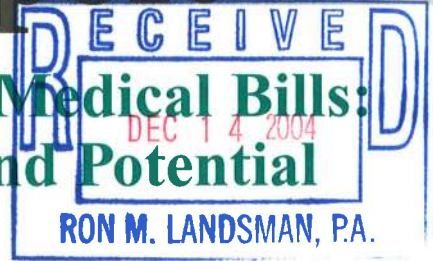


The ElderLaw Report

Editors
Harry S. Margolis, Esq.
Kenneth M. Coughlin

The CMS Letter on Old Medical Bills: Background, Meaning, and Potential Issues



By Ron M. Landsman and Eric Carlson

In This Issue

Keeping Current	4
• <i>Estate of Bergman</i>	
• <i>Estate of Gross v. North Dakota Department of Human Services</i>	
• <i>Lowry v. Georgia Department of Human Resources</i>	
• <i>In the Estate of Herbert</i>	
• <i>In the Matter of Gorsche</i>	
• <i>Rocanova v. Commissioner of Dept. of Social Services</i>	
• <i>Kutnick v. Fischer</i>	
High Court Seeks Brief in Wisconsin Medicaid § 1983 Case	5
Ohio Attorney Sounds Alarm on Post-Eligibility Transfers	6
ElderLaw Fact	7
Reliable Sources	7
Practice Tips	8

The Centers for Medicare and Medicaid Services (CMS) has confirmed that “old” medical bills—bills for medical expenses incurred before establishment of Medicaid eligibility—are to be deducted from current income to determine the Medicaid share-of-cost for a Medicaid-eligible nursing home resident. This confirmation was made in a letter to an attorney, one of this article’s authors, asking about his state’s refusal to follow federal regulations requiring such deductions. (See “Medicaid May Pay Off Old Nursing Home Bills, CMS Confirms,” *The ElderLaw Report*, November 2004.). The letter is available on the Web at www.elderlawanswers.com/resources/documents/LandsmanCMS.pdf.

Medical expenses that are to be deducted on this basis include nursing home charges, and they can be nursing home charges incurred immediately prior to initial eligibility that were not covered only because the resident was ineligible. At least so far as the federal regulations are concerned, the reason for lack of ineligibility is not significant.

The CMS letter noted, and the regulations clearly allow, that a state may impose reasonable limits on what may be deducted, but it must do so in its State Plan, and absent such provisions in the State Plan, there are no limits on the deduction of certifiable *bona fide* medical expenses.

Why Deductibility Can Be Critically Important

Deducting pre-eligibility costs from current income may solve one of the most vexing problems for those who handle Medicaid applications on behalf of nursing home residents and their families. The typical family member managing finances often does not appreciate the nuances of Medicaid. He does not know (for example) that the resource

limitation applies to total resources, not net worth, so that in states without resource spend-down those other \$10,000 in medical bills cannot offset the \$3,500 in savings that precludes eligibility. Or, he thinks that he can achieve eligibility whenever during a month the resident’s resources go below the published resource limit. Or, he does not know that retroactive eligibility requires that the resident meet all of the requirements for eligibility for each of the three months, separately. Or, perhaps there is no family member, and the resident’s income builds up while the facility tries to get a guardian appointed to achieve spend-down.

In these too-common situations, the resident can incur thousands of dollars of facility bills during the poorly managed transition from private-pay to Medicaid eligibility. The resident’s resources fall to the point that there is no longer enough, even with current income, to cover the current monthly cost of care, let alone the growing liability, but do not fall far enough or fast enough to qualify for benefits. Every month’s delay with as little as \$50 of what Medicaid calls, inaptly, “excess resources” can result in liability for \$4,000 to \$8,000 of new nursing home charges that the resident could never pay (absent application of the rules discussed in this article).

The application of the rule expressed in the CMS letter is as follows. Assume that a Medicaid-eligible nursing home resident owes \$5,000 for past-due nursing home expenses and has a monthly share-of-cost of \$500. (For example, a resident with monthly Social Security income of \$626 would get a deduction for his Medicare premium of \$66 and a personal needs allowance (in Maryland) of \$60, making his share-of-cost \$500.) If the \$500 is designated toward the past-due balance (rather than toward the cur-

rent month's expenses), the Medicaid program will pay all of the current month's health care expenses. After 10 months, the past-due balance will be paid off, and the resident can resume designating the \$500 toward current-month expenses.

