Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Arizona Health Care Cost Containment System
Docket Nos. A-12-54 and A-12-103
Decision No. 2490
December 18, 2012

DECISION

In these consolidated appeals, the Arizona Health Care Cost Containment System (Arizona) challenges determinations by the Centers for Medicare & Medicaid Services (CMS) to disallow $13,289,763 in federal matching funds for Medicare Part B premiums that Arizona's Medicaid program paid on behalf of certain "dual eligibles" (persons eligible for benefits under both Medicaid and Medicare) during the period July 1, 2010 through September 30, 2011. CMS determined and we agree that the federal Medicaid statute and regulations do not authorize federal matching funds for a state's payment of Medicare Part B premiums on behalf of dual eligibles unless those persons: (1) are receiving (or are treated as though they are receiving) monthly cash benefits under a public assistance program authorized under the Social Security Act; or (2) are members of one of the groups of low-income individuals (*i.e.*, "qualified medicare beneficiaries," "special low-income medicare beneficiaries," and "qualifying individuals") specified in section 1902(a)(10)(E) of the Act for whom payment of Medicare Part B premiums is a mandatory Medicaid benefit. The State concedes that the Part B premium payments at issue in this appeal do not involve beneficiaries who fall into either of these categories. For that and the other reasons discussed below, we uphold the disallowance.

Legal Background

Under Medicaid, a program created under title XIX (sections 1901-1946) of the Social Security Act (Act),[1] federal financial assistance is available to states that provide health care to certain persons – including the aged, blind, and disabled – with low income and resources. Act §§ 1901, 1902(a)(10); 42 C.F.R. § 430.0. Within constraints established by title XIX (and its corresponding regulations), states that participate in Medicaid (and all do) have considerable flexibility to determine program eligibility, the scope of covered health benefits, and payment levels for medical services. 42 C.F.R. § 430.0.

[1] 42 U.S.C. § 1396-1396w-5. The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_ Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

In order to participate in Medicaid, a state must have a "State plan" that is approved by the Secretary of Health & Human Services (Secretary). Act § 1902(b); 42 C.F.R. § 430.10-430.16. A State plan is a "comprehensive written statement . . . describing the nature and scope" of a state's Medicaid program and "giving assurance that it will be administered in conformity with the specific requirements of title XIX," the regulations implementing that title, and other "applicable official issuances" of the Secretary. 42 C.F.R. § 430.10. A State plan must meet the requirements in section 1902(a) of the Act, which specifies the benefits – or "medical assistance" – that a state must or may provide under its Medicaid program and the groups of individuals eligible for such benefits. *See* Act §§ 1902(a)(10), 1902(a)(17) and 1902(b); 42 C.F.R. §§ 430.10 and 435.10(b). A state with an approved State plan is entitled to receive, from "sums appropriated," federal matching funds – also known as "federal financial participation" (FFP) – for a share "of the total amount expended [by the state] . . . as medical assistance under the State plan[.]" Act § 1903(a). That federal share is known as the "Federal medical assistance percentage," or FMAP, which varies by state according to per capita income. *Id.* §§ 1903(a)(1) and 1905(b); 42 C.F.R. § 433.10(a)-(b).

The Medicare program, established under title XVIII (sections 1801-1899A) of the Act, provides health insurance to individuals who are disabled or at least 65 years old. Unlike Medicaid, Medicare has no income or resource requirements for eligibility; Medicare eligibility depends instead on age or disability, work history, and payments into the Social Security system. Act §§ 1811, 1831, 1836.

Medicare has four main parts (A through D) but we mention only two. Part A covers inpatient hospital and other institutional services. Act § 1812. Part B covers physician services, outpatient hospital care, and other items and services not covered by Part A. *Id.* § 1832. Participation in Part B is voluntary and requires a beneficiary to pay monthly premiums (as well as a deductible and coinsurance for covered services). *Id.* §§ 1833(a)-(b) and 1839; 42 C.F.R. §§ 407.2, 408.4, 410.3(b), 410.152, and 410.160.

Medicare and Medicaid eligibility overlap for persons – the so-called dual eligibles – who qualify for Medicare because of age or disability but whose poverty makes them simultaneously eligible for full Medicaid benefits. *See* 76 Fed. Reg. 28,196 (May 16, 2011). Because of their low income and resources, dual eligibles may be unable to afford the Medicare premiums, deductibles, and coinsurance for which they are responsible. For that reason, section 1843 of the Medicare statute has long authorized states to enter into agreements with the Secretary, known as "buy-in" agreements, under which the states agree to pay the Part B premiums of dual eligibles specified in the agreement. *See* Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 312 (1965) (*codified in* section 1843 of the Act); 42 C.F.R. § 407.40; 48 Fed. Reg. 10,378 (March 11, 1983) (stating that "[t]he primary intent of the 'buy-in' program has been to make Medicare Part B services available to individuals who are eligible but financially unable to pay the monthly Part B premium amounts").

In addition, the Medicaid statute has long authorized FFP for a state's payment of Medicare Part B premiums on behalf of dual eligibles – but with limitations. When Medicaid was created in 1965, section 1903(a)(1) of the Act[2] authorized FFP for "expenditures for premiums under part B . . . for individuals who are recipients of money payments" under a federal assistance program authorized by the Act, such as Supplemental Security Income (SSI) for the aged, blind, and disabled (a title XVI program).[3] Persons who receive such money payments are among the "categorically needy," those whom Congress has identified as most in need of financial assistance to meet their medical costs and for whom Medicaid coverage is mandatory under a State plan.[4] *See* Act § 1902(a)(10)(A)(i)(I); 42 C.F.R. §§ 435.4 (defining "categorically needy") and 435.100-.170; *Schweiker v. Hogan*, 457 U.S. 569, 572 (1982).

