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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

May 16, 2011

Gloria Nagle, Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Department of Health and Human Services
Centers for Medicare and Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Re: CMS Deferrals AZ/2010/4/E/01/MAP and AZ/2011/1/E/02/MAP

Dear Ms. Nagle:

The State of Arizona has received the deferrals of claims of \$5,215,939 and \$5,309,774 in Federal Financial Participation (FFP) for prior quarter expenditures related to Medicare Part B premium payments for Medical Assistance Only (MAO) recipients. We are hereby providing further explanation in support of these claims, pursuant to 42 C.F.R. § 430.40.

The letters state that the deferrals are based on the CMS regulation at 42 C.F.R. § 431.625(d)(1), and CMS State Buy-in Manual sections 110 and 180, which purportedly deny FFP for state payments of Part B premiums for non-cash MAO groups. We believe the deferrals are in error and the claims should be paid. Nearly half of the FFP CMS seeks to defer, \$5,145,637, relates to Medicare Part B premium payments for beneficiaries who were miscoded as Medical Assistance Only (MAO), but in fact fell into other categories plainly entitling a State to FFP for paying their Part B premiums (deemed cash recipients, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualified Individuals 1 (QI-1s), and CMS Buy-In Notification individuals). The remaining \$5,380,076 in FFP covered by the deferrals relates to Part B premiums the State paid for other dual eligibles (but who were not cash recipients, deemed cash recipients, QMBs, SLMBs, or QI-1s). As discussed below, we believe the State should receive FFP for Part B premiums paid on behalf of these individuals.

I. Miscoded Dual Eligibles

In response to the deferrals, Arizona conducted a review of the eligibility records for the individuals associated with the buy-in files for the quarters in question. As mentioned above, that review revealed that, while our reporting system classified all of the individuals in the buy-in files as SSI-MAO (using buy-in code "M"), certain individuals meet eligibility standards as cash recipients, deemed cash recipients, or as Medicare Savings Program participants. As such, the State is entitled to claim federal financial participation for these individuals as they fall within the plain language of the Medicaid Act, its implementing regulations, and the State Buy-in Manual. For the buy-in payments for quarters ending September 2010 and December 2010, Arizona reclassified individuals according to the following rules:

- If the individual was entitled to QMB, their classification code was changed to P (Qualified Medicare Beneficiary).
- If the individual was entitled to SLMB, their classification code was changed to L (Specified Low Income Medicare Beneficiary).
- If the individual was entitled to QI-1, their classification code was changed to U (Qualified Individual).
- If the individual was receiving TANF Cash Assistance or Title IV-E Foster Care or Adoption Subsidy, their classification code was changed to C (deemed cash).
- If the individual was receiving SSI Cash Assistance, their classification code has been left blank to allow CMS to generate the appropriate buy-in code of A, B, or D.
- If the individual was receiving medical assistance under section 1931, or lost coverage under 1931 due to an increase in earnings or child support, their classification code was changed to C (deemed cash). During the OIG audit, OIG agreed that these individuals are classified as deemed cash.

Attached is a summary of the following figures after this reclassification for the quarters at issue: the total computable amount, the total amount of federal financial participation, as well as a breakdown of the amounts of federal financial participation as calculated using the State's base federal medical assistance percentage and the ARRA increased FMAP. Separately, the State is providing the beneficiary-level data in support of this summary to HeeYoung Ansell, Funding Specialist, Centers for Medicare and Medicaid Services, Division of Medicaid & Children's Health, San Francisco Region.

Arizona is in the process of making changes to the system that generates the buy-in file to automate application of these rules. The State expects that the appropriate system changes will be in place before Part B premiums are paid for October of 2011.

II. Remaining Dual Eligibles

As you can see from the summary, there remain dual eligible individuals who qualify for Medicaid under section 1903(f)(4)(C) of the Social Security Act (SSA), 42 U.S.C. § 1396b(f)(4)(C). Arizona was entitled to FFP for the individuals in question under the terms of two State Medicaid Directors Letters. In any event, the deferrals should be withdrawn as a matter of fairness because the federal government has not suffered any harm from providing such FFP.

