EUNICE SMITH, et al. **Plaintiffs**	*	**IN THE**
	*	**CIRCUIT COURT**
v.	*	**FOR BALTIMORE CITY**
S. ANTHONY McCANN, et al. **Defendants**	*	**Case No.: 24-C-05-007421**

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MEMORANDUM

This case is before the court upon motions for summary judgment filed by the parties. Plaintiffs are nursing home residents who are recipients of long-term care benefits under the Medical Assistance (Medicaid) Program. They seek injunctive and declaratory relief on their own behalf, and on behalf of a class of persons similarly situated, against defendants, who administer the Medicaid program in the state of Maryland. The suit challenges defendants' actions relating to the deduction of certain expenses from the income of Medicaid recipients for the purpose of calculating the recipients' responsibility to contribute to the cost of their nursing home care. Plaintiffs contend that defendants' actions are contrary to the requirements of the federal Medicaid statute, and that defendants have violated the Maryland Administrative Procedure Act.

Count I of the complaint asserts that defendants have violated the federal Medicaid statute by failing to deduct for expenses for necessary medical care that are not covered by the Maryland State Medicaid plan because the expenses were incurred prior to financial eligibility for benefits, and which were not the subject of any limits in Maryland's State plan. In Count II, plaintiffs contend that defendants have violated the Maryland Administrative Procedure Act by promulgating a rule relating to the deduction of expenses without compliance with the rulemaking requirements of the Act.

I. INTRODUCTION

The issues presented by the motions are legal in nature and do not depend upon the resolution of any factual disputes. In support of their summary judgment filings, the parties have submitted documents relating to defendants' actions, as well as documents concerning actions and statements of the federal agency that oversees the Medicaid program. The following is an overview of the legal and factual framework of this controversy.

The Medicaid program is authorized by Title XIX of the Social Security Act. 42 U.S.C. § 1396 *et seq.* The statute authorizes the provision of benefits to help finance medical care for the indigent. The federal government provides partial financial support for the costs incurred by a participating state in providing medical care for the poor. The program is administered by the states subject to oversight by the federal government. A participating state must comply with Title XIX and its implementing regulations, including eligibility requirements. 42 U.S.C. § 1396a. The Centers for Medicare and Medicaid Services (CMS)[1], a unit of the Department of Health and Human Services, oversees the operation of the program. A state must submit a State Medicaid plan for approval by CMS and administer its Medicaid program in accordance with that plan, which must comply with numerous prescriptive requirements. 42 U.S.C. §§ 1396; 1396a.

The Medicaid statute requires states that participate in the program to provide coverage to the "categorically needy," those persons with incomes low enough to qualify for cash assistance. States are also permitted to provide benefits to the "medically needy," persons whose income or resources exceed the financial eligibility standards for cash assistance programs.

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[1] Prior to 2001, this agency was known as the Health Care Financing Administration.

Under section 1902(a)(17)(D) of the Act, such individuals may qualify for benefits if they incur medical expenses in an amount that reduces their income to the eligibility level. This provision allows individuals whose incomes are otherwise too high for Medicaid eligibility to offset the portion of their income or assets that exceeds the maximum allowed under eligibility criteria by the amount of incurred medical expenses. This is known as the "spenddown" process, as the individuals are said to spend down their excess income to meet the eligibility criteria.

The current provisions of 42 C.F.R. §435.831(e) governing the spenddown calculation require the deduction of the following types of medical expenses:

> (1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under §§ 447.51 or §§ 447.53 of this subchapter;
> (2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;
> (3) Expenses incurred by the individual or family or by financially responsible relatives 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.

The incurred medical expenses that the states are required to deduct to determine eligibility are limited to expenses incurred within three months prior to the month of application (the retroactive period) and current payments on bills that are more than three months old. 42 C.F.R. §435.831.

Once eligible to receive benefits, Medicaid recipients who are nursing home residents are required to contribute all of their available income to the facility to help pay for the cost of their care, with the balance of the cost of care being paid for by the program. These beneficiaries are permitted to deduct certain items in determining the available income that must be contributed to

cost of care.[2] These items include a personal needs allowance, and a maintenance allowance for an institutionalized individual's spouse or family. Certain medical expenses may be deducted as well.

Section 1902(r)(1)(A) of the Act, 42 U.S.C § 1396a(r)(1)(A), provides as follows:

> (r) Disregarding payments for certain medical expenses by institutionalized individuals
> (1)(A) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, 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, there shall be disregarded reparation payments made by the Federal Republic of Germany, 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 subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

The primary controversy between the parties, which is the subject of Count I, involves the issue of whether amounts owed for medical care expenses incurred prior to the date on which an individual becomes eligible for benefits are included within the amounts to be deducted under this section, as expenses for "necessary medical and remedial care recognized under State law but not covered under the State plan." Count II, a claim under Maryland law, involves the issue of whether defendants established a reasonable limit upon the expenses.

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[2] This process is referred by the parties as the "post-eligibility calculation."