In 1973, Congress amended section 1903(a)(1) to read, in relevant part, as follows:

> From the sums appropriated therefor, the Secretary . . . shall pay to each State which has a plan approved under this title . . . (1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as medical assistance under the State plan *(including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan [i.e., Medicaid-eligible persons] and* (A) are receiving aid or assistance under any plan of the State approved under Title I, X, XIV, or

---

[2] More fully, the original (1965) version of section 1903(a)(1) of the Act stated:

> From the sums appropriated therefor, the Secretary . . . shall pay to each State which has a plan approved under this title . . . (1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are recipients of money payments under a State plan approved under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or any other type of remedial care or the cost thereof) . . . .

Pub. L. No. 89-97 § 121(a), 79 Stat. 349.

[3] At Medicaid's creation, the Act authorized public assistance programs (administered largely by the states) which provided cash benefits for the aged (title I of the Act), blind (title X), disabled (title XIV), and aid to families with dependent children (title IV-A). *See* 42 C.F.R. § 407.40(b); *Schweiker v. Hogan*, 458 U.S. at 572 & n.2. In 1972, Congress restructured and merged the programs for the aged, blind, and disabled to form the supplemental security income (SSI) program under title XVI of the Act. *Schweiker v. Hogan*, 458 U.S. at 581.

[4] A participating state may, at its option, offer Medicaid coverage to other groups, including the "medically needy" – persons whose income and resources make them ineligible for cash assistance but which are nonetheless inadequate to cover the costs of necessary medical care. *See* Act § 1902(a)(10)(C); 42 C.F.R. §§ 435.4 (defining "medically needy") and 435.300-.350; *Schweiker v. Hogan*, 458 U.S. at 573. In general, a person qualifies for Medicaid coverage as medically needy if his expenses for necessary medical care effectively reduce his income to an eligibility level set by the state. *Atkins v. Rivera*, 477 U.S. 154, 157-58 (1986).

> 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[5] 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) . . . ."

Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 349 (1965), *as amended by* Pub. L. No. 93-233, §§ 13(a)(11), 87 Stat. 947, 963 (1973) (italics added).

Based on this statutory language, the Secretary issued 42 C.F.R. § 431.625(d), a version of which was in effect as early as 1978 and whose text has remained unchanged since 1987. *See* 43 Fed. Reg. 45,188, 45,197 (Sept. 29, 1978); 52 Fed. Reg. 47,926, 47,929, 47,923 (Dec. 17, 1987). Section 431.625(d)(1) states that with certain irrelevant exceptions,[6] FFP "is not available in State expenditures for Medicare Part B premiums for Medicaid recipients unless the recipients receive money payments under title I, IV-A, X, XIV, XVI . . . of the Act, or State supplements as permitted under section 1616(a) of the Act, or as required by section 212 of Pub. L. 93-66."[7] This basic rule has not been updated to reflect legislative enactments, which we describe in the following paragraphs, that occurred between 1986 and 1997 and which require state Medicaid programs to pay – and the federal government to share the cost of – Part B premiums on behalf of certain dual eligibles (and non-dual eligibles as well) who do *not* receive monthly cash benefits.

In 1986, Congress amended section 1902(a)(10)(E) and other sections of the Act to allow a state Medicaid program to pay Medicare Part B premiums, deductibles, and coinsurance – financial obligations that the Medicaid statute collectively refers to as "medicare cost-sharing" – on behalf of "qualified medicare beneficiaries" ("QMBs"). *See* Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053-55 (1986) (*codified in* sections 1902(a)(10)(E)(i) and 1905(p) of the Act). As amended by the 1986 legislation, the Medicaid statute

---

[5] State supplementary payments are cash benefits paid by a state to persons who receive federal SSI payments or who would be eligible for SSI but for their income. Act §§ 1616(a), 1905(j); 42 C.F.R. § 407.40(b). A state may use receipt of State supplementary payments to determine eligibility for coverage that it may elect to provide under its Medicaid program. *See* Act §§ 1902(a)(10)(A)(ii)(IV) and (XI).

[6] Among the exceptions to the general rule are premium payments for persons who, for Medicaid eligibility purposes, are considered (or deemed) to be recipients of monthly cash benefits. *See, e.g.,* 42 C.F.R. § 431.625(d)(2)(iv)-(vii); 52 Fed. Reg. at 47,929.

[7] In 1978, the basic rule barring FFP for premium payments for persons who were not cash recipients was codified in 42 C.F.R. § 431.625(c), which stated "[n]o FFP [was] available in State expenditures for medicare part B premiums for medicaid recipients who receive no money payments under title I, IV-A, X, XIV, XVI (AABD), or XVI (SSI) of the Act." 43 Fed. Reg. at 45,197.

defined a QMB to mean an elderly or disabled person entitled to Medicare Part A (and thus eligible to enroll in Part B) who was ineligible for Medicaid and whose income and resources fell within the limits specified in section 1905(p). *Id.* § 9403(b). The income-and-resource limits for QMBs were (and still are): (1) household income, after applying permissible exclusions, less than or equal to 100 percent of the applicable federal poverty guideline, also known as the Federal Poverty Line (FPL)[8]; and (2) resources – *i.e.*, cash, personal property, and other assets – that do not exceed twice the limit for SSI eligibility. *Id.*; *see also* Act § 1905(p)(1)-(2).

