DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: California Department of Health Services
Docket No. 80-71-CA-HC
Decision No. 244

DATE: December 31, 1981

DECISION

The California Department of Health Services (Appellant) appealed a determination by the Health Care Financing Administration (Respondent), disallowing $18,006,058 in Federal financial participation (FFP) claimed under Title XIX (Medicaid) of the Social Security Act. The Respondent determined that the Appellant had made unallowable payments to various providers participating in the Medicaid program.

The major issues presented are whether there can be an "overpayment" to the Appellant within the meaning of Section 1903(d)(2) of the Social Security Act, even though the Appellant has not recovered funds paid to providers, and, if so, whether there is a factually and legally supportable determination here that the disallowed amount does represent such an overpayment. For reasons stated below, we agree with Respondent that generally it may adjust under Section 1903(d)(2) for unallowable payments to providers (including overpayments determined as part of the "cost settlement" process) prior to Appellant's recovery from the providers; we conclude, however, that the Respondent in this particular case has not presented sufficient support for its determination that the Appellant made unallowable payments in the disputed amount.

Our decision is based on the parties' submissions and on the transcript of a hearing held in this case on September 12, 1981.

I. The Scope and Findings of the Federal Audit

The Respondent based its disallowance on an audit report prepared by the Audit Agency of the Department of Health and Human Services (HHS, then Department of Health, Education, and Welfare). 1/

The stated objective of the federal audit was "to evaluate the State's procedures for recovering identified overpayments made to hospitals and skilled nursing facilities" participating in the Medicaid program

1/ "Review of Settlements of Medicaid Overpayments Made by the State of California to Hospitals and Skilled Nursing Facilities for the Period March 1966 through May 1978," Audit Control No. 90204-09, May 29, 1979 (Federal Audit Report).

(called "Medi-Cal" in California). Federal Audit Report, p. 2. The auditors described the scope of their review as follows:

> We reviewed the procedures established at the State level and at MIO (Blue Cross-South) for recovering amounts due from community hospitals and skilled nursing facilities and the State's procedures for obtaining recovery from county hospitals. Since appeals from providers were an integral part of the overall system for recovering overpayments, we also reviewed the State's appeal function.
> Federal Audit Report, p. 3.

MIO was the State's fiscal intermediary for processing and paying Medi-Cal claims from certain service providers.

The federal auditors determined, generally, that the Appellant's policy was to defer adjustments of the federal share of any overpayment made to a hospital or skilled nursing facility until the Appellant had actually collected the overpaid amount from the provider. If the Appellant lost the right to recover the overpayment from the provider because the State statute of limitations had run or for some other reason, the Appellant's policy, the auditors determined, was never to adjust for the federal share. According to the auditors, federal policy required adjustment of the federal share prior to recovery in both instances.

Based on an examination of accounts receivable records, the federal auditors recommended a financial adjustment of approximately $18 million dollars of FFP related to three audit findings. Briefly, these findings were that --

1) The Appellant did not adjust its claim for FFP in overpayments identified through "cost settlement" audits of community and county hospitals and skilled nursing homes where the providers had appealed the audit determinations and the appeals were still pending ($16.1 million). (This type of audit examines a provider's actual costs, as a basis for establishing the final rate of payment to the provider for services rendered.)

2) The Appellant did not adjust its claim for FFP in overpayments to community hospitals and skilled nursing facilities where MIO had been unable to collect the overpayments from the providers and had transferred the accounts to the Appellant. These amounts were either carried as "accounts receivable" on the Appellant's records ("delinquent accounts" - $5 million) or had been written off as being

uncollectible because the State statute of limitations had run, because the provider had been declared bankrupt, or for some other reason ("discharged accounts" - $5.4 million).

3) The Appellant did not adjust its claim for FFP in payments to five hospitals which had been found to have increased their bed capacities without proper authorization. Because of ongoing litigation on the issue, the Appellant had deferred collection of the amount associated with the increased bed capacity issue and of other overpayments to the hospitals, identified by audit ($9.3 million).

The auditors determined the amounts associated with these three findings by examining the accounts receivable records of the Appellant and the fiscal intermediary, MIO. (The total amount found was $36,012,117; the FFP amount $18,006,058.)

