DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Florida Department of Health and Rehabilitative Services
Docket Nos. 79-68-FL-HC
80-88-FL-HC
Decision No. 105

DATE: June 17, 1980

DECISION

The Florida Department of Health and Rehabilitative Services appealed two determinations, made by the Health Care Financing Administration (HCFA), disallowing a total of $1,255,087 in Federal financial participation (FFP) claimed under Title XIX of the Social Security Act for payments for certain pharmaceutical services rendered during the period ended March 31, 1977. The basis stated for the disallowances was that the payments were "duplicate" payments because FFP had previously been claimed and allowed for premium payments to Paid Prescriptions, Inc. (PAID), under an insurance-type contract requiring PAID to cover the costs of services rendered during the period in question. The appeals have been considered jointly upon the request of the State and without objection by HCFA.

There are no material issues of fact in dispute. We have, therefore, determined to proceed to decision based on the written record and briefs. We conclude that, for the reasons stated below, the disallowances should be upheld.

Background

In administering a Medicaid program under Title XIX, pursuant to an approved State plan, a State may enter into contracts with entities called "health-insuring organizations," which, in exchange for a premium or subscription charge paid by the State, pay for services provided to eligible Medicaid recipients and assume an underwriting risk.

Under such a contract, PAID had administered the Florida Medicaid drug program from July 1, 1974 to June 30, 1976. Apparently, PAID sustained certain deficits during this period because of removal for a time of a $20 "cap" on the cost of certain drugs. The parties were requested to explain the temporary removal of the $20 limit, but have not done so.

In June 1976, after a competitive bidding process, the Florida Department of Health and Rehabilitative Services awarded to PAID a new three-year contract under which the State paid a monthly insurance premium to PAID totaling approximately $27 million annually. From this premium, PAID was required to pay pharmacists who provided drugs to eligible Medicaid recipients. The 1976 contract specifically provided that PAID could not use the new contract premiums for obligations incurred prior to June 1976.

In violation of this provision, PAID used approximately $3.2 million in 1976 contract premiums to pay prior contract obligations. On January 12, 1977, upon learning of PAID's misuse of funds, the State gave PAID a Notice of Contract Termination. Pursuant to the contract, the State allowed PAID a 60-day period to cure contract deficiencies, including the use of premiums for payment of prior contract obligations and the failure to provide a performance bond. PAID was unable to cure these deficiencies within the 60-day period, and the State terminated the contract effective April 1, 1977. The State claimed and received FFP for premium payments to PAID for periods prior to the contract termination.

As of March 31, 1977, PAID owed approximately $3.2 million in provider claims and administrative costs. The State initiated suit against PAID and an affiliated organization in the Circuit Court for Leon County, Florida, seeking to force PAID to fulfill its contractual obligations. The Florida Pharmaceutical Association, Inc., on behalf of the providers to whom PAID owed money, intervened in that lawsuit and obtained an injunction on May 19, 1977, ordering the State to process and pay Medicaid drug claims incurred prior to March 31, 1977, and subrogating the State to any and all claims of Florida pharmacists against PAID.

Subsequently, the State made the court-ordered payments, through a fiscal agent, for drug services which were covered by the premium payments to PAID. The State's claim for $1,085,672 in FFP for these services was disallowed by the Director, Medicaid Bureau, HCFA, by letter dated March 9, 1979 (Docket No. 79-68-FL-HC). An additional claim for $169,415, also for services which should have been covered by the contract with PAID, was disallowed by letter dated April 14, 1980, signed for the Director, Bureau of Program Operations, HCFA (Docket No. 80-88-FL-HC).

Payments Pursuant to Court Order

The State concedes that its claim is, in essence, a claim for duplicate payments but asserts that FFP is nonetheless available, relying primarily on the terms of 45 CFR 205.10(b)(3), 38 FR 22007, August 15, 1973. That section provides--

(b) Federal financial participation is available for the following items:

(3) Payments of assistance within the scope of Federally aided public assistance programs made in accordance with a court order.

The State's position is that the disallowed amount represents payments made pursuant to the court order obtained against it by the Florida pharmacists, and the plain meaning of the words used in Section 205.10(b)(3) controls. The State cites the case of Caminetti v. U.S., 242 U.S. 470 (1917), as holding, "In the absence of ambiguity or conflict, the plain meaning of a statute or regulation will not be disturbed."

The State's argument that this section applies to the court-ordered payments here is unpersuasive for several reasons. First, the argument is based on the premise that the meaning of the section is clear and unambiguous. Ambiguity may arise, however, where a provision of otherwise seemingly broad application is placed in a context which indicates that it was intended to be read more narrowly. Section 205.10 deals with requirements for providing fair hearings to applicants for, or recipients of, assistance who are aggrieved by State agency action. It allows, for instance, for FFP in court-ordered payments to an individual applicant even though a state had initially determined that the individual was ineligible under the state plan. Given this context, Section 205.10(b)(3) is ambiguous, and, according some deference to HCFA's interpretation, we conclude that the section was not intended to apply in the circumstances of this case. The court proceeding here was not an appeal of an agency determination denying benefits but a contractual dispute, caused by PAID's default, in which the court subrogated the State to the rights of the providers.