A. THE INSTANT CONTROVERSY

Prior to 2004, defendants followed a policy of not permitting the application of pre-eligibility expenses in the determination of beneficiaries' available income. The State Eligibility Manual explicitly stated that the allowance for incurred medical expenses did "not include medical expenses that would have been covered by the State Plan had the person been eligible for Medical Assistance at the time the expense was incurred, nor . . . any other expenses incurred prior to MA eligibility." (Pl. Ex. 8)(underlining in original).

On December 18, 2003, one of the attorneys who represent plaintiffs in this action wrote to CMS concerning an instance in which the Maryland Medicaid Program declined to permit the deduction from a recipient's income of the unpaid portion of his pre-eligibility nursing home expenses in determining available income to meet his current cost of care. The letter questioned whether this position was consistent with federal law and regulations. (Pl. Ex. 11). CMS responded on September 13, 2004 (Pl. Ex. 5), observing that while the limitation in question was set forth in the State's Medical Assistance Manual, this limitation was not included in the State Medicaid Plan. It opined that because it was not included in the State Medicaid Plan, the limit could not be imposed; while states have the right to impose reasonable limits on expenses, such limits must be set forth in the State Plan.

In response to CMS's position, the State adopted and submitted Plan Amendment 04-27 (Pl. Ex. 12), intended to "clarify current eligibility policy for the post-eligibility determination of available income." This amendment was submitted on June 14, 2004, and was approved by CMS on August 18, 2004, with an effective date of April 1, 2004. It proposed the following limit: "disallow as a deduction any amount of medical expenses for dates of service before the retroactive period associated with the effective date of Medical Assistance eligibility."

According to defendants, SPA 04-27 was adopted as a result of CMS's direction that the only limit that could be placed on the deduction of pre-eligibility expenses was a provision limiting deductible expenses to those incurred within the three month retroactive period.

In 2005, the State submitted a second plan amendment, SPA 05-06, which would have provided that no pre-eligibility expenses could be allowed as a deduction in the post-eligibility cost of care calculation. CMS disapproved this amendment on April 25, 2005. The State petitioned for reconsideration of this denial, and on March 28, 2007, the request for reconsideration was denied in a Decision of the CMS Administrator, representing the final administrative decision of the Secretary of Health and Human Services. Defendants have petitioned the United States Court of Appeals for the Fourth Circuit for review of this decision, and that petition is currently pending.

According to plaintiffs (and not contradicted by defendants), there was no public notice of the change effected by SPA 04-27, and no deductions, even for expenses within the three month retroactive period, were allowed until May 2005. The Eligibility Manual was amended effective August 1, 2005. (Def. Ex. 6). The amendment states that unpaid bills may now be deducted for services received when the recipient was not Medicaid eligible, limited to the three month retroactive period. According to defendants, the timing of the implementation of the 2004 State Plan policy occurred when it became apparent that CMS would not approve the limits that were the subject of rejected plan amendment SPA 05-06. On January 20, 2006, defendants issued Notice of Proposed Action in the *Maryland Register*, proposing to amend COMAR § 10.09.24.10 to conform the Maryland Assistance Regulations to the State Plan Amendment previously approved by CMS.

B. THE PARTIES' CONTENTIONS

Plaintiffs' Motion for Partial Summary Judgment asserts that there is no genuine dispute that prior to April 1, 2004 defendants had not established any reasonable limits on deduction of pre-eligibility expenses and, therefore, that defendants' policy of denying deductions for such expenses violates section 1902(r)(1)(A). The motion further asserts that there is no genuine dispute that after April 1, 2004 defendants did not promulgate any regulation in accordance with Maryland law to establish reasonable limits on the deduction of pre-eligibility expenses, and therefore that the denial of deduction of such expenses violated the Maryland Administrative Procedure Act. Alternatively plaintiffs assert that after April 1, 2004 the state failed to follow its State Plan provision allowing deduction of expenses incurred for three months prior to eligibility.

In their Motion for Partial Summary Judgment, defendants acknowledge that prior to April 1, 2004, they had not established any reasonable limits on the deduction of incurred expenses. But they argue that as a matter of law the Medicaid statute does not provide for the deduction of pre-eligibility expenses, and, therefore, that defendants violated no provision of federal law. In response to the claimed noncompliance with the Administrative Procedure Act that is the subject of Count II, defendants assert that they began to effectuate a State Plan amendment approved by CMS by developing Manual instructions directing eligibility workers to deduct pre-eligibility expenses incurred during the three months prior to application, and concurrently developing implementing regulations with an effective date retroactive to the effective date of the Manual instructions. In further response to plaintiff's APA argument, defendants state that if the policy adopted in 2004 is ineffective, the *status quo ante* is that recipients are not entitled to deduct any such expenses, as there is no statutory requirement for

the deduction and no authority for it other than defendants' policy. As to plaintiffs' alternative argument, defendants concede that some individuals may not have received the benefit of the deduction after April 1, 2004, and may have a right to deduct expenses incurred in the three month period, but in no event are entitled to deduct expenses incurred prior to the three month period.