II. The Respondent's Determination and the Issues on Appeal

The notice of disallowance, issued by the Director of Respondent's Bureau of Program Operations on March 11, 1980, discussed the audit findings described above and adopted the audit recommendation to disallow $18,006,058 in FFP. Citing Section 1903(d)(2) of the Social Security Act (the Act)2/ and 42 C.F.R. 447.296, 3/ the Director stated:

> This adjustment must be made whether or not California has yet recovered, or ever will recover, the amount of overpayments from the providers. The HEW policy in this matter is consistent with the language in the act and the regulation. States are required to adjust the Federal share of any overpayments in full upon

2/ Appellant contended on appeal that the Director's citation to Section 1903(d)(2) as a basis for disallowance was inconsistent with a statement in the Federal Audit Report that Section 1903(d)(2) did not apply to the overpayments here. The auditors were referring to the second sentence of the section, however, and the Director quoted from the first sentence, so we do not find any inconsistency.

3/ This provision was originally published at 45 C.F.R. 250.30(a)(3)(ii)(G), was redesignated as 42 C.F.R. 450(a)(3)(ii)(G) on September 30, 1977, and was recodified as 42 C.F.R. 447.296 on September 29, 1978, without substantial change. The relevant portion requires that "overpayments found in audits" of nursing facility costs be accounted for "no later than the second quarter following the quarter in which found."

> completion of an audit. They cannot wait until the appeal process is completed and overpayments are collected before adjusting the Federal share of costs claimed.
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> Notice of Disallowance, p. 2.

On appeal, Appellant made two major arguments. Appellant contended that Section 1903(d)(2) must be read together with Section 1903(d)(3) of the Act to provide that where, as here, payments are made for "medical assistance furnished under the State plan" they cannot be considered an "overpayment" to the State to be adjusted under 1903(d)(2) until the State recovers them.

Alternatively, Appellant argued that, even if the Respondent could disallow for these overpayments prior to recovery by the Appellant, the Federal Audit Report was limited in scope and did not provide a sufficient factual and legal basis to support disallowance of the amounts here. These issues are addressed separately below.

III. Whether There Can Be an Overpayment To Be Adjusted under Section 1903(d)(2) Prior to Recovery of the Funds by the State

Section 1903(d)(2) (first sentence) of the Act provides that Title XIX payments to the States, based on estimated quarterly expenditures, shall be reduced "to the extent of any overpayment . . . which the Secretary determines was made . . . for any prior quarter . . . ." 4/ Section 1903(d)(3) provides:

> The pro rata share to which the United States is equitably entitled, as determined by the Secretary,

4/ The second sentence of Subsection (d)(2) provides:

> Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

Section 1902(a)(25) requires that a State plan provide that the State will "take all reasonable measures to ascertain the legal liability of third parties to pay for care and services" and will seek reimbursement to the extent of any such legal liability. Generally, third party liability arises where a Medicaid recipient is covered by some form of insurance or where another person has injured a Medicaid recipient through tortious conduct.

> of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.
> (Emphasis added.)

In support of its position that Subsection (3) prohibits the adjustment of a State's quarterly statement of expenditures for the overpayments here prior to recovery of the overpayments, Appellant relied on the principle of statutory construction that the specific rules over the general. Transcript (Tr.), pp. 100-105. According to the Appellant, the payments in question here were payments "with respect to medical assistance furnished under the State plan" because they were payments to Medi-Cal providers for services to eligible recipients. Unlike improper payments, such as payments for ineligible recipients, the Appellant argued, the "cost settlement" overpayments here were made in accordance with State plan provisions. Since the State plan authorizes the making of an interim payment to a Medi-Cal provider, subject to adjustment when a final rate is determined, the Appellant argued, a "cost settlement" overpayment to a provider cannot be considered an "overpayment" for Subsection 1903(d)(2) purposes until recovered.