There is a further policy reason for not applying Section 205.10(b)(3) here. Adopting the State's reading of the section would allow a state to receive FFP for any payments pursuant to court order regardless of the lack of statutory basis for the payments and the state's role before the court. It would reduce the states' incentive to seek full reimbursement from a defaulting contractor or other party which should bear the costs, rather than settling for a lesser amount and claiming FFP in the loss.

In reaching the conclusion that Section 205.10(b)(3) is inapplicable in the circumstances of this case, we do not imply, however, that HCFA is correct in its argument before the Board that the payments in question were not within the scope of Title XIX because they were payments to providers rather than to applicants or recipients. Medicaid assistance is provided

generally through payments to providers, and the Board might find, in another case, that Section 205.10(b)(3) applied to such payments, where made pursuant to a court order following a Section 205.10 hearing.

Requirements for Contracts with Health-Insuring Organizations

Medicaid regulations require that state plans provide for certain types of provisions to be included in contracts with health-insuring organizations. The contract with PAID entered into in June 1976 appears to have been subject to 45 CFR 249.82, as published at 34 FR 3873, February 27, 1971. Amendments to this section were published on May 9, 1975 (40 FR 20516), but their effective date was delayed until August 9, 1976 (42 FR 51583, September 29, 1977). Section 431.512(a)(5)(i) of 42 CFR, cited in the HCFA disallowance letter, was not added until September 29, 1978 (43 FR 45188). (See, also, redesignation at 42 FR 52857, September 30, 1977.)

Section 249.82(a)(1) of the 1971 regulations, defining "arrangements with health-insuring organization," includes as a characteristic of such an arrangement that--

> [T]he State agency would not pay for any loss incurred by the contractor from claims exceeding premiums paid or from increases in administrative costs of the contractor during the covered period....

Section 249.82(b)(1)(iii) requires that State plans under Title XIX must provide that contracts with health-insuring organizations, as a minimum, will--

> Provide that the premium payment constitutes full discharge of all responsibility by the State for costs of covered medical care and services provided to covered eligible recipients during the contract period.

The State complied with the literal requirements of this section by including in its contract with PAID a clause which provides that--

> Payment of the premiums to Contractor for the Contract period constitutes the full discharge of all responsibility of State Agency for costs of covered benefits....
>
> Agency Record, TAB 1, p.20.

As discussed in the Order to Show Cause issued in this case, it would seem, however, that the purpose of the regulatory requirement is not merely that contracts pursuant to the state plans contain such provisions,

but that the states, and thus, indirectly, the Federal government, should be effectively released from further liability where they bear premium costs adjusted to reflect the risk which the contractor has assumed.

The Order directed the State to show cause why the disallowance should not be upheld on the ground that the purpose of Section 249.82(b)(1)(iii) is to preclude FFP in "duplicate" payments such as the amount claimed here. The State, in response, did not specifically address this issue. HCFA, on the other hand, merely responded to the Order with a conclusory statement that the regulations must be read to release the Federal government from further liability once it has participated in premium payments. In the absence of any showing by the State that HCFA's reading is incorrect, however, we will apply the Agency's interpretation that the regulation was not intended merely to require inclusion of the release clause in the contract but also to have the effect of prohibiting FFP in payments which should have been covered by the premiums.

Other Considerations

The court's order, resulting from concern that, if the providers were not paid, some would go out of business or refuse to serve Medicaid recipients and the program beneficiaries would therefore suffer, undeniably placed the State in a difficult position. The State had to pay costs which should have been covered by the contract. The State will, according to information provided by the State, recover from PAID and its affiliates only after protracted litigation and, even then, will not recoup the entire amount. Nonetheless, the State's general argument that the Federal government and the State are "partners in the medicaid venture" is not a sufficient basis on which to provide FFP in the State's loss. The Federal government's partnership in the Medicaid program is circumscribed by the applicable statutory and regulatory provisions. Moreover, while it appears that the State did monitor the contract carefully, it also appears that the State was aware, when it entered the second contract with PAID, that PAID had sustained deficits during the previous contract period and might have some difficulty meeting its obligations. Placing the burden on the State to deal only with reliable contractors is consistent with the procurement standards for grantees in 45 CFR Part 74, Subpart P, as in effect at the time the 1976 contract was awarded to PAID (See, 38 FR 26285, September 19, 1973), and with general principles of grant law.

We are also not persuaded that the Federal government should bear part of the loss based on the State's representation that HCFA officials agreed that the Federal government would participate in the State's loss.

Even if the record supported this contention, which it does not, it is questionable whether Federal officials can obligate the Federal government to pay for costs not authorized by the statute or the implementing regulations.

Conclusion

For the reasons stated above, we have determined to uphold HCFA's disallowances in the amounts of $1,085,672 (Docket No. 79-68-FL-HC) and $169,415 (Docket No. 80-88-FL-HC), claimed for payments to providers of pharmaceutical services which should have been covered by premium payments to PAID.

/s/ Donald G. Przybylinski

/s/ Robert R. Woodruff

/s/ Frank L. Dell'Acqua, Panel Chairman