DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: Maine Department of Human Services
Docket No. 78-24-ME-HC
Decision No. 172

DATE: April 30, 1981

DECISION

The Maine Department of Human Services (State) appealed a decision of the Administrator of the Health Care Financing Administration (HCFA or Agency), upholding a disallowance by the Regional Commissioner, Region I, of $66,242 claimed by the State as Federal financial participation (FFP) for "buy-in" premiums under Titles XVIII and XIX of the Social Security Act for the period July 1, 1976 through December 31, 1976.1/

Based on the parties' submissions and briefing, an informal telephone conference, and the State's response to the Board's Order to Show Cause, we uphold the disallowance.

Background

"Buy-in" premiums are premiums which a State pays to the Federal government under Section 1843 of the Social Security Act (42 U.S.C. 1395v) on behalf of eligible persons for Supplemental Medical Insurance Benefits (SMIB). The State may seek FFP for the premiums under Section 1903(a)(1) of the Act (42 U.S.C. 1396b(a)(1)).

HCFA based the disallowance on a regulation (45 CFR 249.41(c)(1)) which generally limits FFP in "buy-in" premiums to payments made on behalf of "money payment" recipients; i.e., those individuals who received payment in cash, by check, or by immediately redeemable warrant, with no restriction on the recipient's use of the payment (see 45 CFR 234.11; this meaning of the term apparently dates to the mid-1930's).

The record developed by the parties indicates that the disallowance reflects "buy-in" payments by the State on behalf of residents of Intermediate Care Facilities (ICFs) who are not "money payment" recipients. Their care was

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1/ The record in this case also contains evidence and argument presented by the parties in the appeal of an earlier disallowance of $1,208,194 for the period from July 1, 1969, to June 30, 1976 of FFP for "buy-in" payments (Board Docket No. 78-34-ME-HC). This appeal was dismissed on February 8, 1979, because final action by the HCFA Administrator on reconsideration of that disallowance was taken prior to the March 6, 1978 transfer to the Board of jurisdiction over reconsideration cases.

paid for through payments under Title XIX of the Act directly to the ICF. Apparently, for some of these persons, care formerly was paid for under Title XVI (AABD). Record of Reconsideration, item 8; Amended Application for Review, p.7; Memorandum in Support of Appellant's Response to Order to Show Cause (Appellant's Response), p.1.

During reconsideration, the State indicated that it had begun in October, 1974, to "clean up the buy-in list" at all ICFs to comply with §249.41(c)(1), but that "technical problems involved around the area of ID numbers" prevented a complete solution. Record of Reconsideration, item 13. The State argued that, overall, expenditure claims submitted to HCFA would have been the same even if the State had fully met the requirement of the regulation. Id.2/ The Agency acknowledged that the State was correct that in most instances, Medicaid costs overall would be the same. Reconsideration Decision, p.2. The Agency's position was that its intent was to assure that the proper program bore its proper charge. Record of Reconsideration, item 12, p.5. The State, in turn, responded that while "certainly a fair reading of 45 CFR 249.41(c) would lead one to [the] conclusion" that FFP was unavailable for non-money payment recipient premiums, "the statutory language is a good deal more complicated and in fact may be at odds with the conclusion that the regulations would lead one to reach." Record of Reconsideration, letter from Robert W. McGraw to HCFA Administrator dated May 3, 1978 (unnumbered item).

The State admitted that it "bought-in" for non-money payment recipients, and that 45 CFR 249.41(c) on its face would prohibit FFP for the premiums in question. Amended Application for Review, p.5; Appellant's Response, p.1. The State argues that the regulation is administratively irrational and inconsistent with the Act.

Major Applicable Provisions of Law and Regulation

Section 1903(a)(1) of the Act authorizes FFP in--

> . . .expenditures for premiums under Part B of title XVIII, for individuals who are eligible for medical assistance under the [Title

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2/ However, in the right circumstances, the State can experience savings through "buy-in": since Titles XVIII (Medicare) and XIX (Medicaid) both can result in provision of essentially the same medical services to the aged poor, payment by the State of premiums for services which are fully federally funded means the State pays less than if it provided the same services under Medicaid and received FFP. The State argues that there is no difference between the amount of expenditures claimed here by the State and the amount that would have been claimed by the individual recipients had they bought-in for themselves, so that the Agency's decision to deny FFP is arbitrary and capricious. Appellant's Response, p.3. We discuss this argument infra, at p.7.

> XIX] plan and (A) are receiving aid or assistance under any plan of the State approved under Title I, X, XIV, or XVI, or Part A of Title IV, or with respect to whom supplemental security income benefits are being paid under Title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration and scope to the medical assistance made available to individuals described in Section 1902(a)(10)(A). . . (emphasis added).

