

December 18, 2003

Ms. Barbara Collins
Center for Medicaid and State Operations
Center for Medicare and Medicaid Services
7500 Security Blvd. - Mail Loc S2-14-26
Baltimore, Maryland 21244

Re: Medically needy programs; deduction of pre-eligibility medical expenses in determining eligibility and cost of care liability.

Dear Ms Collins:

I am writing to request clarification of the meaning of Federal statute law and regulation on two closely related questions: first, whether and to what extent State Medicaid programs are required to deduct nursing home expenses incurred by a beneficiary prior to Medicaid eligibility in calculating income deductions under the medically needy program, and second, whether and to what extent they must deduct such expenses in determining what income is available, post-eligibility, for a resident's cost of care. Related to this, my examination of the Maryland procedures in the context of this case appear to raise a question, in my mind, as to whether its procedure for determining - spenddown eligibility is consistent with 42 C.F.R. § 435.831.

Background and facts. These questions arose in a case in which I was appointed special guardian by the Montgomery County (Maryland) Circuit Court (the Court) specifically for the purpose of pursuing Medicaid benefits for an elderly gentleman, named Anival Monteagudo. Mr. Monteagudo was admitted to a nursing home (the facility) on March 23, 2002; benefits through Kaiser Permanente paid for his care for a short period of time after that. Because a friend agreed to assist in applying for Medicaid benefits, the facility did not independently attempt to resolve eligibility issues, and when the friend backed out in the fall, 2002, it turned out that Mr. Monteagudo was slightly over eligibility for that entire period. (He had one account with a balance of about \$2,640, along with his nursing home account, which received his current income less the anticipated personal needs allowance of \$40 per month.) I was then retained and through the guardianship proceeding got Mr. Monteagudo spent down so that he qualified effective February 1, 2003, for two months of retroactive eligibility, as well as for a prospective budget period beginning April 1, 2003. Between March 2002 and January 31, 2003, Mr. Monteagudo incurred an unpaid nursing home bill of approximately \$54,000.

In my application for benefits for Mr. Monteagudo, I asked the Maryland Medicaid program to deduct from Mr. Monteagudo's current otherwise available income the unpaid portion of his pre-eligibility nursing home expenses, both in determining his spenddown eligibility, and also as part of the post-eligibility procedure for determining available income to meet his current cost of care.

It declined to take either step, for somewhat different reasons. As to spend-down eligibility, Maryland does not permit any of the deductions listed in 42 C.F.R. § 435.831(e)(2) and (3), or (f)(3) or (6), if a nursing home resident's income is less than his projected cost of care. The only deductions allowed in that case are cost-sharing expenses (*cf.* COMAR § 10.09.24.10D(2)(d)(I) *with* 42 C.F.R. § 435.831(e)(1)) and necessary medical or remedial care, as defined in state law, if not covered under the State plan. As to "not covered," the Maryland Medicaid program means services not of the type for which it pays, under its State plan.

As to post-eligibility determination of available income, its regulations track those in the Code of Federal Regulations, requiring the deduction, from current income, of charges incurred for "[n]ecessary medical care ... recognized under State law but not covered under the State Plan," COMAR § 10.09.24.10D(2)(d)(ii); *cf.* 42 C.F.R. § 435.832(c)(4)(ii). However, its position is that nursing home care, whenever provided and whether or not actually paid for, is a service that is "covered under the State Plan," so that there is never any post-eligibility deduction for unpaid pre-eligibility nursing home costs, or indeed for any other medical good or service that would have been paid for had the person been eligible and had it been provided by a Medicaid provider.

It is our understanding, based on a review of the relevant regulations, and consultation with you and other staff, that the Maryland program is not operating its program consistent with the Federal law and regulations in either regard.

First, the Federal medically needy program regulations require a deduction from income for all incurred medical expenses, and specifically including those incurred prior to initial eligibility. This is covered by 42 C.F.R.435.831.

Subsection (f) sets out the "required deductions based on the age of bills," which I would characterized as "last in, first out": once the State goes through bills during the budget period, it then must deduct payments to be made "on other expenses incurred

before the current budget period and not previously deducted from income in any budget period in establishing eligibility for such period” *Id.*,435.831(f)(5)(emphasis added).