In 1988, Congress made the payment of a QMB's medicare cost-sharing a mandatory State plan requirement. *See* Pub. L. No. 100-360, § 301, 102 Stat. 683, 748 (1988) (deleting "at the option of a State" from section 1902(a)(10)(E)(i) of the Act). Also in 1988, Congress redefined the term QMB to include dual eligibles. *See* Pub. L. No. 100-647, § 8434(a), 102 Stat. 3342, 3805 (1988) (repealing § 1905(p)(1)(B), which defined a QMB in part as an individual who is ineligible for medical assistance under the State plan); Pub. L. No. 100-485, Title VI, § 608(a)(14)(I)(iii), 102 Stat. 2343, 2416 (deleting section 1396a(a)(15), which related to the payment of Medicare premiums and deductibles but only with respect to dual eligibles); *Rehabilitation Assoc. of Virginia, Inc. v. Koslowski*, 42 F.3d 1444, 1455-57 (4th Cir. 1994), *cert denied*, 516 U.S. 811 (1995). Hence, QMBs include two general groups: (1) persons who are ineligible for full Medicaid benefits but who meet the income-and-resource limitations in section 1905(p), a group that CMS calls "QMB-Only"; and (2) dual eligibles – Medicare-eligible persons who meet the financial and other criteria for full Medicaid benefits – who also meet the statutory income-and-resource limitations in section 1905(p), a group that CMS calls "QMB-Plus." *See* AZ Exs. 6-7.

In 1990, Congress amended section 1902(a)(10)(E) to require that state Medicaid programs pay the Part B premiums for another group of low-income individuals called "special low-income Medicare beneficiaries" (SLMBs). *See* Pub. L. No. 101-508, § 4501(b)(3), 104 Stat. 1388, 1388-164-65 (1990) (*codified in* section 1902(a)(10)(E)(iii) of the Act). A SLMB is an individual with a household income greater than 100 percent but less than 120 percent of the FPL and who would be a QMB if his income did not exceed the FPL. *Id.*

Finally, in 1997, Congress amended sections 1902(a)(10)(E) and 1933 to mandate that a state's Medicaid program pay the Part B premiums, or a portion of those premiums, for two additional groups of low-income Medicare beneficiaries known as "qualifying

[8] The federal poverty guidelines are updated and published annually by HHS. *See, e.g.*, Notice, *Annual Update of the HHS Poverty Guidelines*, 76 Fed. Reg. 3637 (Jan. 20, 2011).

individuals" (QIs). Pub. L. No. 105-33, § 4732(a), 111 Stat. 251, 520 (1997) (*codified in* sections 1902(a)(10)(E)(iv) and 1933 of the Act); AZ Ex. 6 (Enclosure 2). The first group of QIs, known as "QI-1s," is defined to mean individuals who: (1) have a household income of at least 120 percent but less than 135 percent of the FPL; (2) would be QMBs but for their income; and (3) are ineligible for full Medicaid benefits. Act § 1902(a)(10)(E)(iv). QI-2s, the provisions for whom expired in 2002,[9] were defined as persons who met the criteria for QI-1s except that their household incomes were at least 135 percent but less than 175 percent of the FPL. Pub. L. No. 105-33, § 4732(a)(2), 111 Stat. 520.

In addition to requiring state Medicaid programs to meet the Medicare cost-sharing obligations of QMBs and other groups, Congress amended the provisions of the Medicaid statute which govern the availability of FFP for those costs. First, the 1986 legislation amended section 1903(a)(1) to authorize FFP for a state's payment of Part B premiums (and Part A deductibles as well) on behalf of QMBs. Pub. L. No. 99-509, § 9403(g)(2), 100 Stat. 1874, 2053 (1986). In 1990, Congress struck the language in section 1903(a)(1) relating to Medicare premiums and deductibles and incorporated similar language, which we quote and discuss later, into the definition of medical assistance in section 1905(a). Pub. L. No. 101-508, § 4402(d)(2)-(3), 104 Stat. 1388, 1388-163-64 (1990).

Case Background

Since 1982, Arizona has participated in Medicaid under a section 1115 demonstration project waiver,[10] which allows it to deliver medical assistance through contracted "managed care" plans.[11] AZ Ex. 15 ¶ 3. In June 1998, Arizona began to pay the Medicare Part B premiums of dual eligibles whom its Medicaid program coded as "medical assistance only" (MAO). *Id.* ¶ 5. The record contains no evidence about the

[9] *See* Pub. L. No. 108-89, § 401(a), 117 Stat. 1134 (2003) (striking sub-clause II of section 1902(a)(10)(E)(iv)).

[10] Under section 1115 of the Act, 42 U.S.C. § 1315, the Secretary may allow a state Medicaid program to operate "experimental, pilot, or demonstration" projects that are likely to promote Medicaid program objectives. To enable the state to carry out such a project, section 1115 authorizes the Secretary to waive a state's compliance with certain Medicaid rules. Act § 1115(a)(1). Section 1115 waivers are typically issued to test innovations in delivery and payment for medical services and to enable states to extend Medicaid program benefits to persons who would not be eligible for the services absent the waiver. *See* 65 Fed. Reg. 3136 (Jan. 20, 2000); 63 Fed. Reg. 52,022, 52,023 (Sept. 29, 1998).

[11] Although Arizona did not elect to participate in Medicaid until 1982, it has had a section 1843 buy-in agreement with the Secretary since 1966. AZ Ex. 2. The agreement authorizes Arizona to pay Medicare Part B premiums on behalf of "eligible individuals receiving money payments" under Titles I, IV, X, and XIV of the Act. *Id.* ¶¶ A(4), B-C; *see also* AZ Br. at 7.

state's coding procedures or definitions, so it is unclear what particular group (or sub-group) of dual eligibles the MAO code was intended to cover. In the State Buy-in Manual, a Medicaid program manual issued by the Health Care Financing Administration (CMS's predecessor) in 1996,[12] the term "medical assistance only" refers to elderly or disabled dual eligibles who are not QMBs, SLMBs, or receiving (or deemed to be receiving) monthly cash benefits under a Social Security Act public assistance program such as SSI. *See* AZ Ex. 5 (State Buy-in Manual §§ 110 and 180, identifying the groups for whom federal matching of Part B premium payments is available, referring to a "medical assistance only" recipient as "non-cash," and stating that "[t]he premium payment made on behalf of a non-cash Medical Assistance recipient (MA Only) does not qualify for Federal matching").

