DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SEP 13 2004

Ron M. Landsman, P.A.
200-A Monroe Street, Suite 110
Rockville, Maryland 20850-4421

Dear Mr. Landsman:

This is in response to your correspondence in which you requested clarification of federal law and policy related to spenddown and post-eligibility rules in the Medicaid program. Your questions arise from a somewhat complex situation in which you were appointed as the guardian for an elderly individual who resides in a nursing home. The Centers for Medicare & Medicaid Services does not have the authority to review or act on specific Medicaid eligibility decisions made by states, either in the initial determination or appeal phase. We note however, that your letter raises two broader policy issues with respect to treatment of incurred medical expenses, which we will address.

Briefly stated, your questions pertain to the following circumstances: An individual enters a nursing home with assets slightly above the Medicaid resource standard set by the State. Due to various factors, including the individual's incapacity, he neither reduces the assets nor applies for Medicaid, for many months. Upon appointment of a guardian for the individual, the assets are reduced and the Medicaid application is submitted and approved from the month of application forward and for two retroactive months. In the months intervening between the nursing home admission and Medicaid eligibility, several thousand dollars of nursing home charges have gone unpaid. You have two questions: first, whether the unpaid balance still owed to the nursing home should have been deducted as part of the determination of eligibility under the spend-down rules; and second, should the unpaid balance owed to the nursing home have been deducted in the post-eligibility process? For the reasons explained below, the determination of eligibility should not have been based on deduction of these incurred expenses, but they should have been taken into account in the post-eligibility process.

For individuals seeking Medicaid coverage for nursing home care, federal statute and regulation require the State to use a two-step process. The first step involves determination of eligibility based on non-financial and financial eligibility factors. The financial criteria include resource and income limits. Once Medicaid eligibility has been determined for a nursing home resident, federal law and regulation require the State to

follow the post-eligibility process to determine the amount of patient income that must be applied to the cost of care in the institution.

Maryland determines Medicaid eligibility for individuals in nursing facilities under a special income standard, equal to 300 per cent of the Supplemental Security Income (SSI) federal benefit rate. Currently that amount is $1,692. In a situation in which the individual's monthly income is below that monthly income standard and resources do not exceed the resource limit, Medicaid eligibility is determined based on income without making deductions of any kind, including deductions for incurred medical expenses. If the applicant's income is in excess of the special income standard he cannot become eligible as a result of deduction of medical expenses. Thus, there would be no need for the State to determine whether any expenses incurred for prior care should be deducted from income at this step in the process.

In the case described in your correspondence, the Medicaid applicant, Mr. Monteagudo, apparently had total monthly income of $819.70 from Social Security at the time of application. Since his income was less than the special income standard, he was categorically eligible for Medicaid on the basis of that standard without any deductions from income, whether for current or past medical expenses, in order to determine eligibility. It seems that the source of confusion might be the document you submitted dated August 20, 2003 and titled "Notice of Eligibility." Despite its title, this document appears to show calculations for post-eligibility budgeting.

Once Medicaid eligibility has been determined for a nursing home resident, federal law and regulations require the State to follow the post-eligibility process to determine the amount of patient income that must be applied to the cost of care in the institution. Under Section 1902 (r) (1) of the Social Security Act, and regulations at 42 CFR 435.725, amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party must be deducted from patient income in the post-eligibility process.

These post-eligibility provisions would apply to the unpaid nursing home charges that were involved in the case described in your correspondence. Thus, the $54,000 in incurred medical expenses representing the balance Mr. Monteagudo owed to the nursing home should have been deducted from his income as "other" medical expenses in the post-eligibility process, reducing the amount shown on the last line of the August 20, 2003 "Notice of Eligibility" as the "Available Income to be Paid to Cost of Care" to zero. This deduction would continue to be made for as many months as necessary to satisfy the outstanding bill.

While States have the ability to place "reasonable limits" on a resident's expenditures for medical or remedial care that may be deducted in the post-eligibility process, they must include such limits in their State Medicaid Plan. See State Medicaid Manual Section 3703.8.

Based on the material you have submitted it appears that the State limits deduction of medical expenses in the post-eligibility process by excluding "…any medical expenses that would have been covered by the State Plan had the person been eligible for Medical Assistance at the time the expenses were incurred" or "expenses incurred prior to MA eligibility." This limitation is set forth in the State's Medical Assistance Manual. However, after review and consultation, it does not appear that the State included these limits as part of its Medicaid State plan.

If a State has not included its definition of reasonable limits in its State Medicaid plan, such limits cannot be imposed in the post-eligibility process. Thus, the State must deduct incurred medical or remedial care expenses fully. In Mr. Monteagudo's case, if the State chooses in the future to submit a State plan provision excluding medical expenses that were incurred prior to Medicaid eligibility, CMS would review the provision and determine if it constitutes a reasonable limit consistent with federal law and policy.

Sincerely yours,

Mary Jean Duckett

for Gale P. Arden
Director
Disabled and Elderly Health Programs Group

cc: Maryland Department of Health and Mental Hygiene

Regional Administrator
Region III, Philadelphia
Attn: Associate Regional Administrator
Division of Medicaid and State Operations