As the CMS letter states, the debt reflecting "the balance [the resident] 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 . . . 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."

The deduction of medical expenses can arise in two different situations; first, in all states, in making post-eligibility determinations of how much of current income is available to pay for the current cost of care; and second, in states with a medically needy program, in determining eligibility. The CMS letter concerns the first issue, pertain-

ing to post-eligibility treatment of income and medical expenses. This article first will discuss the CMS letter and post-eligibility treatment of income in all states, whether income-capped or medically needy, since the basic rule applies in all cases. It will then briefly discuss how old medical bills can be applied to eligibility determinations in medically needy programs.

The Legal Basis for CMS's Position

During the 1980s, federal regulations required a deduction for non-covered services, including pre-eligibility medical expenses, but in 1988, the Health Care Financing Administration (HCFA, the predecessor to CMS) proposed making the deduction optional for states. [53 Fed. Reg. 3,596 (1988).] Congress disapproved of HCFA's proposal, adding (apparently in conference) to the then-pending Medicare Catastrophic Coverage Act an amendment placing the income deductions into the statute and, as phrased, making it self-executing. The enacted statutory language is found at 42 U.S.C. § 1396a(r)(1)(A)(ii) and states that

with respect to the post-eligibility treatment of income of [institutionalized] individuals . . . there shall be taken into account amounts for incurred medical expenses for medical or remedial care that are not subject to payment by a third party, including . . . necessary medical or remedial care recognized under State law but not covered under the State plan . . . subject to reasonable limits the State may establish on the amount of those expenses.

In releasing corresponding regulations, HCFA explained that the statutory language required deductions for "expenses incurred for necessary medical and remedial care recognized under State law but not included in the State Medicaid plan." Medicare and Medicaid Programs: OBRA '87 Conforming Amendments, Final Rule with Comment Period, 56 Fed. Reg. 8832, 8,836 (1991). The regulatory language requires a deduction from the income of a nursing home resident for "[n]ecessary 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." [42 C.F.R. § 435.725(c)(4)(ii).]

The same rule applies whether the individual is categorically needy in an SSI state, § 435.725, getting services under a home- and community-based services waiver as an alternative to nursing home care, § 435.726, a nursing home resident in a § 209(b) state, § 435.733, or nursing home resident receiving benefits through a medically needy program, § 435.832. Similar language is set forth in the CMS State Medicaid Manual, § 3703.8.

Each of these regulations (in parallel provisions) provides that the State Medicaid agency must reduce payments to facilities by the amount of the resident's income remaining "after deducting the amounts specified in" the respective subparagraphs. [See, e.g., 42 C.F.R. §§

435.725(a)(1).] Next, "[t]he individual's income *must* be determined in accordance with paragraph (e)" of the respective section, and "[m]edical expenses *must* be determined in accordance with paragraph (f)" of the respective section. [See, e.g., 42 C.F.R. § 435.725(a)(2), (3) (emphasis added).]

The regulatory subparagraphs then provide the required deductions, in the order in which they are to be deducted—personal needs allowance, spouse's maintenance needs, family member's maintenance needs, then "[a]mounts for incurred expenses for medical or remedial care that are not subject to payment by a third party . . ." [See, e.g., 42 C.F.R. § 435.725(c)(4).] Subparagraph (c)(4)(I) in each regulation requires the states to deduct Medicare and other health care premiums, deductibles, and co-insurance charges, and the next subparagraph, (c)(4)(ii), requires deduction of "necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan," subject only to "reasonable limits the agency may establish on amounts of these expenses." The last subparagraph of each regulation provides for projecting, using budget periods not to exceed six months, and when prospective calculations are used, reconciling them after the fact. [See, e.g., 42 C.F.R. § 435.725(f)(1)-(3).]

Potential Issues

The potential contested issues involve the meaning of the statutory language "not covered under the State's Medicaid plan," and the lack of specificity in the regulations about the age or time of the medical expenses.

"Not covered" theoretically could be limited to items not normally paid for under the state plan, for example, podiatry or dental services or eyeglasses, and in fact, this was the position taken by the Maryland Medicaid agency in the case that was the subject of the CMS letter. The primary value of the CMS letter is its refutation of the position taken by Maryland and other states.

Under the CMS letter, the services "not covered" under the Medicaid plan include not only those services that never are covered under the Medicaid plan but also those services that were not covered because the Medicaid beneficiary was not eligible for Medicaid at the time the expenses were incurred. It is irrelevant why the beneficiary was ineligible, even if the beneficiary was ineligible due to a transfer-of-assets penalty imposed pursuant to 42 U.S.C. § 1396p(c)(1).