A. State Medicaid Directors Letters (SMDLs)

Two separate SMDLs issued in 1997 and 2000¹ provide that, at the State's option, Medicare cost-sharing is available for individuals eligible for both Medicaid and Medicare, but whose income exceeds 100% of the Federal Poverty Level (FPL). The first letter, issued by the Health Care Financing Administration (HCFA) on November 24, 1997, lists "Non-QMBs" as a category of dual eligibles for which FFP is available for the cost of Medicare Part B premiums. See Letter from Sally K. Richardson, HCFA, to Medicaid Directors (Nov. 24, 1997). The 1997

¹ Copies of both letters are enclosed.

letter expressly states that for non-QMBs, “[p]ayment of Medicare Part B premiums is optional. FFP equals FMAP.” *Id.* Enclosure 2 ¶ 2 (emphasis added). Three years later, on December 14, 2000, HCFA issued another SMDL again advising States that FFP is available for Part B premiums paid for non-QMB dual eligibles. *See* Timothy M. Westmoreland, HCFA, to State Medicaid Directors (Dec. 14, 2000). In defining “**Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2)**,” the 2000 letter clarifies that “[p]ayment by Medicaid of Medicare Part B premiums is a State option . . . FFP equals FMAP.” *Id.* at 4 ¶ 7 (emphases added). Taken together, the two letters expressly inform States that FFP is available for Medicare Part B premium payments made for dual eligibles who are not QMBs, SLMBs, Qualified Disabled and Working Individuals (QDWIs), or QI-1s.

Arizona justifiably relied upon the two letters as authority for claiming FFP for the cost of Medicare Part B premiums for the dual eligibles coded as MAO. Arizona began using the “M” code for dual eligibles for whom the State paid Part B premiums in June 1998, *after* HCFA issued the first State Medicaid Directors Letter clarifying that FFP is available for payment of such premiums for non-QMBs. Arizona should not be penalized for taking action that CMS’s own guidance had apparently authorized.

B. 42 C.F.R. § 431.625(d)(1), and State Buy-in Manual Sections 110 and 180

CMS based the deferrals on its understanding that 42 C.F.R. § 431.625(d)(1), and sections 110 and 180 of the State Buy-in Manual prohibit FFP for state payment of Part B premiums for non-cash MAO individuals. It is inappropriate to read these provisions so broadly.

The regulation, 42 C.F.R. § 431.625(d)(1), provides that “FFP is not available in State expenditures for Medicare Part B premiums unless the recipients receive money payments under the [Social Security] Act,” subject to certain exceptions not relevant here, *see id.* § 431.625(d)(1), (2). This language, which dates back to 1969,² cannot be read literally. As you know, Congress subsequently created the QMB, SLMB, QI-1, and other categories expanding FFP for Part B premiums paid for individuals in addition to those receiving cash assistance.³ There is no doubt that FFP is available for payment of Part B premiums for QMBs, SLMBs, and QI-1s. *See* SSA § 1902(a)(10)(E), 42 U.S.C. § 1396a(a)(10)(E). Nevertheless, 42 C.F.R. § 431.625(d)(1) has not been amended to recognize this. Thus, 42 C.F.R. § 431.625(d)(1) cannot constitute a universal rule governing FFP eligibility for State payment of Part B premiums. It therefore should not be read as contradicting the SMDLs, which clarify that FFP is available for dual eligibles such as those at issue in these deferrals.

Similarly, sections 110 and 180 of the State Buy-In Manual should not be read to prohibit FFP for Part B premiums for the dual eligibles in question here. Section 110 of the Buy-In Manual

² Subsection (d)(1) of the current regulation had been codified at 45 C.F.R. § 249.41(c)(1), which provided as follows: “There will be no Federal financial participation in the monthly insurance premium under [Medicare], part B . . . which the . . . State pays on behalf of nonmoney payment individuals eligible to receive [Medicaid].” 34 Fed. Reg. 1324 (Jan. 28, 1969).

³ *See* Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9403(a), 100 Stat. 1874 (1986) (amending SSA § 1902(a)(10), 42 U.S.C. § 1396a(a)(10) to add subparagraph (E)).

provides that only “a cash assistance recipient, a deemed cash recipient, a [QMB], or a [SLMB] . . . is subject to the Federal matching formula.” This section of the Buy-In Manual was last updated and published in 1996. Section 110 is plainly incomplete. It does not list QI-1s as individuals eligible for cost-sharing because Congress did not amend the Medicaid statute to make FFP available for QI-1s until the following year. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4732(a), 111 Stat. 251, 520 (1997) (amending SSA § 1902(a)(10)(E), 42 U.S.C. § 1396a(a)(10)(E), to add clause (iv)). Like the regulation discussed above, section 110 does not comprehensively list every category of recipient eligible for FFP relating to State payment of Part B premiums.