Section 1843 of the Act, which is the provision dealing with "expenditures for premiums under part B of title XVIII" mentioned in Section 1903(a)(1), states in pertinent part as follows:

> (a) The Secretary shall, at the request of a State. . .enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.
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> (b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:
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> (1) individuals receiving money payments under the plan of such State approved under Title I or Title XVI; or
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> (2) individuals receiving money payments under all of the plans of such State approved under Titles I, X, XIV, and XVI, and Part A of Title IV. (emphasis added)

45 CFR 249.41(c), as codified during the period relevant here, stated:

> There will be no [FFP] in the monthly insurance premium under Title XVIII, Part B of the Act which the Title XIX State agency pays on behalf of nonmoney payment individuals eligible to receive medical assistance under Title XIX of the Act, except for [individuals falling in categories not alleged to be relevant here].

Discussion

The parties acknowledged that this case does, in fact, arise under a "buy-in" agreement entered into under Section 1843(a). The Agency's argument is that the regulation chiefly involved in this appeal, 45 CFR 249.41(c), was in fact based on both Sections 1843(b) and 1903(a)(1), although HCFA's brief (styled a "motion to dismiss or in the alternative for summary judgement" because it was largely directed to the earlier dismissed action) mentioned only Section 1903(a)(1) as the basis for the regulation. See Discussion in the Board's Order to Show Cause, p.4.

The State's arguments, the Agency's responses, and our analysis are as follows:

1. The State's main argument was stated somewhat differently in its original Application for Review (pp. 2-3) and the later Amended Application for Review (pp. 5-7), but apparently can be summarized and restated for clarification as follows:

   — A former Section 1121(a) of the Social Security Act, effective January 2, 1968 but deleted from the Act effective January 1, 1972, authorized assistance in the form of institutional services under Title XVI(AABD) in ICFs to persons otherwise also entitled to "money payment" assistance.

   — Section 1903(a)(1) does not specify the eligibility of only "money payment" recipients. It authorizes FFP for Title XVIII "buy-in" premiums for those persons who are eligible for medical assistance under the Title XIX plan and ". . .(A) are receiving aid or assistance under any plan of the State approved under title. . .XVI. . . ." Section 1903(a)(1) has been in the law in substantially its present form since 1965.

   — Reading the two provisions together, the State argued that the statutory scheme originally laid out by Congress called for persons who receive "aid or assistance" under Title XVI(AABD) (in the form of institutional services) to qualify to have their "buy in" premiums covered under Section 1903(a)(1), whether or not they are "money payment" recipients.

   We think there are two obvious difficulties with this position of the State.

   First, Section 1121 was repealed in 1972 and, so far as the record indicates, has no bearing on the disallowance in this case (whether or not the provision is relevant to disallowances for earlier periods covered by the previously dismissed appeal is not a question before the Board). In response to the Board's Order to Show Cause, the State admitted that former Section 1121 was "not applicable to the time period at issue in this appeal," yet argued that the provision "underscores the position that non-money payment recipients qualify to have their buy-in premiums covered under the Medicaid program." Appellant's Response, p.2. While that position might have been arguable prior to repeal of the provision, it is unpersuasive for this disallowance.

   Second, even if the provision were somehow applicable in this appeal, the State originally failed to note the impact of the provisions of Section 1843(b) which restrict the applicability of that provision to

"money payment" recipients. Any ambiguity arising from the relationship of the general language of Sections 1121 and 1903(a)(1) is resolved by the express limitations of Section 1843(b), where there is a "buy-in" agreement under that section.

When this was pointed out in the Board's Order to Show Cause, the State responded by arguing that another provision of Section 1843--paragraph (h)--permits coverage of all persons eligible for assistance under the State's Medicaid program. Appellant's Response, p.2. Section 1843(h)(1) states:

> The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under Title XIX.

By its express terms, this provision is not applicable in the absence of a modified agreement requested prior to 1970, and neither party has produced evidence of such a modification.

The State also pointed to 45 CFR 234.120 as support for the proposition that assistance under Titles I, X, XIV, XVI, and IV-A of the Act extends to payments of kinds other than cash payments (e.g., rent payments to housing authorities, vendor payments, foster care payments). But §234.120 is merely a general summary of what types of assistance are available to individuals under various other provisions of that chapter of the Code of Federal Regulations, and does not conflict with the specific provisions of §249.41. More importantly, vendor payments to ICFs under §234.120(e) are only considered vendor payments "in a state that did not, as of January 1, 1972, have an approved plan under Title XIX," and the State has admitted that as of January 1, 1972, it was paying for ICF services under Title XIX. Amended Application for Review, p.6. These vendor payments therefore could not be assistance under Title XVI (see first paragraph of §234.120).

