DEPARTMENTAL GRANT APPEALS BOARD

Department of Health and Human Services

SUBJECT: New Jersey Department of Human Services
Docket No. 78-159-NJ-HC
Decision No. 115

DATE: August 8, 1980

DECISION

Background

Title XIX of the Social Security Act (hereafter Act), popularly known as Medicaid, was enacted in 1965 for the purpose of enabling each state, as far as practical under conditions in the state, to provide medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals with insufficient financial resources to meet the costs of necessary medical services. Medicaid is a joint Federal/state program. States initiate, design and operate the programs. The Department of Health and Human Services (formerly Health, Education, and Welfare), through the Health Care Financing Administration (HCFA), approves each State's plan which provides the basis for claiming Federal financial participation (FFP).

People who receive cash assistance under Aid to Families with Dependent Children (AFDC) authorized by Title IV-A of the Act are automatically covered under Medicaid. Aged, blind and disabled people who receive cash assistance under the Supplemental Security Income (SSI) program authorized by Title XVI of the Act or under state supplementation programs are also automatically covered. However, states can impose Medicaid eligibility requirements on SSI recipients that are more restrictive than SSI requirements. States can also cover certain people not entitled to cash assistance. In all cases, however, the terms and conditions of eligibility must be specified in the State plan which is approved by HHS. Each state determines who is eligible for various benefits within the state. Accordingly, eligibility requirements and benefits available to individuals may vary among the states.

Under the provisions of Section 121(b) of Public Law 89-97 (Title XIX) enacted July 30, 1965, no payment may be made to any State under Title I, Title IV-A, Title X, Title XIV or Title XVI of the Act for medical care and services after December 31, 1969. Thereafter, FFP in vendor payments for medical or remedial care is only available under Title XIX of the Act.

There is evidence that New Jersey was aware of some of the ramifications of participating in Medicaid. A report to the New Jersey General Assembly dated September 10, 1968, prepared by its Committee on Institutions and Welfare

(Tab No. 35, Record of Reconsideration) pointed out that the State was obligated to develop a State plan to implement Title XIX or lose Federal funding for medical assistance. The report recognized the differences between "categorically needy," "medically needy," and "categorically related" individuals and how the inclusion of one group in the State plan might require extending coverage to other groups because of the provisions of the law.

The report specifically addressed New Jersey's Medical Assistance for the Aged (MAA) program which is the focus of this appeal. Noting the various options available to the State, the Committee recommended that all MAA recipients eligible for Old Age Assistance (OAA) (Title I) be transferred to that program and that the State continue to provide medical assistance for the remainder at its own expense. The Committee rejected the option of covering all MAA recipients under Medicaid because this would require the inclusion of additional individuals not then receiving MAA, without the benefit of Federal matching funds.

There is also evidence that when State officials were formulating procedures to implement Title XIX, Federal officials were involved in the planning. It appears that both the New Jersey Legislature and State administrators were informed by Federal officials that some recipients of New Jersey's MAA program would not be able to qualify for the OAA program because of income and resources in excess of the eligibility standards (Tab No. 25, Record of Reconsideration). At that time, monthly income of $160 or less would satisfy the standard of need for the OAA program (Division of Public Welfare Circular Letter No. 715, dated November 12, 1969).

New Jersey's Medicaid State Plan, effective January 1, 1970, since its initial submission, covered only the categorically needy, but included the optional categorical group described in 45 CFR 248.10(b)(2)(ii) as eligible individuals. (See State Medical Assistance Manual, effective Januray 1, 1970, Section C, page 223, Item 3a)(Tab No. 30, Record of Reconsideration).

Regulations at 45 CFR 248.10(b)(2)(ii) permit a state, at its option, to extend Medicaid coverage to a categorically eligible group described as:

> Persons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the appropriate State plan....

During the period from January 1, 1970, through June 30, 1971, New Jersey's Title I, X, and XIV plans, and therefore its Title XIX State plan, provided for the recognition of "special circumstance items...essential for the physical health and safety of persons in specified situations" in calculation of recipients' budgets. Thus, individuals with incomes in excess of the basic monthly standard of need, against which applicants' incomes were ordinarily assessed in the course of determining eligibility for benefits, could be eligible for public assistance benefits if their incomes were below the financial limit augmented to include special need items.