The Respondent contended that, although the original payments to the providers may have been made under the State plan, they were made only on an interim basis and, once a final rate was established through the cost settlement process, any excess paid under the interim rate became unallowable under the State plan. 5/

We agree with Respondent. An overpayment to a provider, determined by a difference between an interim payment to the provider and the final payment to which the provider is ultimately entitled, is not medical assistance furnished under the State plan. "Medical assistance" is defined in Section 1905(a) of the Act as "payment of part or all of the cost" of covered care and services. The interim rate does not determine the appropriate cost of the services. The State plan may

5/ At the hearing, Respondent appeared to be relating Subsection 1903(d)(3) to the third party liability provision in the second sentence of (d)(2), quoted in note 3 above. Tr., pp. 11-15. While Subsection 1903(d)(3) was added to the Act in 1967 with the second sentence of (d)(2), by its plain language Subsection (d)(3) has potentially broader application, applying to any recovery of an amount which is "medical assistance furnished under the State plan." Thus, we do not think it is necessarily limited to the third party liability situation.

provide for such provisional payment, but it also establishes the limits of final payment. Thus, the overpayment, while not improperly made initially, cannot be considered to be medical assistance furnished under the State plan. 6/

Subsection (d)(3) is more specific than (d)(2), but it simply does not apply to costs which are not allowable "medical assistance" costs. Therefore, Subsection (d)(3) does not preclude adjustment for such costs prior to recovery.

The more general language of Subsection 1903(d)(2) has been consistently read together with Section 1116(d) of the Act, which provides for reconsideration of a determination that "an item or class of items on account of which Federal financial participation is claimed . . . shall be disallowed . . . ." Under this construction, a determination that a State has claimed and received FFP in unallowable costs is tantamount to a determination that the disallowed amount is an overpayment to be adjusted under subsection 1903(d)(2). See, 45 CFR 201.10 et seq.; California Department of Health Services, Decision No. 159, March 31, 1981; Solomon v. Califano, 464 F. Supp. 1203, 1204 (D. Md. 1979).

6/ There is a further issue here, discussed by the parties, which we do not need to reach in the context of this case. Appellant argued that there was no State determination of the final rate until exhaustion of the provider appeal process. Respondent, on the other hand, pointed to regulatory provisions related to reimbursement of costs for nursing homes in the Medicaid program. These regulations state that, following cost settlement audits, a State "must account for overpayments found in audits on the quarterly statement of expenditures no later than the second quarter following the quarter in which the overpayment was found." The State argued that "found" in this provision meant "found as a result of recovery" or, alternatively, "found as a result of the provider appeal process." While either reading seems strained in view of the usual meaning of an audit "finding," the Respondent apparently took the position that an overpayment was not finally "found" until exhaustion of the provider appeal process in a section of the Medical Assistance Manual, transmitted to the States as AT-77-85. On the other hand, a statement in the preamble to the final regulations at 41 Fed. Reg. 27304, July 1, 1976, indicates a different interpretation of the term "found." It is not clear how the regulations or manual provisions affect the time period here, or relate to payments to providers other than nursing homes. In any event, we need not reach the issue in view of our holding below.

Moreover, we are not convinced by the Appellant's argument that adjustment for cost settlement overpayments prior to recovery by the States contravenes Congressional intent to advance money to the States to operate their programs. Although Congress did provide for advance payment, based on States' estimates of their costs, Congress also specifically provided for adjustments where the Secretary determines that an overpayment was previously made. Congress did not limit this general authority to situations where a State has recovered the funds in question.

A further issue has been raised here, however, regarding the basis for the Respondent's determination that these amounts, indeed, do represent unallowable costs and therefore constitute an overpayment to be adjusted. This issue is discussed below.

IV. Whether the Disallowance Appealed Is Factually and Legally Supported by the Record

As stated above, the Respondent relied on the Federal Audit Report, which in turn relied on accounts receivable records of the State and of the fiscal intermediary, for determining the amount of overpayments to be disallowed. Respondent contended that these records were sufficient as a basis for disallowance since they were derived from State audits and its experience was that such State audits were reliable. Since Appellant itself identified these costs as "overpayments," Respondent argued, Appellant bears a burden of establishing that they are allowable costs.