In January and April 2011, CMS notified Arizona that it had deferred a total of $10,525,713 in FFP for Part B premiums paid by Arizona on behalf of dual eligibles coded as MAO during the two quarters from July 1, 2010 through December 31, 2010.[13] AZ Exs. 8-9. In its deferral notices, CMS stated that FFP is "not available for states[']buy-in for *non-cash* Medical Assistance Only (MAO) groups" and is "available only for those individuals who are considered some class of cash recipient, or deemed to be a cash recipient, or one of the Medicare Savings Program (MSP) groups [*i.e.*, QMBs, SLMBs, or QI-1s]." AZ Ex. 9, at 1 (italics added).

In a response to the deferral notices, Arizona provided information to CMS demonstrating that some of the deferred FFP had been claimed for premium payments made by its Medicaid program on behalf of QMBs, SLMBs, QIs, or "cash assistance" dual eligibles. *See* AZ Ex. 10, at 1-2. Based on that demonstration, CMS reduced the deferral amount by roughly half. AZ Ex. 13, at 1 n.1.

The record indicates that the remaining deferred FFP was claimed for premium payments that Arizona made for persons who were *not* QMBs, SLMBs, QI-1s, or receiving cash benefits – persons we refer to collectively as the "MAO group." *See* AZ Br. at 2 (conceding that the dual eligibles implicated by the disallowance "do not qualify for cash assistance"). In a declaration, Melanie Norton, Acting Assistant Director of Arizona's Medicaid agency, describes the MAO group as "made up of dual eligibles in the aged, blind, and disabled categories" with incomes "up to 300 percent of the Supplemental Security Income [SSI] benefit level." AZ Ex. 15 ¶ 7. Ms. Norton further states that the

[12] Relevant excerpts from the Buy-in Manual are found in Arizona Exhibit 5. CMS is in the process of updating the State Buy-in Manual and publishing the updated version online.

[13] CMS issued the deferrals based on findings of an audit conducted by the Department of Health & Human Services' Office of Inspector General (OIG). *See* AZ Ex. 10, at 2.

"great majority" of that group "requires an institutional level of care based on their functional, medical, nursing, and social needs," and that all participate in the Arizona Long-Term Care System (ALTCS), a component of Arizona's Medicaid program, "through which they can receive long-term care services in a variety of settings, including nursing facilities, various community-based facilities, and their homes."[14] *Id.*; *see also* AZ Br. at 7-8.

In a letter dated January 31, 2012, CMS notified Arizona that it was disallowing $5,426,642 in FFP for the Part B premiums it paid on behalf of the MAO group for the period July 1, 2010 through December 31, 2010, stating that "FFP is not authorized for such payments under the Act or pertinent implementing regulations and guidelines." AZ Ex. 13. CMS identified the "pertinent" regulations and guidelines as 42 C.F.R. § 431.625(d)(1) and sections 110 and 180 of the State Buy-in Manual. *Id.* CMS also reaffirmed an earlier statement (contained in its deferral notices) that FFP is authorized for a state's Part B premium payments only if the payments are for persons who receive or are deemed to be receiving cash benefits or for persons who are QMBs, SLMBs, or QIs. *Id.*

In a letter dated May 25, 2012, CMS notified the State that it was disallowing an additional $7,863,121 in FFP for Part B premium payments on behalf of the MAO group during the period from January 1, 2011 through September 30, 2011.[15] AZ Ex. 14.

While the FFP deferrals were pending, CMS approved Arizona's request for a new section 1115 waiver, which became effective for a five-year period that began on October 22, 2011. *See* AZ Ex. 12; AZ Br. at 10. Under the waiver's Special Terms and Conditions, Arizona is authorized to claim FFP for its payment of Medicare Part B premiums on behalf of--

> individuals enrolled in ALTCS [Arizona Long-Term Care System] with income up to 300 percent of the FBR [federal benefit rate[16]] who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are

[14] As permitted by section 1903(f)(4)(C) of the Act, Arizona has extended Medicaid benefits under the ALTCS to certain persons with incomes up to 300 percent of the SSI benefit level. *See* Ariz. Admin. Code §§ 9-28-408(E)(1) and 9-28-401.01(B).

[15] Arizona's appeal of the January 31, 2012 disallowance was assigned docket number A-12-54, and the appeal of the May 25, 2012 disallowance was assigned docket number A-12-103.

[16] The "federal benefit rate" is the income limit for SSI eligibility and is equal to the maximum cash benefit payable to an individual or couple without income. 20 C.F.R. §§ 416.1101 (defining "Federal benefit rate") and 416.1130. The FBR is typically about 75 percent of the FPL for a single person. *See* http://www.ssa.gov/oact/cola/SSIamts.html (FBR table) (last visited Dec. 16, 2012) and http://aspe.hhs.gov/poverty/figures-fed-reg.shtml (HHS poverty guidelines) (last visited Dec. 16, 2012).

> eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.

AZ Ex. 12 (document entitled *Arizona Medicaid Section 1115 Demonstration, Medicaid Costs Not Otherwise Matchable,* ¶ 13).