New Jersey, however, did not initially make a claim for FFP in paying the costs of medical services rendered to these individuals during the period prior to June 30, 1971. The State, without FFP, paid the costs of care for individuals with incomes over the monthly public assistance need standard, yet insufficient to meet the costs of nursing home care. This group apparently included some persons who actually belonged to the optional Medicaid categorically eligible group as well, and thus should have been covered under the Medicaid Federal cost sharing program.

On July 1, 1971, New Jersey altered its State plan to provide for a consolidated standard or "flat grant." That is, all recognized need items were averaged into single money amounts, which varied only according to family size. Although provision remained in the plan for making needed homemaker services available to individuals or family units already determined to be eligible for assistance, neither the cost of homemaker service or of any other special circumstance item was included as a factor in the process of determining financial eligibility for benefits. The income standard against which institutionalized individuals' incomes were to be compared for purposes of establishing Medicaid eligibility was a set monetary level that remained constant irrespective of any special needs that an individual might have if he were residing in the community.

The State apparently believed that the income limitation was absolute and did not initially request FFP for those individuals in medical facilities whose income and resources exceeded OAA eligibility standards but whose means were insufficient to meet the costs of institutional care. According to the Deputy Director, Division of Medical Assistance and Health Services (Tab No. 17a, Record of Reconsideration), State officials did not become aware of the fact that at least some of the individuals could qualify for Medicaid until late September 1973. After learning that a reasonable fee for homemaking services could be added to the standard of need for institutionalized individuals, New Jersey amended its State plan to provide for this category of beneficiary. The amended State plan was approved by HHS on December 10, 1973, with an effective date of October 1, 1973.

The State included in its Quarterly Statement of Expenditures for the period October 1 through December 31, 1974 a claim for FFP in the amount of $14,842,373 in the costs of rendering services to institutionalized MAA patients whose special needs would have inflated their basic cost of living if they had resided in the community, during the period from January 1, 1970 through October 30, 1973. The Agency informed the State on May 5, 1975, that the claim was being denied, "[a]s New Jersey only covered in its State Plan for Titles I, X and XIV, persons whose income was less than $162 until the Plan was amended in November 1973, it is not possible to claim federal matching prior to that date."

On May 15, 1975, the State requested reconsideration of the disallowance (SRS Docket No. ME-NJ-7501). After considering substantial input from the State and Agency officials, including a conference with the then Acting Administrator on July 1, 1976, the Administrator of HCFA issued a decision on November 22, 1978 which upheld the Regional Commissioner's disallowance of the claim for $14,842,373 for FFP in the State's MAA program for the period July 1, 1971 to September 30, 1973 because under Section 1903(a)(1) of the Act, FFP is allowable solely for costs incurred in rendering medical assistance to individuals covered under an approved State plan. The Administrator did hold, however, that the State could submit a revised claim for the period from January 1, 1970 through June 30, 1971, because the State plan did in fact provide coverage of the institutionalized population upon which the State based its claims.

The State did submit a revised claim with its June 1979 Quarterly Statement for $2,839,237 in FFP for the period from January 1, 1970 through June 30, 1971. It is assumed that this claim has been satisfied and the only amount still in dispute is for the period from July 1, 1971 to September 30, 1973.

This decision is based on the State's application for review dated December 20, 1978 and filed in accordance with 45 CFR Part 16, the Agency's Record of Reconsideration, the Agency's response to the appeal and the State's reply brief.

This case presents two issues on which the decision could turn. The primary argument of the State appears to be that the Agency is estopped from denying New Jersey's claim for FFP because Federal officials provided inaccurate, incomplete or misleading information upon which the State relied to its detriment. The State further argues that at least some of the individuals for whom Federal sharing is being claimed were in fact covered under the State plan.

As has been noted by both parties in submittals to the Board, the events leading to formulation of the State plan and its implementation have become blurred by the passage of time. There does not appear to be a genuine dispute as to the factual content of evidentiary material submitted for consideration, and therefore,

there is no need for a hearing under 45 CFR 16.8(b)(2), as was requested by the State. There is, however, disagreement as to the import of the information and the conclusions to be drawn therefrom.

Estoppel

New Jersey alleges that Federal officials not only failed to advise the State that it could increase eligibility standards so as to permit the MAA population to participate in Medicaid but made material misrepresentations of fact and law with respect to the State's rights and options. The State argues that but for Federal officials' incomplete or erroneous advice, New Jersey would have amended its State plan to allow for Medicaid coverage of the MAA population since the State did furnish a full range of services to that group solely at its own expense.

