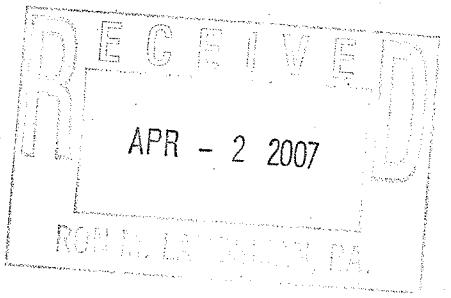
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-20
Baltimore, Maryland 21244-1850
Telephone 410-786-3176 Facsimile 410-786-0043

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of the Attorney Advisor

MAR 3 0 2007



CERTIFIED MAIL

Ms. Lori A. Mayorga
Mr. Joel L. Tornari
Assistant Attorney General
Department of Health & Mental Hygiene
300 W. Preston Street, Suite 302
Baltimore, MD 21201

Re: Maryland State Plan Amendment 05-06, Docket No. SPA-05-06

Dear Ms. Mayorga and Mr. Tornari:

Enclosed is a copy of the final decision of the Administrator, Centers for Medicare & Medicaid Services (CMS), regarding the above-captioned case. On reconsideration, this decision disapproves the State plan amendment SPA-05-06.

This decision constitutes a "final determination" within the meaning of section 1116(a)(3) of the Social Security Act and 42 CFR 430.102(c) and "final agency action" within the meaning of 5 U.S.C. 704. If the State is dissatisfied with this determination, it may, within sixty (60) days after it has been notified, file a petition for review with the United States Court of Appeals.

Sincerely yours,

Jacqueline R. Vaughn
Attorney Advisor

Enclosure

cc: Ms. Noreen O'Grady
Ms. Stephanie McGee Azar
Mr. Toby S. Edelman
Mr. Ron M. Landsman

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the matter of:

The Disapproval of the Maryland State Plan Amendment 05-06

Docket No. SPA-05-06

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for final agency review pursuant to 42 CFR 430.102. The State requested that the Administrator reconsider the issue of whether the State Plan Amendment (SPA) 05-06 conforms to the requirements for approval. The Hearing Officer's recommended decision was issued January 31, 2007, affirming the disapproval of SPA 05-06. The State filed timely exceptions, requesting that the Administrator approve the SPA 05-06. Accordingly, this case is now before the Administrator for final administrative action.

ISSUE

The issue is whether CMS' denial of Maryland's proposed amendment to its State Medicaid Plan was proper.

BACKGROUND

In 2005, the Maryland Department of Health and Mental Hygiene (State) submitted SPA 05-06 to CMS for review. The SPA was entitled "reasonable limits on amounts for necessary medical and remedial care not covered under Medicaid."[1] CMS confirmed, through consultation with the State, that the State intended to limit the deduction of medical expenses in the post-eligibility process to only those expenses incurred during a period of eligibility for Medicaid. CMS considered the State's treatment of medical expenses in the post-eligibility process more restrictive than under the spend-down procedure. The CMS Administrator disapproved SPA 05-06.

The Administrator found that §1902 (r)(1)(A) of the Act requires States to take into account, under the post-eligibility process, amounts for incurred medical and remedial care expenses that are not subject to payment by a third party. Further, that section permits States to place reasonable limits on the amount of necessary medical and remedial care expenses recognized under State law, but not covered under the State plan. However, those reasonable limits must ensure nursing home residents are able to use their own funds to purchase necessary medical or remedial care not covered, i.e. not paid for, by the State Medicaid program. The Administrator concluded that it would not be reasonable "to exclude from post-eligibility protection an incurred medical expense that could be deducted from a person's income under the medically needy spend-down process."

Similarly, the Administrator found that it would be unreasonable to recognize an expense for purposes of the spenddown process, but not to deduct that same expense from an individual's income for purposes of calculating the contribution to the post-eligible cost of care. The Administrator concluded that, while States may establish reasonable limits on the amount of non-covered services, such a proposed limit is not reasonable if the result were to deny the individual the ability to pay for a non-covered expense used to establish eligibility during a budgeted period.

The Administrator noted that § 1902(r)(1) of the Act, as originally enacted, repealed revised post-eligibility regulations promulgated by the Secretary in February 1988. The legislation reinstated the policies set forth in previous regulations. Congress specifically rejected the revised regulations which would have given the State the authority to implement the limits proposed here.

The Administrator found that by not protecting income to pay for non-covered expenses which were used to establish eligibility under the medically needy

---

[1] Maryland's Brief in Support of Approval of Maryland SPA No. 05-06, Exhibit 4.

spenddown provision, the State proposed amendment undercuts the Medicaid statute's purpose of requiring the State to deduct incurred expenses under the spenddown process. Therefore, the Administrator found that such a proposal was not reasonable. As a result, the Administrator found that the State's limit does not meet the requirement of §1902(a)(17) of the Act, as refined by §1902(r)(1) of the Act. For individuals whose post-eligibility calculation is determined using spousal impoverishment rules, specified at §1924 of the Act and refined by §1902(r)(1) of the Act, the Administrator found that the limit does not meet the requirements of §1902(a)(51) of the Act (which requires the State plan to meet the requirements of §1924 of the Act).