Discussion

We consider the State's appeal by first addressing whether the Medicaid statute and regulations authorize FFP for the State's premium payments on behalf of the MAO group. We then address the State's various arguments that CMS had the legal authority to make FFP available for those payments despite the lack of express statutory authorization. We also address the State's contention that CMS exercised that alleged authority by notifying states in two State Medicaid Directors Letters that FFP was available for Part B premiums for the MAO group. Finally, we consider whether the State made the Part B premium payments for the MAO group in accordance with its State plan, and whether those payments were matchable expenditures under the terms of its section 1115 waiver during the relevant period.

1. *The Medicaid statute and regulations do not authorize FFP for Arizona's payment of Medicare Part B premiums for the MAO group.*

The State takes issue with the disallowance partly by criticizing CMS's reliance on 42 C.F.R. § 431.625(d)(1) and on sections 110 and 180 of the State Buy-in Manual. The State asserts that the regulation and manual "cannot be read as a proper description of FFP eligibility for State payments for Part B premiums" because they fail to account, or fully account, for the legislation enacted between 1986 and 1997 that mandated buy-in payments on behalf of QMBs, SLMBs, and QIs. AZ Br. at 18. That argument is without merit because it overlooks CMS's reliance on the Medicaid *statute* (the disallowance notices state that FFP was not authorized "under the Act"). AZ Exs. 13 and 14. As the source of the Secretary's authority to provide FFP, the statute is the appropriate departure point for our analysis.

Section 1903(a)(1) of the Act authorizes FFP for expenditures on "medical assistance under the State plan." Medical assistance, a "statutory term of art,"[17] is defined largely in section 1905(a). The first sentence of section 1905(a) states, in relevant part, that

[17] *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029, 1034 (9th Cir. 2011).

medical assistance means "*payment of* part or all of the cost of . . . care and services" (italics added) for eligible individuals specified in that section. After enumerating 29 categories of medical care and services, section 1905(a) further states that:

> "[t]he *payment described in the first sentence* [of section 1905(a)] may include expenditures **for *medicare cost-sharing*** and ***for premiums under part B of title XVIII for individuals who are eligible for medical assistance*** [i.e., eligible for Medicaid coverage] under the 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), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. [italics and emphasis added]

"Medicare cost-sharing" is defined in section 1905(p)(3) to mean amounts spent or costs incurred for Medicare premiums, deductibles, and coinsurance "with respect to a qualified medicare beneficiary." Hence, the definition of medical assistance in section 1905(a) appears to include only three categories of Medicare-related expenditures:

> Expenditures for Medicare Part B premiums on behalf of dual eligibles (those who the statute says are "eligible for medical assistance") who are receiving "aid or assistance" – namely, cash benefits (*see infra* footnote 3) – under a public assistance program authorized by title I, IV-A, X, XIV, or XVI of the Social Security Act;
>
> Expenditures for medicare cost-sharing (premiums, deductibles, and coinsurance) on behalf of QMBs, who may be either dually eligible for Medicaid and Medicare or eligible for Medicare only; and
>
> Expenditures for Medicare Part B premiums on behalf of dual eligibles who receive "State supplementary payments" (which augment federal SSI benefits).

The definition of medical assistance in section 1905(a) does not mention premium payments for SLMBs or QI-1s. However, section 1902(a)(10)(E) implicitly expands the definition to include those payments by requiring states to "mak[e] medical assistance available" for them (as well as for medicare cost-sharing for QMBs). *See* Act § 1902(a)(10)(E)(i), (iii), and (iv).

In short, the Medicaid statute authorizes FFP for a state's payment of Medicare Part B premiums only to the extent that the payment constitutes medical assistance (as defined in the statute), and a state's Part B premium payment constitutes medical assistance only if it is made for: (1) dual eligibles who receive cash benefits under an income support program such as SSI; (2) other dual eligibles who receive State supplementary payments; (3) QMBs; (4) SLMBs; or (5) QI-1s. MAO group members do not fall, and are not alleged to fall, within any of these categories, and Arizona does not argue that textual ambiguities in the statute permit us to define medical assistance more broadly. Because the Medicaid statute does not authorize FFP for payment of Medicare Part B premiums for the MAO group, we are compelled to affirm the disallowances in this matter. 45 C.F.R. § 16.14 (stating that the Board is bound by applicable statutes and regulations).

The regulation cited by CMS also compels affirmance. Section 431.625(d)(1) expressly bars FFP for Part B premium payments on behalf of dual eligibles who do not receive cash assistance. It is true, as Arizona asserts, that the Secretary has never amended section 431.625(d)(1) to reflect legislation that authorizes FFP for dually eligible QMBs and SLMBs,[18] who may qualify for Medicaid based on circumstances other than their receipt of cash benefits, such as meeting income and other requirements for "medically needy" coverage. *See* 42 C.F.R. 435.301; *infra* footnote 4. However, members of the MAO group are not QMBs or SLMBs, and the buy-in legislation enacted between 1986 and 1997 did not render the regulation inapplicable to dual eligibles who are not QMBs or SLMBs (such as the MAO group). For these dual eligibles, the general rule in section 431.625(d)(1) still applies: FFP is unavailable for a state's payment of their Part B premiums unless they receive income support under SSI or another federal welfare program. Because section 431.625(d)(1)'s prohibition of FFP for the MAO group's premium payments is consistent with the Medicaid statute, it was not improper for CMS to rely on that regulation in disallowing FFP for those payments.

2. *Section 1903(a)(1) of the Act does not authorize CMS to make FFP available for Part B premium payments that do not constitute medical assistance (as defined in the Medicaid statute and regulations).*

Arizona makes various arguments in this appeal, none of which undercuts the foregoing analysis. Although Arizona concedes that the Medicaid statute does not "expressly" authorize FFP for its premium payments for the MAO group, it contends that reversing the disallowance "would not require the Board to override the Medicaid statute" because "[n]othing in the statute precludes FFP for the premiums at issue." AZ Br. at 10-11; Reply Br. at 1. Arizona seems to be saying here that FFP must be provided for any

[18] QI-1s are not dual eligibles by definition. Act § 1902(a)(10)(E)(iv) (stating that QIs "are not otherwise eligible for medical assistance").