Under cover of a letter dated April 7, 1976 (Tab No. 17, Record of Reconsideration), New Jersey submitted affidavits from various State officials purporting to show that Federal officials did in fact fail to inform and guide the State in formulating its Medicaid Plan. In addition, the letter pointed out that the Medicaid State Plan did provide for coverage of an optional categorically eligible group of individuals who had enough income to meet their needs while institutionalized but not enough to meet their needs outside the facility. It seems, however, that the State did not fully understand the significance of this information with respect to the period from January 1, 1970 through June 30, 1971 because it did not argue that it was clearly entitled to FFP for at least this period of time.

On July 30, 1976 (Tab No. 25, Record of Reconsideration), New Jersey submitted additional material intended to show that Federal officials were aware of the State's erroneous beliefs with respect to the potential eligibility of its MAA population to Medicaid coverage and were responsible, at the very least, for allowing the State to maintain its misunderstanding of Federal requirements.

In response to a legal opinion furnished by HHS's Assistant General Counsel to the Director of the Division of Special Claims (Tab. No. 26, Record of Reconsideration), the State argued (Tab. No. 28, Record of Reconsideration) that it is immaterial whether Federal officials misled the State by statements or silence; the Federal Government was still liable because of its affirmative duty to provide the State with technical and legal advice.

In the State's view, the Agency, as a fiduciary of Title XIX monies, has an affirmative duty to assist the states in developing as inclusive a program as possible with the aid of Federal funds. The State points out that Title XIX is remedial legislation and urges that its provisions be given liberal interpretation in order to fulfill the objectives of the legislation. Further, the State characterizes 45 CFR 248.10(b)(2)(ii) as ambiguous and notes that

New Jersey could not be expected to understand and apply its provisions without special guidance from Federal officials. The State argues that by denying the claim for FFP, the Agency thwarts the State's discretion to develop a medical assistance program to meet its needs and undermines the framework of cooperative federalism since the State can no longer rely upon Federal expertise.

The Agency's response to the State's application for review denies that the record established a factual basis for the allegations regarding incorrect or misleading information furnished by Federal officials. The Agency states that even if the allegations were true, the Federal Government would not be estopped from denying New Jersey's claim for benefits. In essence, the Agency argues that the government could not be estopped when acting in its sovereign rather than proprietary capacity. In addition, HCFA proposes that the government could not be bound by its employees' unauthorized representations or by its employees' passive failure to provide information.

Although the record is by no means conclusive as to what occurred during the time in question, it is reasonable to assume that the State was not specifically informed that it could claim FFP for the MAA population under the State plan in effect January 1, 1970 through June 30, 1971. Otherwise, New Jersey would have claimed the Federal share from the outset and retained the provisions of the State plan which granted eligibility to that group. This is not to say, however, that the Board accepts the State's theory that the Agency is estopped from denying payment of the claim for the period from July 1, 1971 to September 30, 1973.

Title XIX of the Social Security Act was carefully considered by both Houses of Congress prior to its passage. The precise language of the statute demonstrates that it was the intent of Congress that each State would determine, within a broad general framework, the extent to which it would participate in the program. Section 1901 of the Act specifies that "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State..." (emphasis added), to furnish medical assistance and other services, sufficient sums will be appropriated to carry out the purpose of the Title. The instrument evincing the state's degree of participation was to be the State plan for medical assistance (Section 1902 of the Act). While the state was charged, as a condition of Federal participation in funding, with formulating and implementing the State plan, the Secretary of HHS was given the responsibility to insure that the State plan, as formulated, conformed to the statutory requirements (Section 1116 of the Act) and to determine whether the State plan, as implemented, complied with statutory requirements (Section 1904 of the Act). Thus, the Federal role in administering this cooperative program was essentially limited to ensuring that the states were acting in accordance with the conditions set forth in the legislation.

Given these circumstances, the Board rejects the theory that Federal officials have a legally enforceable obligation to provide advice and guidance to states

regarding the content of State plans. This is particularly true in view of the fact that states are not bound to follow such advice. Federal officials are not privy to the various policy considerations which determine the scope of a State plan and cannot be expected to anticipate problems which might result from the State's implementation of its plan. To the extent that there is a national policy of "cooperative federalism," it is inconsistent to allow a state to shift the responsibility for its errors or omissions to Federal officials and thereby avoid the consequences of its actions.