The State filed a timely Petition for Reconsideration pursuant to 42 CFR 430.18. The issues to be considered during the hearing were whether the amendment's limit violated the requirements of §§ 1902(a)(17) and 1902(a)(51) of the Act by imposing an unreasonable limit on expenses for medical and remedial care which would be protected under the post-eligibility process.

Pursuant to 42 CFR 430.76(c)(3), several individuals, States and organizations petitioned for, and were granted permission, to participate as amicus curie in the proceedings.

HEARING OFFICER'S RECOMMENDED DECISION

The Hearing Officer's recommended decision stated that CMS holds the authority to oversee the standards that States develop for their medical assistance program and that CMS operated within its legislative mandate when it established the policy that requires consistent treatment of incurred expenses in the spend-down and post-eligibility process. Therefore, Maryland's SPA 05-06 is inconsistent with the CMS policy and was properly denied.

SUMMARY OF EXCEPTION REQUEST

The State submitted an exception which challenged many aspects of the Hearing Officer's recommended decision and reiterated its legal arguments to support its request for the SPA 05-06's approval. The State challenged CMS' legal authority to prescribe "reasonable limits" applicable to the post-eligibility deduction in the form of an expansion of Medicaid eligibility. The State also argued that the CMS' policy

for applying spend-down limits to post-eligibility has no basis in the legislative history, or statutory provisions.[2]

DISCUSSION

The entire record, which was furnished by the Hearing Officer, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Hearing Officer's decision. All exceptions received timely are included in the record and have been considered.

Title XIX of the Act provides for joint Federal and State financing of medical assistance for persons whose income and resources are insufficient to meet the costs of necessary care and services.[3] Section 1905(a) of the Act defines medical assistance as the payment of part or all of the cost of certain medical care and services. In return, participating States must comply with requirements imposed by the Act and by the Secretary of Health and Human Services.[4] States are required to submit a State plan for medical assistance to the Secretary of the Department of Health and Human Services for approval. The State plan reflects the State's choices as to the medical assistance it offers different categories of recipients. A State plan must meet the statutory and regulatory requirements set forth in Title XIX and at 42 CFR 430, et seq.

The Medicaid statute requires States participating in the program to provide coverage to the "categorically needy", i.e., those individuals with incomes low enough to qualify to receive cash assistance.[5] The statute also permits States to elect to provide medical benefits to the "medically needy", i.e., persons who meet the non-financial eligibility requirements for cash assistance, but whose income or resources exceed the financial eligibility standards for those programs. Under §1902(a)(17)(D), the medically needy may qualify for Medicaid if they incur medical expenses in an amount that effectively reduces their income to the eligibility level. This provision is called the "spenddown" and recognizes that when medically needy individuals pay the amount by which their income exceeds medically needy levels they are in the same position as persons eligible for cash assistance.[6]

---

[2] CMS submitted an untimely response to the State's exception request to the proposed Hearing Officer's decision which were not considered or included in the record.

[3] 42 U.S.C. §§ 1396 *et seq.*.

[4] § 1902 of the Act.

[5] *See* § 1902(a)(10)(A) of the Act.

[6] *See* Atkins v. Rivera, 106 S. Ct. 2456, 2458-59 (1986).

Section 1902(a)(17) of the Act states in part that a State Plan for medical assistance must include reasonable standards for determining eligibility for, and the extent of, medical assistance under the plan which, under paragraph (D), in part, provides:

> [F]lexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs ... incurred for medical care or any other type of remedial care recognized under State law.

Consistent with the authorities granted to the Secretary under §1902(a)(17), the Secretary promulgated the regulations at 42 CFR 435.831 which set standards for determining income eligibility for medically needy individuals. The regulations require that States first determine an individual's countable income by subtracting from his/her income amounts that would be subtracted to determine eligibility for cash assistance. If the individual's countable income exceeds the Medicaid standard, States must then deduct incurred Medical expenses.

