DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Division of Medicaid and Children's Health Operations / Boston Regional Office**

February 22, 2011

JudyAnn Bigby, M.D., Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Dear Dr. Bigby:

The purpose of this letter is to notify you of two issues regarding MassHealth's treatment of pre-eligibility medical expenses in determining the post-eligibility cost-of-care contribution for institutionalized individuals.

**Issue 1: Exclusion of Pre-eligibility Medical Expenses in Determining the Post-eligibility Cost-of-care Contribution**

On November 10, 2010, the Centers for Medicare & Medicaid Services (CMS) Boston Regional Office received a letter from the Massachusetts Senior Care Association (MSCA) regarding MassHealth's treatment of pre-eligibility medical expenses in determining the post-eligibility cost-of-care contribution for institutionalized individuals. This cost-of-care contribution is also called the member's patient-paid amount (PPA). The MSCA argues that MassHealth has not been in compliance with federal law because MassHealth does not allow deductions to the PPA to the nursing home for non-covered, necessary medical and remedial-care expenses incurred during the three-month period prior to establishing eligibility. This office's subsequent conversations with MassHealth eligibility staff confirmed that the State only allows deductions for those expenses that are incurred after the individual is approved for MassHealth long-term care services. The underlying issue revolves around the State's interpretation of §1902(r)(1)(A) of the Social Security Act (the Act). Below is MassHealth's interpretation of §1902(r)(1)(A) copied from 130 Codified Massachusetts Regulations (CMR) 520.026:

> (E) Deductions for Health-Care Coverage and Other Incurred Expenses.
> (1) Health-Insurance Premiums or Membership Costs. The MassHealth agency allows a deduction for current health-insurance premiums or membership costs when payments are made directly to an insurer or a managed-care organization.

(2) Incurred Expenses.

(a) After the applicant is approved for MassHealth, the MassHealth agency will allow deductions for the applicant's necessary medical and remedial-care expenses. These expenses must not be payable by a third party. These expenses must be for medical or remedial-care services recognized under state law but not covered by MassHealth.

(b) These expenses must be within reasonable limits as established by the MassHealth agency. The MassHealth agency considers expenses to be within reasonable limits provided they are

(i) not covered by the MassHealth per diem rate paid to the long-term-care facility; and

(ii) certified by a treating physician or other medical provider as being medically necessary.

Section 1902(r)(1)(A) 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. Section 1902(r)(1)(A)(ii) permits States to place "reasonable" limits on the amounts of necessary medical and remedial care expenses recognized under State law but not covered under the State plan. However, those reasonable limits must ensure that nursing home residents are able to use their funds to purchase necessary medical or remedial care not paid for by the State Medicaid program or another third party.

CMS believes some limitations imposed on the age of an incurred expense could be considered reasonable. But the deduction of the expense cannot be further limited by requiring that the expense be incurred only during a period of eligibility for Medicaid. Our position is supported by the medically needy spenddown rules described in the Federal regulations. While the medically needy spenddown rules at 42 CFR 435.831(g)(2) permit States to exclude expenses incurred earlier than three months before the month of application, 42 CFR 435.831(f)(4) requires that expenses incurred in the three months prior to the month of application must be considered under the spenddown process.

Several States have submitted State Plan Amendments (SPAs) proposing to limit the deduction of incurred medical or remedial care expenses to expenses incurred no earlier than three months preceding the month of application. CMS considers such a limitation, which is based on the age of the incurred expense, to be reasonable. However, the States in question proposed an additional limitation under which the expenses would be deducted only if the individual was actually eligible for Medicaid when the expense was incurred. CMS does not consider this to be reasonable.

Any reasonable limits used by a State must be specified in the State's Title XIX State plan in Supplement 3 to Attachment 2.6-A, "Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered by Medicaid." It is important to note that if a State does not specify its reasonable limits in the Supplement, it will be assumed that the State does not apply any limits to the

deduction of medical or remedial expenses under the post-eligibility process. We reviewed Supplement 3 to Attachment 2.6-A of the approved Title XIX Massachusetts State plan and there is no mention of reasonable limits placed on necessary medical and remedial care expenses that are not covered under the State plan. Therefore, we assume that an incurred medical or remedial expense not covered by the State plan can be deducted from an individual's PPA regardless when it was incurred. We recommend that you revise your State plan to recognize incurred medical or remedial care expenses as those that are incurred during the three months preceding the month of application.

We would also like to clarify the meaning of "not covered under the State plan." For post-eligibility purposes as required by section 1902(r)(1) of the Act, expenses for services not covered under a State's plan are any services not paid for by Medicaid for that particular individual. These include services listed as covered services in the State plan, as well as services the plan does not cover. They also include services the individual received prior to becoming eligible for Medicaid, as well as services received after becoming eligible.

**Issue 2: Treatment of Medical Expenses Incurred During a Period of Ineligibility Resulting from Imposition of a Transfer of Assets Penalty**

During our review of Issue 1, we discovered that the approved Title XIX Massachusetts State plan does not address the treatment of medical and remedial care expenses incurred as the result of the imposition of a penalty for transferring assets for less than fair market value. States have the option of not allowing these expenses to be deducted from the member's PPA. In this scenario, individuals cannot have expenses deducted from their PPA if those expenses were incurred as a result of a penalty.

On April 19, 2006, this office issued State Agency Regional Bulletin No. 2006-06 "Medicaid Eligibility - Treatment of Medical Expenses Incurred During a Period of Ineligibility Resulting from Imposition of a Transfer of Assets Penalty under the Post-Eligibility Treatment of Income Process." This guidance provided States with the option of not allowing any deductions for medical and remedial care expenses incurred as a result of imposition of a transfer of assets penalty period. States that would like to implement this approach were told to amend their Title XIX State plan to reflect their election of this option. Specifically, States should amend Supplement 3 to Attachment 2.6-A, "Reasonable Limits on Amounts for Necessary Medical or Remedial Care not Covered Under Medicaid". When amending the Title XIX State plan, CMS suggested that States use the following language:

> "The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero."

It is our understanding that MassHealth has implemented this in practice but it is not reflected in the State plan.

We are asking that you review the policy described in both sections above and submit a SPA to be consistent with Federal requirements. If you have any questions, please contact Robert Cruz of my staff at (617) 565-1257 or by email at robert.cruz@cms.hhs.gov.

Sincerely,

Richard R. McGreal

Richard R. McGreal
Associate Regional Administrator

cc:
Terry Dougherty, State Medicaid Director
W. Scott Plumb, Senior Vice President, MA Senior Care Association