In the instant case, there is evidence that New Jersey was familiar with the concept of adjusting the standard of eligibility to allow for special circumstances. The State plan in effect in 1970 contained an artfully drafted proviso (Tab No. 17b, Record of Reconsideration) which granted coverage to the MAA population and entitled New Jersey to FFP in the expenditures made for this group. The fact that State officials administering the plan may have been misinformed or uninformed would not alter the outcome with respect to its claim for FFP for the period from July 1, 1971 through September 30, 1973. If a state has any doubt whether it is entitled to FFP, it may submit a claim and receive an official Agency determination. Likewise, if a state has a question whether any group may be properly included within the state plan, it may include the group and receive an official Agency determination whether such inclusion conforms with the statutory requirements. In both instances, there are review and appeal rights which the state may pursue. Thus, even if New Jersey was misinformed, the Board can only conclude that the State was not diligent in protecting its interests.

Federal regulations encourage the states to consult with regional staff when a plan is being prepared or revised. Also, regional staff is expected to initiate discussions with the state on clarification of significant aspects of the plan (see 45 CFR 201.3(a)(b)). This in no way, however, shifts the responsibilities of the respective parties. The state still must present a comprehensive plan for medical assistance describing the nature and scope of its program and the Agency, on behalf of the Secretary, must determine prior to approval whether the plan meets the requirements set forth in the statutes.

Eligibility of MAA Recipients

The State alleges that institutionalized MAA recipients qualify for "aid or assistance" under the State plan for Title I, X and XIV programs and thus are eligible, in accordance with the provisions of Section 1902(a)(10) and Section 1905(a) of the Act, for Title XIX benefits. The "aid or assistance" which the MAA recipients were eligible to receive was purchased social services, but the State argues that this is sufficient to meet the statutory requirement in that they would have been eligible for financial assistance under another State plan had they returned to the community at large.

The Agency rejected the State's theory that provisions in the State plan for furnishing social services to individuals with special needs was sufficient to qualify the MAA population for Title XIX participation. The Agency stated that the controlling regulation, 45 CFR 222.55, which stipulates that the State may elect to provide services to certain specified subgroups of people, applied to former or potential recipients of financial assistance. The fact that the MAA population would be potentially eligible to participate in various programs intended to provide special social services was insufficient.

The Board does not agree with the State's interpretation of Section 1902(a)(10)(A) of the Act. Under 45 CFR Part 222, as in effect during the critical period, various mandatory provisions for all service programs under Titles I, IV, X, XIV and XVI of the Act are set forth and include certain mandatory services which must be made available to all persons eligible under the State plan. In addition, the regulations provide that states may provide a wide range of optional services. The optional provisions include in addition to homemaker services such services as home delivered meals, companionship services, education services related to consumer protection and money management, assistance in obtaining recreational and educational services and services for such groups as alcoholics. If the State's theory is correct, recipients of any of these services would qualify for medical assistance under Title XIX because they received "aid and assistance" under one of the appropriate Titles of the Act.

In the opinion of the Board, when Section 1902(a)(10) speaks of making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under Titles I, IV-A, X, XIV or XVI of the Act, it is referring to the "categorically needy." Any other result would require as a matter of law that medical assistance be furnished to anyone receiving optional services under the State plans of any of the other Titles. Judging from the evidence of record, New Jersey intended to restrict its plan to the categorically needy (See Tab No. 35, Record of Reconsideration).

Retroactivity of Plan Amendment

New Jersey urges that the revision of its State plan in the final calendar quarter of 1973 be applied retroactively to July 1, 1971. In support thereof, the State argues that there is no statutory proscription against retroactive amendment. Noting that 45 CFR 201.3(g) stipulates that the effective date of a new plan or a plan amendment that makes new groups eligible for assistance or services provided under the approved plan may not be earlier that the first day of the calendar quarter in which it was submitted, the State cites Smale & Robinson v. United States for the proposition that although Federal administrators may not waive substantive requirements of a statute, they do have the power to waive regulatory requirements as to procedure and form which are shown to be intended solely for administrative convenience which should not bar retroactivity of the amended State plan.