Medicaid program expenditure unless the statute expressly directs otherwise. This view cannot be squared with section 1903(a)(1), the statutory provision under which Arizona's FFP claim arose. Section 1903(a)(1) does not purport to create exceptions to an otherwise unrestricted authorization to provide federal funds. Instead, section 1903(a)(1) says that federal funds may be provided only if the state's expenditures meet specific conditions – namely, that they be for "medical assistance under the State plan." *See also* 42 C.F.R. § 435.1000 *et seq*. (specifying "when, and the extent to which," FFP is available). Permitting Arizona, a Medicaid grantee, to obtain FFP for a purpose (*i.e.*, the payment of Medicare premiums on behalf of the MAO group) not authorized by Congress in section 1903(a)(1) (or other sections of the Medicaid statute) would violate applicable principles of appropriations law, which hold that a "grantee's entitlement to federal funds does not extend beyond the [FFP] authorized in the grant statute." *Oklahoma Office of State Finance*, DAB No. 1668, at 4 n.4 (1998); *see also New York State Dept. of Social Services*, DAB No. 1358, at 2 (1992) (stating that in a federal grant program, "the State's entitlement to funds is limited to payments authorized by statute, which meet the conditions established by the statute and implementing regulations); 31 U.S.C. § 1301(a) (appropriations may be applied only to the "objects for which the appropriations were made").

Arizona further contends that, notwithstanding the absence of "express" statutory authorization, CMS had the legal authority to make FFP available for the MAO group's premium payments. AZ Br. at 6 & n.11. According to Arizona, CMS's alleged authority emanates from congressional concern for the "special needs" population – "elderly and disabled individuals in need of an institutional level of care" who have "limited income that [is] higher than the State cash assistance level" but who are still "in need of financial assistance to defray the costs of long-term care." *Id.* at 11-12, 17. Citing two Senate Committee Reports, Arizona contends that Congress expressed its concern for the special needs population in 1967, and then again in 1973 when it rejected a proposal by the Department of Health & Human Services' predecessor agency to cap the income level – at 133⅓ percent of a state's cash assistance payment – at which persons needing nursing home or other institutional care could be deemed eligible for medical assistance (as "medically needy") under a State plan. AZ Br. at 4. In lieu of the agency's proposal, says Arizona, Congress adopted a higher income threshold, known as the "special income" level, permitting states to extend Medicaid coverage (supported by FFP) to nursing home and other institutionalized persons with incomes up to 300 percent of the FBR. *See* Pub. L. No. 93-233, § 13(a)(12), 87 Stat. 947, 963 (1973) (*codified in* section 1903(f)(4)(C) of the Act); *see also* Act § 1902(a)(10)(A)(ii)(V) (authorizing a state to provide Medicaid coverage to persons "who are in a medical institution for a period of

not less than 30 consecutive days," whose assets fall within certain limits, and whose incomes do not exceed the 300 percent standard established under section 1903(f)(4)(C)); 42 C.F.R. §§ 435.230(c)(2)(v), 435.236 and 435.622.[19]

Arizona asserts that "in making Medicaid coverage available for the special needs population [which purportedly include the MAO group], Congress recognized that beneficiaries residing in institutions can be overwhelmed by their high medical costs" and encouraged states to help defray that population's medical costs. AZ Br. at 12. It would "make little sense," says Arizona,

> for Congress to authorize States to claim FFP for the costs of the special needs population's Medicaid costs, but not to authorize a federal match for States' payment of the Medicare Part B premium for this population. For many members of this fragile group, Medicare can be a key source of funding for medical care. *It is unlikely that Congress would have extended Medicaid coverage to these individuals while leaving them or the State to bear the brunt of the Part B premiums*. This would impose financial hardship on the special needs beneficiaries, the very result Congress aimed to avoid by extending coverage to this group. While Congress might hope that States would step in to pay the Part B premiums, it could not count on this. It is *more likely that Congress intended to use FFP to incentivize States to pay these premiums, to provide greater protection for the special needs individuals*.

Id. at 12-13 (italics added).

This argument is not persuasive, largely because it asks us to infer a grant of authority from statutory silence. Arizona does not point to any provision(s) of the statute that could plausibly be construed as authorizing the Secretary to provide FFP for Medicare Part B premium payments that the statute does not define (either expressly or by implication) as medical assistance.[20] Nor can Congress's intent be gleaned from the 1973

[19] The reference in 42 C.F.R. § 435.236 to 42 C.F.R. § 435.722 is outdated. In 1993, CMS redesignated section 435.722 as section 435.622. 58 Fed. Reg. 4908, 4921 (Jan. 19, 1993).

[20] Arizona's argument is also inconsistent with the Secretary's regulations. Those regulations state that for persons who qualify for medical assistance under the special income rule, FFP is limited to expenditures for "services," a term that the regulations define to mean the "the types of medical assistance specified in section 1905(a) of the Act and defined in subpart A of part 440 of this chapter [42 C.F.R. §§ 440.1-440.185]." 42 C.F.R. § 435.1005; 42 C.F.R. § 400.203 (setting out definitions "specific to Medicaid"). The types of medical assistance defined in subpart A of part 440 of CMS's regulations do not include the payment of Part B premiums or other Medicare financial obligations.

legislation which created the special income rule. In that legislation, Congress also amended the language in section 1903(a)(1) governing the availability of FFP for Medicare Part B premiums (language that was later moved to section 1905). Pub. L. No. 93-233, § 13(a)(11), 87 Stat. 963. Although this amendment to section 1903(a)(1) and the special income rule appear in *adjacent paragraphs* of the legislation, there is no apparent connection between them in the legislation's text, and the amendment to section 1903(a)(1) essentially retained the rule that FFP was authorized only for premiums paid on behalf of dually eligible cash recipients. *Id.* §§ 13(a)(11) and 13(a)(12), 87 Stat. 963.