The Appellant challenged use of the Federal Audit Report as a basis for the disallowance determination, stating that the audit was limited in scope to determining whether the State was complying with the proper procedures for adjusting for overpayments to providers and did not itself identify any overpayments. The Appellant further contended that the disallowance letter issued by Respondent was legally deficient because it did not cite to any provision of Federal law or regulations, or of the State plan, which would support a determination that the disallowed costs were unallowable. Citing the case of Solomon v. Califano, 464 F. Supp. 1203 (D. Md. 1979), 45 CFR 16.91 (1979), and "basic tenets of due process," the Appellant argued that the grounds for a disallowance must be clearly articulated. Appellant's Opening Brief, p. 23.

In California Department of Health Services, Decision No. 159, March 31, 1981, the Board reversed a disallowance because the record was inadequate to support the factual and legal determination that the appellant there had claimed FFP in unallowable costs. We

conclude that the record before us in the present case is similarly inadequate for the following reasons:

- While the Respondent has shown that some of the amounts here may be related to payments identified by reliable State audits as "overpayments" to providers, there is a substantial question as to whether all the accounts receivable figures were derived from reliable audits. Respondent's witness at the hearing, one of the auditors who performed the Federal Audit, testified that a study had been done which showed that most State audits were performed in accordance with generally accepted principles and were reliable. Tr., pp. 49-58. This testimony was not related to the entire time period in dispute, however, and was too vague to form the basis for a conclusion that all the "overpayments" reflected in the accounts receivable records were derived from such audits. Moreover, the Federal Audit Report itself indicates that some of these overpayments were identified in MIO desk audits or in audits performed by independent accountants rather than the State. Federal Audit Report, p. 9. In addition, there is no formal finding in the Federal Audit Report regarding the source of the accounts. There is nothing in the Federal Audit Report to relate the accounts to any specific audits and only minimal identification of the particular providers involved. With respect to Audit Finding No. 3, involving over $4.7 million in FFP, the Respondent's witness acknowledged that the "finding" that the five hospitals had improperly increased their bed capacities was not made as part of the State's regular audit processess in the Medi-Cal program but was the result of a legislative review and that such reviews are often headline-seeking devices. Tr., p. 69.

- The Appellant alleged, and Respondent did not deny, that the accounts receivable figures may also have included some "overpayments" charged against a provider because the provider had failed to obtain payment from a third party payor which was liable for the services provided. 7/ Where third party liability is the

7/ The Appellant stated:

> Between the advent of the Medi-Cal program in 1966 and approximately 1970, all Medi-Cal providers were required to bill third party payors. Where the state thought a provider had failed to properly bill third party payors prior to billing the state, it alleged an overpayment against the provider. After about 1970, Medicare and CHAMPUS continued to be billed directly by the skilled facilities and hospitals which are the subject of this audit. Finally in about 1976 the state decreed that skilled nursing facilities (SNF) and hopsitals would also bill two major HMO's . . . .
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> Appellant's Opening Brief, p. 2.

basis for an "overpayment" finding by the State, there is a question as to whether recovery by the State is a prerequisite to adjustment under Section 1903(d). See note 4 above.

- The Appellant alleged that the accounts receivable figures included some "overpayments" to providers in which the Appellant had not claimed FFP since they related to services funded solely by the State. The disallowance represents a straight 50% of the total "overpayments" listed on the accounts receivable records, which would be incorrect if some of the provider payments were State-only payments. At the hearing, the Respondent offered to show in a post-hearing submission that the State audits which created the accounts receivable did separate out the payments subject to FFP from those which were not. Tr., p. 135. Even if we provided the Respondent with the opportunity to make such a showing, however, there would be a further question as to whether the accounts receivable figures to which the 50% was applied reflected the separation and included only payments reimbursed at the 50% rate.

- Although Respondent's own policy permits a State to delay adjustment of FFP for up to six months after an overpayment is "found" as a result of a cost settlement audit, see note 3 above; Tr., pp. 33-35, the Federal Audit Report indicates that the disallowance included "overpayment" amounts where the provider appeal had been pending less than six months. Federal Audit Report, pp. 11-12. This may have included amounts related to audit findings less than six months old, but neither the auditors nor the Respondent discussed this question.