With respect to the spenddown provision, prior to 1994 the States were required to deduct all medical expenses incurred before application, no matter how far back in time the expenses were incurred if they had not already been used in another budget period, if the individual was still liable for them, or if the individual had paid for them in the current budget period.[7] In 1994, the Secretary revised the regulations to require that States deduct only current medical expenses, those incurred within three months prior to the month of application, and current payments on bills more than three months old. The revisions allowed States to deduct medical expenses incurred more than three months prior to the month of application, and on which the individuals made no payments in the current budget period but the revision did not make the deduction a requirement.[8]

The Secretary considered the three-month limit "reasonable" because it afforded some administrative relief to the state while recognizing that individuals may remain liable for old bills. The Secretary also considered the three-month limit consistent with the limits set by the Congress for the States to provide medical assistance in §1902(a)(34) and, therefore, a suitable guideline for determining how far back the States should account for incurred health costs.[9]

---

[7] 59 Fed. Reg. 1659, 1666 (January 12, 1994) ("Medicaid Program; Deductions of Incurred Medical Expenses (Spenddown.").

[8] 42 CFR 435.831(f) and (g).

[9] 59 Fed. Reg. 1659, 1666.

The revised regulations at 42 CFR 435.831 requires States to deduct expenses incurred during or after the three-month retroactive period for all medical and remedial services recognized under State law, whether or not such services are included in the State's plan and whether or not such expenses exceed State limitations on the amount, duration or scope of services. If, after deduction such medical expenses, the individual's remaining income falls below the Medicaid income standard, the individual is eligible for Medicaid. However, he/she remains responsible for paying any expenses deducted in the spenddown process.

In revising the spenddown regulation in 1994 with respect to incurred expenses, the Secretary ultimately rejected a proposal to allow States to limit deductible medical expenses to services "covered under the State plan." The Secretary noted that:

> We now believe that offering States this administrative option would reduce a person's Medicaid eligibility or the amount of medical assistance provided. Further, Congress passed legislation in 1988 amending the Social Security Act (section 1902(r)(1)) to override a similar option we provided States in the post-eligibility process. We believe it would be inconsistent with the direction taken by Congress in the post-eligibility process to allow a similar limitation in the spenddown process.[10] (Emphasis added.)

Likewise, when discussing deductibles and coinsurance in the spenddown process, the Secretary again recognized the inter-connection and consistency between the spenddown policy and the post-eligibility policy, stating that:

> Congress passed legislation on the post-eligibility process requiring the deduction of expenses for deductibles and coinsurance in the post-eligibility process. It would be inconsistent with the direction taken by Congress to allow States to exclude these expenses in the spenddown process altogether. Therefore, States are required to deduct a reasonable amount of these expenses from income.

Regarding the post-eligibility process, Medicaid requires recipients who are nursing home residents to contribute a portion of their income to the cost of their care.[11] To ensure that nursing home residents pay for their care to the extent that they are capable, the Medicaid statute and regulations require States to perform a second calculation for institutionalized individuals. The calculation is called the post-

---

[10] 59 Fed. Reg. 1659, 1670.

[11] §1902(a)(17) of the Act.

eligibility contribution to care and permits Medicaid to determine the extent of Medicaid's payment for medical assistance for institutionalized individuals.

Prior to 1988, the Secretary had implemented rules making post-eligibility deductions for medical expenses for services not covered under the State plan mandatory. However, the Secretary published a final rule in 1988 that allowed States to disregard income needed to cover expenses incurred for necessary medical and remedial care recognized under State law but "not covered in the State Medicaid plan."[12] Generally, the Secretary proposed to allow States to disregard incurred expenses for services not covered under the plan , i.e., where "no payment is made for them."[13] The rule addressed States' complaints that deducting medical expenses not covered under the State plan produced an indirect subsidy of services that the State had determined not to cover. The Secretary specifically addressed comments regarding medical expenses incurred during a period of ineligibility in the context of the phrase "not covered' under a State plan. Specifically, the Secretary stated that:

> Several commenters suggested that we revise the regulations to place limits on medical deductions for expenses incurred during a period of ineligibility. One of these commenters argued that deductions should be permitted only for services furnished within a budget period. Otherwise, a State is subsidizing medical expenses for a period during which an individual was ineligible. The second commenter asked if States may limit the amount of deductions for institutional expenses during periods of ineligibility to no more than the Medicaid reimbursement rate. A third commenter asked for specific examples of limits or parameters in guidelines.
>
> Response: Services furnished to an individual during a period of ineligibility are services not covered under the State plan. Therefore, the State is not required to deduct medical expenses for services furnished during a period of ineligibility, and may limit deductions to services within the budget period. If the State chooses to allow deductions for medical expenses furnished during a period of ineligibility, it may place reasonable limits on these deductions. This includes institutional expenses incurred during a period of ineligibility and expenses for other covered services. States have the option to deduct institutional expenses at the private rate or at the Medicaid

---

[12] 53 Fed. Reg. 3586 (Feb 8, 1988)("Medicaid Program Payments to Institutions") .

[13] 53 Fed. Reg. 3586 at Subsection B.

> reimbursement rate, subject to reasonable limits imposed by the State.[14] (Emphasis added.)