Deriving the alleged authorization from such statutory silence would be inappropriate here because, both before and after 1973, Congress used express terms to make FFP available for Medicare Part B premium payments. *Kimbrough v. United States*, 552 U.S. 85, 103 (2007) ("Drawing meaning from silence is particularly inappropriate . . . [when] Congress shows that it knows how to [address an issue] in express terms"). When Medicaid was created in 1965, section 1903(a)(1) specified that the Part B premium payments eligible for FFP were the payments made on behalf of the neediest of the needy – persons who were receiving public assistance. When Congress later made FFP available for premium payments on behalf of QMBs, SLMBs, and other groups, it either included those payments in section 1905(a)'s definition of medical assistance (as it did for QMBs) or expressly labeled them as medical assistance (as it did in section 1902(a)(10)(E) for SLMBs and QIs).

Arizona submits that the Medicaid statute's silence about premium payments for the special needs population – in contrast with provisions that expressly authorize FFP for premium payments for QMBs and other groups – does not undermine its position. AZ Br. at 14. "[T]he difference," says Arizona, "is that these other groups are entitled only to Medicare cost-sharing benefits, whereas those in the special needs category are eligible broadly for all benefits provided under the State Medicaid Plan." *Id.* That assertion is not persuasive because, as we indicated, QMBs may include persons who are eligible for full Medicaid benefits. *See* State Medicaid Manual,[21] CMS Pub. 45, § 3490.3.

Because the Medicaid statute is silent regarding premium payments for the MAO group – and there is nothing in the legislative materials submitted by Arizona suggesting that Congress even *considered* making FFP available for Part B premiums for persons who qualify for Medicaid under the special income rule – we do not need to address Arizona's

[21] The State Medicaid Manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html.

assertion that Congress "likely" intended to do so. *In re Catapult Entertainment, Inc.*, 165 F.3d 747, 753-54 (9th Cir. 1999) (finding no need to resort to legislative history to uncover Congress's intent when there is no ambiguity in the relevant statutory language). For the same reason, we reject Arizona's suggestion that upholding the disallowance would produce a nonsensical or anomalous result.

3. *The 1997 and 2000 SMDLs did not contain clear or authoritative guidance concerning the availability of FFP for a state's payment of Medicare Part B premiums for the MAO group, and Arizona's purported reliance on those documents was unreasonable.*

Assuming that CMS had statutory or regulatory authority to approve FFP for premium payments on behalf of the MAO group, Arizona contends that CMS exercised that authority in State Medicaid Director Letters (SMDLs) dated November 24, 1997 and December 10, 2000. AZ Br. at 13, 14. Arizona also suggests that it reasonably relied on the SMDLs in deciding to pay Part B premiums on behalf of the MAO group. *See id.* at 17. We find both of these contentions to be meritless.

The November 24, 1997 SMDL states that its purpose was to provide "guidance" on implementing a statutory provision which allowed states to determine Medicare cost-sharing amounts for QMBs "based either on the full Medicare-approved amount or on the amount that the State pays for the same service on behalf of a Medicaid receipient not entitled to Medicare." AZ Ex. 6. The letter had two "enclosures," the second of which describes various categories of dual eligibles, who, the letter says, are "individuals entitled to Medicare and eligible for some type of medical assistance" (either full Medicaid benefits or merely payments to offset Medicare cost-sharing obligations). For example, the enclosure describes QMBs this way:

> Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding twice the SSI limit. QMBs may be eligible for full Medicaid or may have Medicaid eligibility limited to payment of Medicare Part A and Part B (supplemental medical insurance) premiums and Medicare cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

AZ Ex. 6. The enclosure describes another group called "Non-QMBs":

> Individuals entitled to Medicare and eligible for full Medicaid benefits, but not as a QMB (typically, medically needy individuals who have to spend down income to qualify). Medicaid benefits are for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid

> rate exceeds any Medicare payment for the service covered by both Medicare and Medicaid. Payment of Medicare Part B premiums is optional. FFP equals FMAP.

The second SMDL, dated December 14, 2000, provided state Medicaid programs with information and resources to help them locate and inform individuals who might be eligible for "Medicare Savings Programs" (referring to those elements of state Medicaid programs that pay the Medicare premiums, deductibles, or coinsurance of QMBs, SLMBs, and others). Like the November 1997 SMDL, the December 2000 SMDL had an enclosure which defines various groups of dual eligibles who are potentially eligible for full or partial payment of their Medicare cost-sharing expenses. One of the listed groups is "Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI,[22] QI-1, or QI-2)":

> These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, Q1-1, or QI-2. . . . Payment by Medicaid of Medicare part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

AZ Ex. 7.

Arizona asserts that "[b]y stating that 'FFP equals FMAP' immediately after providing that Part B premium buy-ins may be paid at the State's option" on behalf of Non-QMBs and Medicaid Only Dual Eligibles, the SMDL enclosures informed states that the federal government would provide matching funds for their expenditures on Part B premiums for those groups. AZ Br. at 16. Arizona asserts that the disallowances conflict with the "guidance" found in the SMDL enclosures and that it reasonably relied on that guidance in deciding to make and claim FFP for the MAO group's premium payments. *Id.* at 10-11, 14-15; *see also* AZ Ex. 10, at 3.