- With respect to Audit Finding No. 3, the Appellant, while reluctant to make any statement which might jeopardize its litigation with the hospitals, has shown that the increased bed capacity issue involves a complex question of State law. If the Appellant does recover ultimately from the hospitals, it is not clear that it will recover the total amount paid to the hospitals during the relevant time period or merely those costs associated with the increased capacity. 8/ As the Board stated in Decision No. 159, cited above,

8/ The Respondent attempted at one point during the course of our proceedings to establish a basis for determining that the full amount paid to the hospitals represented costs unallowable under Federal requirements. This analysis, however, was based in part on the misunderstanding that California was a State which had an agreement under "Section 1122" of the Act, relating to reimbursement of providers' capital expenditures. The Respondent subsequently acknowledged that California was not a Section 1122 State. Respondent's Submission of November 21, 1980.

where a State is involved in litigation with a provider we may consider that as a factor in determining what burden we will place on the State to dispute the Federal findings.

- The Federal Audit was limited to examining the Appellant's procedures and reviewing the accounts receivable records. The Federal auditors did not themselves examine the question of whether overpayments, in fact, had been identified which represented costs unallowable as charges to federal funds, nor specifically examine the question of reliability of any audits from which the accounts receivable figures may have been derived.

Considering all these factors together, we conclude that the record is insufficient as a basis for upholding the disallowance of over $18 million in FFP, claimed over a 12-year period. In reaching this conclusion, however, we do not adopt the State's position completely. The Federal Audit here is not defective as a basis for disallowance merely because the focus of the audit was on Appellant's compliance with procedural requirements. A compliance-type audit may provide a sufficient basis for disallowance if it also contains findings adequate to support a determination that a grantee has charged unallowable costs to federal funds. Moreover, a compliance-type audit may be sufficient if a finding of noncompliance necessarily leads to the conclusion that unallowable costs were incurred. In such circumstances, a burden may be placed on a grantee to establish the amount of unallowable costs. Cf., Massachusetts Department of Public Welfare, Decision No. 155, March 20, 1981; Ohio Department of Public Welfare, Decision No. 226, October 30, 1981.

Where, as here, however, a federal audit merely adopts figures from State records, assuming that overpayments for State purposes are necessarily overpayments for federal purposes, and where the State has shown that this assumption may not be warranted, the Respondent must provide more specific evidence and authority to support its allegations.

We do not hold here that Respondent may never base a disallowance on findings adopted from a State audit. However, Respondent should not adopt State audits where there are indications that the State audits are not reliable. California Department of Benefit Payments, Decision No. 71, December 14, 1979; see, also, Federal Management Circular 73-2.

Also, a deficient disallowance letter does not necessarily lead to reversal of the disallowance, so long as the defects are cured during the course of the appeal and the appellant has an adequate opportunity to respond to any issues raised by the respondent. New York Department

of Social Services, Decision No. 151, February 26, 1981. Here, however, while Respondent ultimately cited some authority for determining that the disallowed amounts related to unallowable costs, Respondent has never provided us with a sufficient analysis of the relationship of those authorities to the time periods and amounts involved here. 9/

V. The Effect of Our Decision

Our decision here is not based on a legal conclusion that Respondent misapplied the law nor a factual finding that Appellant did not make unallowable overpayments. Therefore, our decision does not preclude Respondent from disallowing amounts which may have been included in the accounts receivable figures here, so long as Respondent identifies a sufficient factual and legal basis for doing so.

Conclusion

For reasons stated above, we agree with Respondent that Subsection 1903(d)(3) does not preclude adjustment for unallowable costs, including overpayments which represent the difference between an interim and final rate of reimbursement to a provider, since such costs are not "medical assistance furnished under the State plan." We further conclude that the disallowance here should be reversed because there is not sufficient support in the record for a determination that the disallowed amount actually represents costs which were unallowable under applicable federal requirements. Nothing in this decision precludes the Respondent from making a new determination.

/s/ Cecilia Sparks Ford

/s/ Donald F. Garrett

/s/ Norval D. (John) Settle, Presiding Board Member

9/ For example, the Respondent cited provisions on reasonable cost reimbursement for providers. However, these provisions went through numerous changes during the time period in question here. In addition, earlier versions of some of these provisions indicate that a State might be permitted to pay some providers in excess of costs determined under applicable principles so long as average payments to providers did not exceed prescribed limits. See, e.g., 45 C.F.R. 250.30(b)(6) (1976).