State Buy-In Manual Section 180 also fails to provide a universal rule governing when FFP is available for Part B premiums paid by the State. This section does not even identify the specific categories of dual eligibles listed in section 110 for whom such FFP is available. Instead, section 180 asserts generally that non-cash MAO recipients do not “qualify for Federal matching,” which, as shown above, is clearly incorrect. Thus, neither 42 U.S.C. § 431.625(d)(1), nor sections 110 and 180 of the State Buy-In Manual can be read as comprehensively defining the dual eligible categories eligible for FFP. They certainly cannot provide a basis for disregarding the explicit guidance in the SMDLs, and denying Federal matching for the dual eligibles at issue here.

C. Absence of Harm to the Federal Government

Even if CMS concludes that Arizona was not authorized to receive FFP for its Part B premium payments for the non-cash MAO individuals, CMS still ought to withdraw its deferrals as a matter of fairness and equity. Absent the availability of FFP (which the SMDLs appeared to authorize), Arizona would not have paid the Part B premiums on behalf of these individuals, who were Medicaid-eligible by reason of the special income standard applicable to persons who meet the institutional level of care requirement. *See* SSA § 1903(f)(4)(C), 42 U.S.C. § 1396b(f)(4)(C) (special income limit as an exception to the limitations on FFP). Instead, these persons would have been expected to pay the premiums themselves from their income, which would, at a minimum, exceed 120 percent of the FPL, and could be as high as 300% of the Social Security Income (SSI) income level. This ordinarily would not have imposed a financial burden for the individuals because the amounts expended for Part B premiums would generally qualify as incurred medical expenses that would be deducted from income in the post-eligibility income determination. *See* 42 C.F.R. § 435.725(c)(4). This would have reduced the share of costs of long-term care that these persons are required to bear. *See id.* § 435.832. By the same token, this would result in a higher payment by the State to the long-term care providers, and thus, a *higher FFP contribution*. In this way, the FFP not contributed to Part B premium payments made by the State would have been paid in the form of a greater Federal contribution to the cost of care provided to these dual eligibles.

The foregoing describes conceptually why it would not be equitable to pursue the deferrals in this case. The actual operation in Arizona’s case is somewhat more complicated because virtually all services are provided through managed care plans. This means that FFP is not paid for specific services rendered to Medicaid recipients, but rather as the federal share of capitation payments that cover the cost of all the care provided to enrolled recipients. But the net effect of having the dual eligibles pay their own Part B premiums is the same. The capitation rates are

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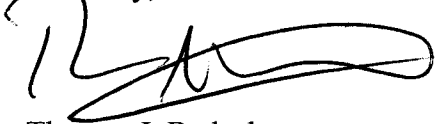
established based on the anticipated payments to be made to the participating providers. Like the case posited above, health plan payments for long-term care and thus, capitation payments, in which the federal government shares, would be higher due to the reduced share paid by recipients who are bearing the cost of their Part B coverage.

In light of CMS' position that FFP is unavailable for Part B premiums the State pays for the special income population, Arizona intends to modify its program to require these recipients to purchase Part B coverage as a condition of receiving the services that Medicare would cover. As such, in September 2011, AHCCCS plans to provide notice to over 10,000 members currently receiving long term care services that AHCCCS will not cover the cost of their Part B premiums due in October 2011 and thereafter. The cost will be deducted from their Social Security payments, but because of delays in the Social Security Administration's processing of the change, these frail elderly or disabled members are likely to have several month's premium deducted from their Social Security checks at once, causing unexpected financial hardship. The members will need to decide whether to continue with the monthly reduction in their income, or ask Social Security to discontinue the Part B benefit. Some members, including those who are institutionalized, may continue with the Part B and request AHCCCS to reduce their share of cost payment by the amount of the Part B premium. Each case requiring a share of cost adjustment will require AHCCCS staff to verify the facts, update the eligibility system and produce notices.

But, we do not think it right that Arizona should be penalized when it was entitled to rely upon guidance previously provided by CMS (which the Departmental Appeals Board has consistently held that states should follow), and there has been little to no real adverse financial impact on the federal government. In these circumstances, it would not be appropriate for CMS to defer or disallow the amounts at issue.

Please let me know if you require additional information. If you have any questions, please contact Jim Cockerham at (602) 417-4059 or at jim.cockerham@azahcccs.gov.

Sincerely,



Thomas J. Betlach
Director

Enclosures

cc: HeeYoung Ansell
Jim Cockerham
Matt Devlin
Charles Miller, Covington & Burling