[22] The acronym QDWI refers to "qualified disabled and working individual." A State plan must provide for the payment of Part B premiums on behalf of this group. *See* Pub. L. No. 101-239 § 6408(d)(1), 103 Stat. 2106, 2268 (1989) (*codified in* section 1902(a)(10)(E)(ii) and 1905(s) of the Act). A QDWI is a disabled individual who is eligible to enroll in Medicare Part A, whose household income does not exceed 200 percent of the applicable FPL, whose resources do not exceed twice the SSI eligibility limit, and who is otherwise ineligible for Medicaid. Act § 1905(s).

This argument is without merit because any reliance on the SMDL enclosures was unreasonable for several reasons. First, although the passages that define Non-QMBs and Medicaid Only Dual Eligibles state that a program's payment of Part B premiums is optional, and that "FFP equals FMAP," neither positively states that all premium payments made to persons within those groups are eligible for FFP. Second, the SMDL enclosures contain few if any signs that they express an authoritative agency position on the relevant issue. The enclosures were attached to letters whose purposes were other than communicating CMS policy regarding the availability of FFP. They do not identify the CMS employee(s) who authored them. The enclosures also do not state that they constitute CMS "policy," "guidance," or an interpretation of relevant statutes or regulations, nor do they mention, much less discuss, the Medicaid statute and regulations. And to the extent that they can be construed as implying that FFP was available for premium payments for the MAO group, the enclosures fail to acknowledge conflicting provisions in the State Buy-in Manual, a publication which was issued only one year prior to the 1997 SMDL and which identifies itself as the official repository of agency policies and procedures regarding state buy-in programs. Although the Buy-in Manual was issued prior to the 1997 legislation (which added QI-1s to the list of low-income individuals entitled to Medicaid payment of their Medicare Part B premiums), that legislation did not contain any provision that undermines the manual's statements prohibiting FFP for premium payments on behalf of "medical assistance only" individuals.

Furthermore, the SMDL enclosures are not legally binding on the Board, and at best their pronouncements are merely guidelines that interpret the Medicaid statute and regulations. *See Massachusetts Executive Office of Health and Human Services*, DAB No. 2218, at 12 (2008) (stating that "less formal rules or guidelines, including CMS interpretations of the Medicaid statute and regulations contained in CMS program manuals and policy letters, are not binding on the Board"), *aff'd*, *Commonwealth of Massachusetts v. Sebelius*, 701 F.Supp.2d 182 (D. Mass. 2010). Thus, even if Arizona's reading of the guidelines in the SMDL enclosures was correct (which it is not), we could not rely on or defer to those guidelines here because they would be, for reasons previously stated, inconsistent with the applicable statute and regulations, whose meaning is plain with respect to the issue before us.

4. *Arizona has failed to show that its State plan called for payment of Medicare Part B premiums for the MAO group, or that the payment of those premiums was a matchable expenditure under the terms of its section 1115 waiver during the relevant period.*

FFP is unavailable for Medicaid expenditures that are not in accordance with the State plan. Act § 1903(a)(1) (authorizing FFP for medical assistance "under the State plan"); *Arizona Health Care Cost Containment System*, DAB No. 1569, at 14 (1996) ("State plan provisions are not mere technicalities but are statutory preconditions for federal

funding."). A state bears the burden of proving that its Medicaid expenditures were in accordance with the State plan and otherwise eligible for FFP. *Maine Dept. of Health and Human Services*, DAB No. 2292, at 9-10 (2009). Arizona submitted no evidence (and does not even allege) that its State plan called for the payment of Part B premiums on behalf of the MAO group.[23] Moreover, Arizona does not contend that during the period for which CMS issued the disallowance (July 1, 2010 through September 30, 2011), the payment of Medicare premiums on behalf of the MAO group was a matchable expenditure under the terms of its section 1115 demonstration project.[24]

Arizona's current section 1115 waiver, which became effective after the period covered by the disallowance, authorizes matching funds for the payment of Part B premiums on behalf of the MAO group. AZ Ex. 12. Arizona contends that the disallowances "penalize" it "for not seeking [that] waiver sooner, even though federal agency guidance [we presume that Arizona is referring here to the 1997 and 2000 SMDLs] suggested that there was no need to seek a waiver and, in retrospect, it is clear that a waiver application would have been granted." Reply Br. at 1. According to Arizona, CMS's "prompt" decision to grant a waiver allowing FFP for Part B premiums paid on behalf of the MAO group "reflects the view that Arizona's claiming of FFP for such premium payments is consistent with the goals and requirements of the Medicaid program." *Id.* at 3.

This argument has no merit. During the period covered by the disallowance, the Medicaid statute and regulations did not authorize CMS to provide the FFP sought by Arizona, and there was also no section 1115 waiver in effect which permitted CMS to provide the FFP despite the absence of such statutory authorization. In these circumstances, CMS was legally obligated to issue the disallowance. Its decision to do what was legally required cannot plausibly be viewed as penalizing Arizona for not taking action sooner to obtain a waiver. Furthermore, the State's vague suggestion that it elected to forego seeking a waiver based on the content of the SMDLs is unsupported by any evidence.

[23] The State plan for Arizona's Medicaid program is available at http://www.azahcccs.gov/reporting/PoliciesPlans/stateplan.aspx. Neither party submitted for the record any relevant portion of the State plan.

[24] Demonstration project expenditures may, "to the extent and for the period prescribed by the Secretary," be "regarded as expenditures under the State plan[.]" Act § 1115(a)(2)(A).

Conclusion

For the reasons discussed, we sustain the disallowance determinations issued by CMS on January 31, 2012 and May 25, 2012.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member