Moreover, this applies for later budget periods where the outstanding bills were for “expenses incurred before the current budget period but not previously deducted from income ...” *Id.*,435.831(f)(6). This includes by cross-reference “[e]xpenses incurred ... for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration or scope of services.” *Id.*,435.831(e)(3).

The Federal model State Medical Manual reflects these provisions, as it should. It directs the State Medicaid programs to “[d]educt from countable income the medical and remedial care expenses listed below that are not subject to payment by a third party”; these include “[e]xpenses incurred during the month of application and the 3 preceding months ... Current payments or unpaid balances on old bills incurred outside the current prospective and 3-month retroactive period not previously deducted in any budget period are also deducted.” *State Medicaid Manual* §3628.1.

With respect to the related question, noted, above, of Maryland’s bifurcation for determining spend-down eligibility (distinguishing between those with income greater than their cost of care, and those with income less than that amount), I fail to see anything in the Maryland State Plan that would support this procedure. The relevant portion is Supplement 2.2-A, Section C, pp. 24-26a.

Second, under the regulations respecting *Post-eligibility treatment of income of institutionalized individuals: Application of patient income to the cost of care*, 42 C.F.R. §435.832, *Required Deductions*, the States “*must* deduct... from the individual’s total income... [a]mounts for incurred expenses for medical ... care that are not subject to payment by a third party ... including [n]ecessary medical or remedial care recognized under state law *but not covered* under the State’s Medicaid plan...” §435.832(c), (c)(4) and (c)(4)(ii) (emphasis added).

This is also reflected in the Federal model State Medical Manual, *State Medicaid Manual* §3703.8, second bullet (necessary medical care, as recognized under state law, “but not covered under the State plan”).

Maryland does not disagree with that formulation, but it diverges from Federal law by limiting services “not covered” under the State plan to those of a type never paid for by Medicaid. That is, to be sure, a recognized category, but that is what Federal law and

regulation refer to as “not included” in the State plan; “not covered” has a different meaning. Your agency addressed this distinction some time ago in its explanation of the spenddown rules:

Expenses “included” in the State plan are those for services which are listed in the State plan, whether or not Medicaid will pay for them. By contrast, “covered” expenses are a subset of “included” expenses. Covered expenses are expenses for services for which Medicaid will pay if furnished to the individual by a Medicaid provider. Expenses incurred for services which are for care which exceed State plan limits on amount, duration, and scope are not considered to be covered expenses.

59 Fed. Reg. at 1671. That is, covered services are those that are actually paid for because the individual is eligible and the service is included in the State plan. The reason not to reference covered services here, as used for spenddown eligibility, is that this covers post-eligibility determinations – when the person is already eligible for benefits – so that covered services are already being paid for.

I would appreciate your addressing these two specific questions. To confirm Maryland’s position, I have included copies of the relevant regulations, *Manual* pages, State plan material, and some items from the pending matter involving Mr. Montegudo that reflect the State’s position. I have also taken the liberty of including copies of the two memos that I filed in that case.

Thank you for your attention to this matter.

Yours truly,

s/12/18/03

Ron M. Landsman

RML/

Enclosures:

1. WGatesman ltr to Montgomery County DHHS, April 16, 2003
2. RLandsman ltr to JIvy, October 1, 2003
3. Notice of Eligibility, Anivel Montegudo, Md MA Case no. 494028420, August 20, 2003
4. Local Department Summary for Appeal Hearing, Anivel Montegudo, Md MA Case no. 494028420, November 3, 2003

5. RLandsman, Memorandum of Law, OAH Docket no. DHMH-MONT-10-03-36980, November 21, 2003
6. DCarter ltr to LPritchard, ALJ, Anivel Monteagudo, OAH Docket no. DHMH-MONT-10-03-36980, November 27, 2003
7. RLandsman, Reply Memorandum of Law, OAH Docket no. DHMH-MONT-10-03-36980, December 2, 2003
8. COMAR § 10.09.24.10D
9. Maryland Medical Assistance Manual, pages 1000-20 through 1000-22 and 1000-33 through 1000-43
10. Maryland State Plan, Supplement 2.2-A, Section C, pp. 24-26a.

bcc:

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