The Board does not agree. While it is true that Title XIX of the Act does not specifically prohibit retroactive application of a State plan, it appears that Congress intended an approved State plan as a requisite for FFP. Section 1902(a) of the Act requires a State plan to include a variety of provisions which must be applied contemporaneously with the service provided. Obviously, these provisions cannot be enforced retroactively. In this case, for example, the Agency would have no way of knowing if the State during the period in question granted MAA benefits to all individuals who met the standards set forth in the December 1973 amendment to the State plan. The State itself probably has no way of knowing if this was done. While the Agency could determine the Federal share of the cost for the institutionalized MAA population, it could not determine whether in the administration of the MAA program during the period from July 1, 1971 through September 30, 1973 the State applied the revised standard of eligibility established by the amended State plan to all eligible or potentially eligible individuals. If it did not, such actions would constitute failure to comply substantially with various provisions of Section 1902(a).

Thus, 45 CFR 201.3(g), which limits the effective date of the amended State plan, is not a mere procedural matter promulgated for administrative convenience. It is an important portion of the Agency's process in fulfilling the statutory obligation to determine whether the State plan was administered in compliance with the provisions of Section 1902(a).

Income Eligibility Level

The Board has also considered the State's contention that the income eligibility level for MAA recipients should be $170 rather than $162. This contention is apparently based on the fact that during the time in question, the State allowed to those individuals requiring assistance in day-to-day living arrangements, $150 per month for boarding home care plus $20 per month as a personal allowance. It is not clear, however, how this can be related to a determination of eligibility for the MAA population. The section of New Jersey's Financial Assistance Manual which is cited clearly limits expenditures for designated classes of eligible individuals rather than sets forth eligibility standards. It is assumed that the State relies on Section 131.1 of the Manual which allows $170 for individuals requiring boarding home care rather than Section 131.2 of the Manual which allows $220 for individuals requiring services in an Intermediate Care Facility because it wants to invoke the provisions of 45 CFR 248.10(b)(2)(ii). This will not do, however, in the absence of provisions in the State plan which specifically provide for special needs when determining eligibility. It is the absence of such provisions which is cause of this controversy. The State cannot bootstrap allowances for eligible individuals to exceptions in the established eligibility standards for individuals not otherwise eligible.

Finally, the State also asserts that the Agency's final decision failed to include $139,317 attributable to MAA recipients for the period July 1973 through September 1973, representing FFP disallowed for five State mental hospitals resulting from adjustment of interim per diem rates to a final approved rate. It appears, however, that the State raised this claim for the first time in its application for review. The $14,842,373 which was the amount originally

in dispute was identified on New Jersey's Quarterly Statement of Expenditures as "MAA claims for institutionalized patients 1/70 - 10/73." The supporting worksheets do not indicate that any of this amount was for adjusted rates. If the State wishes to present a claim for additional FFP, it must do so in accordance with the pertinent regulations and Agency policy. The Board, in accordance with 45 CFR 16.91, does not have jurisdiction over this subsequent claim and will not consider it at this time.

Conclusion

There is no dispute regarding the central fact in this matter. New Jersey did not include coverage under its State plan for the period from July 1, 1971 through September 30, 1973 for a portion of its aged, institutionalized citizens, referred to throughout this decision as the MAA population. Likewise, there is no dispute that the State could have properly claimed FFP for services rendered to members of this group had the State plan continued to provide them coverage. The State has urged the Board to apply the equitable remedy of estoppel because of the alleged failure of Federal officials to properly perform their duty. Although there is some dispute as to the Federal officials' role in the formulation, administration and amendment of the State plan, the Board does not believe it is necessary to resolve this issue. The Board bases its decision on the conclusion that Title XIX of the Social Security Act, as a condition of Federal financial participation, places sole responsibility for formulation and implementation of the State plan upon the State. The role of the Agency vis-a-vis the State is to ensure that the State plan is in conformance with Title XIX and that it is administered in compliance therewith.

The Board also finds that the State failed to establish that the State plan provided coverage for at least a portion of the MAA population during the period from July 1, 1971 through September 30, 1973.

Accordingly, the decision of the Administrator of the Health Care Financing Administration dated November 22, 1978, is sustained with respect to the denial of the claim for FFP for the period from July 1, 1971 through September 30, 1973.

/s/ Frank L. Dell'Acqua

/s/ Robert R. Woodruff

/s/ Donald G. Przybylinski, Panel Chairman