"Reasonable Limits"

A remaining issue is what freedom is retained by state Medicaid programs to "reasonabl[y] limit" income deductions in the state's Medicaid plan. § 3703.8 of the State Medicaid Manual, CMS cautions that reasonable limits

must ensure that institutionalized individuals be able to use their own funds to purchase necessary medical or remedial care not covered by the

Medicaid program, while minimizing opportunities for providers to take financial advantage of either the Medicaid program or the individuals.

Thus, CMS says, states could provide that only uncovered services prescribed by a physician may be deducted [or could] impose specific dollar limits for specific services or items, provided that these limits reflect annual increases in the cost of medical or remedial services and supplies.

By contrast, it would not be reasonable according to CMS "to set an overall dollar limit . . . for all noncovered services" or "to impose a limit on the number of medically necessary services or items that an individual could deduct each month." [CMS State Medicaid Manual, § 3703.8, last unnumbered paragraph.]

Another possible limitation relates to the age of the bill; it certainly would seem reasonable for a medical bill from 10 years ago (for example) to be refused an income deduction. To be reasonable, any restriction based on the age of a bill would have to be connected to the whether the validity of the bill could be determined.

Application to Medically Needy Programs

Nursing home residents in states with medically needy programs who are eligible by reason of current nursing home costs can take advantage of this post-eligibility rule respecting pre-eligibility expenses. But there will be some individuals who are not eligible but for pre-eligibility expenses. CMS requires that pre-eligibility expenses be deducted in that situation as well. The relevant regulation is 42 C.F.R. § 435.831(d)-(g). CMS requires deduction for health insurance premiums, deductibles and co-insurance, (e)(1), incurred expenses for services "not included in the [State] plan," (e)(2), those included but exceeding limits on amount, duration, or scope, (e)(3), and current payments on expenses from before the current budget period, (f)(5). A state must provide a deduction for an "old" medical expense if the beneficiary has paid the expense. [42 C.F.R. § 435.831(f)(5).] By contrast, post-eligibility income deductions require only that expenses be incurred. [See, e.g., 42 C.F.R. § 435.832(c)(4).]

In the vast majority of cases, the distinction between incurring an expense or paying a pre-eligibility expense will not matter. The different descriptions of pre-eligibility expenses that are deductible for eligibility purposes is not likely significant given the catch-all where payments are actually being made. [42 C.F.R. § 435.831(f)(5).] In the typical case (like the fact pattern used throughout this article), the nursing home resident wants to be able to pay off a past-due bill owed to the nursing home.

Working With Facilities

To represent nursing home residents is to be frequently in adversarial relationships with nursing home management. This is particularly true, not surprisingly, when the attorney's client owes the facility thousands of dollars.

The ElderLaw Report

EDITORS

Harry S. Margolis
Kenneth M. Coughlin

Group Publisher

Richard Kravitz

Editorial Director

Beverly Salbin

Production

Paul Iannuzzo

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought—From a Declaration of Principles jointly adopted by a Committee of the American Bar Association and a Committee of Publishers.

© 2004 by Harry Margolis

The ElderLaw Report (ISSN 1047-7055) is published monthly, except bimonthly July/August, by Aspen Publishers, 111 Eighth Avenue, New York, NY 10011. One year subscription costs \$209; two year subscription, \$355; three year subscription, \$502. To subscribe, call 1-800-638-8437. For customer service, call 1-800-234-1660. Send address changes to The ElderLaw Report, Aspen Publishers, 7201 McKinney Circle, Frederick, MD 21704. All rights reserved. Duplication in any form without permission, including photocopying or electronic reproduction, is prohibited. Printed in U.S.A. To order 100 or more reprints of any article, contact Journal Reprint Services toll-free at 1-866-863-9726 (outside the U.S. at 610-586-9973), or visit their Web site at www.journalreprint.com. For information on multiple orders or multiple purchases of back issues, please call Terry Watkins at 212-597-0302.

www.aspenpublishers.com

If (using the fact pattern discussed above) a resident owes \$5,000 in a past-due nursing facility bill, the facility will be pressuring the resident or the family to somehow come up with the money. In turn, the resident may be blaming the facility for contributing to the Medicaid snafu that caused the unpaid bill in the first place.