However, Congress intervened before the rule became final by adding paragraph (r) to §1902 of the Act.[15] Congress ratified the Secretary's prior regulatory language by incorporating this language in the statute. Congress thereby rejected the Secretary's proposal to make these deductions optional including making optional deductions for services not covered by a State plan that were incurred during a period of ineligibility. In particular, §1902(r)(1) states that:

> (r)(1)(A) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915 with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, …., and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance, and
> (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses…..
> (Emphasis added.)

Congress enacted this provision to protect institutionalized individuals and ensure that they were "able to use their own funds to purchase necessary or remedial care not covered by the State Medicaid program."[16] When Congress ratified this language, the Secretary reasonably concluded that Congress was ratifying the

---

[14] 53 Fed. Reg. 3586 (February 8, 1988).

[15] Section 303(d) of the Medicare Catastrophic Coverage Act of 1988 (MCC) amended section 1902 of the Act to add a new subsection (r); redesignated as (r) (1) by § 303(e)(5) of the MCC.

[16] H.R. Conf. Rep. 100-661, 1988 U.S.C.C.A.N. 923, 1044.("The conferees note that until recently, HCFA regulations required that Medicaid–eligible nursing home residents be allowed to deduct uncovered medical costs from their income before contributing towards the cost of nursing care. However, a recent HCFA regulation, 53 *Fed. Reg.* 3586 (Feb 8, 1988), altered this rule to allow Stats to limit this deduction substantially, or to eliminate it altogether. The conference agreement is intended to reinstate the previous rule, retroactive to the effective date of the recent change …." (Emphasis added.)

Secretary's interpretation of "services not covered under a state plan" as including medical expenses incurred during a period of ineligibility.

The regulatory language that pre-dates the enactment of §1902(r) (1) of the Act is set forth at, among other places, 42 CFR 435, subparts H and I which address both the categorically needy and medically needy post-eligibility rules. The regulations at 42 CFR 435.832 and 436.725, inter alia, require States to determine the extent of Medicaid's payment by deducting certain expenses from an institutionalized person's income. The regulations at 42 CFR 435.725 and 42 CFR 435.832 similarly state that:

> Required deductions. In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.
>
> ****
>
> (4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—
>
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
>
> (ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.... (Emphasis added.)

States are required to deduct a personal needs allowance, spousal and family maintenance allowances and certain incurred medical expenses. States may elect to deduct other specified expenses in addition to these required deductions. For medical expenses not subject to payment by a third party, States must deduct "necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on the amounts of these expenses.[17] Once the deductions are made, Medicaid assumes that an individual can use the remaining income to pay for his/her own care and that amount is deducted from the payment that Medicaid makes to the institution.

Section 1902(a)(17) of the Act requires that State plans include reasonable standards to determine eligibility for, and the extent of, medical assistance taking into account

---

[17] 42 CFR 435.725(c)(4)(ii).

only the costs incurred for medical or remedial services recognized under state law, except to the extent prescribed by the Secretary. The Secretary has delegated his authority to administer the Medicaid program to the Administrator of CMS. The Administrator has determined that States are required to treat incurred medical expenses consistently in both the spenddown and post-eligibility processes.[18] The Secretary explicitly stated in 1988 that "services not covered under a State plan" includes services furnished to an individual during a period of ineligibility. Thus, when Congress reinstated the rule requiring that States deduct necessary medical or remedial care recognized under State law "but not covered under the State's Medicaid plan", the Secretary reasonably concluded that Congress reinstated the Secretary's policy with respect to post-eligibility treatment of costs for services incurred during a period of ineligibility.

The Secretary's policy reasonably treats expenses for medical or remedial care incurred in the period prior to eligibility as "not covered under the State plan." The policy recognizes that the intent of §1902(r)(1) of the Act in refining §§1902(a)(17) and 1902(a)(51) of the Act (in reference to §1924) is to afford an institutionalized individual with income the ability to pay non-covered medical expenses for medical or remedial care. Failure to protect income to pay for non-covered expenses which were used to establish eligibility under the medical needy spend down, would undercut the purpose of requiring States to deduct incurred expenses under the spend down provisions. As the State Plan amendment fails to protect income to enable the individual to actually pay for these incurred expenses, the State's proposed limit is not reasonable. The Maryland SPA 05-06 which allows that deduction in the post-eligibility program process only if an individual is eligible for Medicaid during the period is inconsistent with the CMS policy. In light of the foregoing, the Administrator finds that CMS' denial of Maryland SPA 05-06 was proper.

---

[18] The Supreme Court considers §1902(a)(17) and "explicit grant of rulemaking authority" and affords "legislative effect" to regulations that the Secretary adopts pursuant to its authority. Atkins v. Rivera, supra, 106 S. Ct. at 2461.

DECISION

Accordingly, the Administrator adopts the Hearing Officer's decision and affirms CMS' disapproval of the Maryland SPA-05-06.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 3/29/07

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services