or $68,169.

This decision constitutes the final administrative action on this matter.

/s/ Malcolm S. Mason, Chairman