The income-deduction procedure offers a welcome opportunity for the elder law attorney to solve a problem both for the client and the nursing home. By facilitating the use of the Medicaid income deduction, the resident's attorney can stabilize the client's residence in the nursing home and obtain payment for a nursing home bill that the facility likely had despaired of ever collecting.

KEEPING CURRENT

Assets Transferred by Spouse Are Subject to Medicaid Claim

■ *Estate of Bergman* (N.D., Nos. 20030356 and 20030357, Oct. 20, 2004). The North Dakota Supreme Court rules that assets that a Medicaid applicant transferred to his wife before he died and that she later transferred prior to her own death are subject to a claim against her estate for Medicaid benefits paid.

Carl Bergman purchased a \$50,000 single-premium annuity in 1993. In 1995, he transferred \$5,000 from the annuity to a joint money market account with his wife, Lucille. The following year, Mr. Bergman applied for Medicaid benefits to cover his nursing home care, and in order to qualify, he transferred the proceeds from the annuity and the joint money market account to Mrs. Bergman, who opened an account at the same institution in her name. Mr. Bergman died in 1998. After moving funds between accounts over the next few years and pre-paying burial and funeral expenses, and after being informed of a possible Medicaid claim, Mrs. Bergman made gifts of the remaining funds to her children and grandchildren. Following Mrs. Bergman's death less than one month later, the North Dakota Department of Human Services filed a claim against her estate for the cost of Medicaid benefits provided to her husband. The trial court dismissed the Department's claim, holding that Mr. Bergman had no interest in the annuity at the time of his death.

The Supreme Court of North Dakota reverses, ruling that the trial court had erred in determining that there were no assets in Mrs. Bergman's estate that were traceable to Mr. Bergman. The court concludes that the assets are traceable to Mr. Bergman and that they are subject to a claim against Mrs. Bergman's estate for the Medicaid benefits provided. Further, Mrs. Bergman's subsequent transfers violated the Uniform Fraudulent Conveyance Act because she did not receive reasonably equivalent value and was rendered insolvent. (Also in this case, Mrs. Bergman's estate sought to void the transfers and the Department filed a motion to intervene in the estate's action, a motion that the court's ruling authorizes.)

Conclusion

The CMS letter is clear and unequivocal. For representatives of both residents and facilities, the letter is a superb opportunity to join together where all agree that the issue is payment and their interests merge.

Ron M. Landsman is a Fellow of the National Academy of Elder Law Attorneys and practices in Maryland and Washington, DC.

Eric Carlson is an attorney in the Los Angeles office of the National Senior Citizens Law Center (NSCLC) and the author of NSCLC's Nursing Home Law Letter, a comprehensive bimonthly summary of legal developments in long-term care.

For the full text of this decision, go to <http://www.court.state.nd.us/court/opinions/20030356.htm>. ❖

Annuity Is Countable Because Income Is Said To Be Marketable

■ *Estate of Gross v. North Dakota Department of Human Services* (N.D., No. 20040071, Oct. 12, 2004). The North Dakota Supreme Court rules that a nonassignable annuity issued to the spouse of a Medicaid applicant is a countable asset because the income stream from the annuity, as opposed to the annuity itself, was allegedly saleable in the secondary "factors" market.

The North Dakota Department of Human Services' denied George Gross's application for Medicaid coverage of his nursing home care, concluding that an actuarially sound \$150,000 annuity purchased by and issued to his wife, Julia, was an available asset. The Department determined that, although the annuity itself was not assignable, the stream of income from the annuity was an available asset because it could be sold in a factors market for at least 75 percent of its fair market value. Nationally known annuity practitioner Dale Krause later testified that there were no buyers for the annuity and that two entities had declined to make an offer to purchase the income stream. Nevertheless, the Department found that Mrs. Gross had failed to make a good faith effort to sell the stream of income from the annuity.

Mr. Gross died pending an appeal to the district court, and his estate was substituted as the appellant. The district court affirmed the Department's decision, basing its evidence for a secondary market for the stream of income on the testimony of a Medicaid administrator and an official of the company that issued the annuity.

The Supreme Court of North Dakota affirms, holding that "there is evidence from which a reasoning mind could have reasonably concluded there was a market for the monthly payments or income stream from the annuity, and Julia Gross did not make a good faith effort to sell those monthly payments from the annuity."

For the full text of this decision, go to <http://www.court.state.nd.us/court/opinions/20040071.htm>. ❖