Furthermore, even if there were no specific legal basis for differentiating between "money payment" and "non-money payment" recipients, the Agency's argument that it has to be concerned with attributing expenditures to the proper program would deserve serious consideration, even if charges to the Title XVIII or Title XIX programs might, in the right circumstances, be the same.

2. The State also argued that ". . .the application of 45 CFR §249.41 was clearly intended to be confined solely to those ICF services paid for

under Title XIX, something Maine did not begin to do until January 1, 1972." Amended Application for Review, p.7. Again, this appears to reflect some confusion about the timing of the disallowances in question in this case, where the disallowances were for expenditures in 1976.

3. The State argued that the policy decision reflected in the disallowances is unreasonable because it would impose undue administrative burdens (e.g., a need to separately account for "buy-in" ineligibles, nonparticipating eligibles, and eligibles; to constantly update lists of names; to risk more errors). The Agency did not address this argument on appeal, but during reconsideration, the Agency responded to the argument by noting that it had offered procedures and guidance to ameliorate administration and reduce processing errors (Record of Reconsideration, item 12, p.4). The State alleged that an informative manual was not developed until February, 1976 (Amended Application for Review, p.9), but again this seems to have meaning only for the earlier disallowances in the case not now before us. The State acknowledged that the Agency, beginning in October, 1975, took some administrative steps which "minimized the responsibility to the State for dealing with removal of non-money payment recipients from the buy-in list." Record of Reconsideration, item 13, p.2. Overall, the State's argument concerning administrative inconvenience is no more than a collection of conclusory complaints, related primarily to the period that preceded the disallowance in this case. Further, an argument of administrative inconvenience would have to be addressed to Congress, since the statute appears to require differentiation between "money payment" and "non-money payment" recipients for purposes of "buy-in" agreements not modified in accordance with Section 1843(h).

4. The State also argued on appeal that the Agency assumed part of the record-keeping responsibility related to identification of the categories of recipients beginning in 1974, but thereafter ". . .disallowances. . . were based only on estimates of the number of ineligible recipients and not on accurate figures." Amended Application for Review, p.9. The Agency did not respond to this argument on appeal. At the same time, the State referred to a mysterious "adjustment"--not mentioned by the Agency—which increased the disallowance by $2,178 to $68,421, which the State argued ". . .reflects improvements in the accuracy of Departmental records for the time period in question which resulted from research undertaken at the invitation of the Defendants." Id., p.4. The record indicates that the Agency was forced to use estimating techniques because the State ". . .was unable to furnish the actual number of ineligible recipients." Record of Reconsideration, item 8. Since the State contributed to the difficulty in determining the disallowance amount, had a long-standing obligation to maintain a related system of accountability under 45 CFR 249.41(c)(1), appeared to acknowledge "improvements in the accuracy" of the disallowed amount in this case, and presented no evidence that the

amount of the disallowance is incorrect, there is no basis for overturning the Agency's determination of the amount of the disallowance. The Agency did not modify its disallowance to reflect the additional sum of $2,178, although given an opportunity to do so in the Board's Order to Show Cause, so the Board's decision addresses only the amount indicated in the record (i.e., $66,242).

5. The State argues that even if 45 CFR 249.41(c)(1) does not exceed statutory authority, it is arbitrary and capricious because it is overbroad and denies FFP "even where there is no difference between the amount of expenditures actually claimed and the amount that would have been claimed had the recipients bought in for themselves." Appellant's Response, p.3. But we do not find it as easy as the State apparently does to dismiss two considerations underlying the distinction: first, the wide range of potential variations in individual circumstances of eligible persons, and the questions of when and if each person would apply for Medicare and how much money each would get, leads us to conclude that there could reasonably be differences in the amount of expenditures the State might claim and the amounts individuals might claim. Second, it is not unreasonable for the Agency to demand separate accountability for the two types of payments. More important, Congress has dictated a specific requirement differentiating money payment from non-money payment buy-in eligibility in the circumstances here, which the Agency has implemented through a regulation which comports with the statutory requirement; arguably the Agency was without authority to do otherwise.

It should be noted that in response to the Board's Order to Show Cause, the State concurred that there were no material facts in dispute, and restricted its reiterated arguments to the matters discussed in paragraphs 1 and 5 above.

Conclusion

For the reasons stated above, we uphold the disallowance in the amount of $66,242.

/s/ Alexander G. Teitz

/s/ Cecilia Sparks Ford

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