It thus appears that the parties' positions revolve around the issue of whether the statute requires the State to permit the deduction of these expenses. If, as plaintiffs contend, the statute requires the deduction of such expenses, then plaintiffs are entitled to deduct them, subject to any reasonable limit validly adopted by defendants, and the court must go on to determine whether defendants have imposed a reasonable limit and how it applies to plaintiffs and the class. If, on the other hand, the statute does not require the allowance of the deduction, then the court must determine the effect of the adoption of SPA 04-27.[3]

II. COUNT I - THE FEDERAL STATUTE

Plaintiffs assert that the statutory language "not covered by" the State Plan means not paid for by the State Plan. Therefore, in plaintiffs' view, an expense that is not paid for by the state, for whatever reason, is an expense not covered by the State Plan, regardless of the reason. Accordingly, expenses incurred before a recipient is eligible for Medicaid, which the state will not pay because the applicant is not eligible to receive benefits, are not "covered" by the State Plan, because the state will not pay for them.

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[3] It also appears that decision of Count I cannot be avoided on the theory that defendants' current policy confers a right to the deduction. Defendants apparently take the position that SPA 04-27 confers a right to the deduction of expenses incurred within the three month retroactive period. However, the language of the Plan amendment does not expressly state that these expenses may be deducted; rather it imposes a temporal limitation on expenses that may be deducted, without specifying what those expenses might be.

In defendants' view, "not covered" by the State Plan means expenses of a type that the state will not pay for if the recipient is eligible for Medicaid. The State Plan specifies the expenses that will be paid on behalf of a Medicaid recipient. "Not covered" refers to those expenses which the state has excluded from payment by not including them in the Plan. Implicitly, in defendants' view, the statute refers only to expenses incurred during a period of eligibility, because inherently the statute does not provide for payment of expenses on behalf of person not eligible for Medicaid.

In the court's opinion, neither view is an implausible reading of the words of the statute. In one sense, pre-eligibility expenses are not "covered" by the state plan, since the plan will not pay for them because they were incurred while the participant was ineligible for benefits. In another sense they are "covered" by the state plan because they are expenses of the sort which the plan would pay if they were incurred while the participant was eligible. *Per sese*, the words permit either interpretation, and, therefore, the issue cannot be resolved from the words of the statute itself without resort to other sources of statutory construction.

Each party marshals several arguments concerning statutory construction. Plaintiffs contend that the legislative history reveals a Congressional intent to require the deduction of such expenditures. They also assert that CMS interprets the section to include such expenses and that deference is due to this interpretation. Additionally, plaintiffs argue that it would be incongruous to permit these expenses to be used to render the participant poor enough to qualify as needy (referring to the fact that these expenses may be deducted to determine eligibility) but then require the participant to pay them anyway.

Defendants contend that the statute is not intended to apply to such expenditures. Defendants assert that the purpose of the deduction is to permit recipients to have funds to pay

for necessary medical services needed for their care while in a nursing home, and that deducting expenses incurred prior to eligibility does not further this goal. They observe that to the extent that such expenses are deducted from the recipient's contribution to the cost of care, the State indirectly pays for these expenses, as its contribution to the cost of care is correspondingly increased. Defendants argue that it would be incongruous to require the State to pay for expenses that are by definition not within the State's responsibility, i.e., are incurred during a period when the individual was not eligible for benefits. Finally, they attack the interpretation given to the statute by CMS, arguing that it is entitled to no deference.

In order to consider the parties' arguments relating to the statutory history and subsequent administrative interpretation, it is necessary to review that history at some length.

A. LEGISLATIVE HISTORY

The statutory language that is the subject of this debate was inserted as part of the Medicare Catastrophic Coverage Act of 1988. It is identical to the language that appeared in the HCFA regulations prior to 1988, requiring the deduction of expenses not covered by the State plan. *See* 42 C.F.R. § 435.832 (1987). That regulatory language appears first in the regulations that were adopted in 1978. *See* 43 Fed.Reg. 45176. At that time HCFA reorganized the regulations for the Medicaid program. According to the preface to the new regulations, the changes were not intended to make any policy changes, but rather to make clarifying editorial changes.

Included among the regulations adopted in 1978 was section 435.725, relating to post-eligibility treatment of income of institutionalized individuals, which contained the language "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." Also adopted at the same time were regulations relating to spenddown, which require deductions of "expenses . . . for necessary medical and remedial services that are recognized under State law but not included in the plan." 42 C.F.R. 435.831 (1987)(43 Fed. Reg. 45215).

The regulations do not contain any more specific indication of the meaning of these terms. There is no contemporaneous explanation of what the agency intended the language to mean at the time it was promulgated. Prior to 1978, the regulations existed in a different organizational format. The only provision in the prior regulations that seems to be somewhat comparable is former 42 C.F.R. §448.3(c)(2) relating to the definition of available income for contribution to cost of care, which stated: "income will be applied to costs incurred for medical insurance premiums . . . , for any co-payments or deductibles . . . , and for necessary medical or remedial care recognized under State law and not encompassed within the state plan for medical assistance. States may set reasonable limits on such medical services for which excess income may be applied." 42 C.F.R. §448.3(c)(2)(ii)(1977).

In 1985, HCFA issued a Notice of Proposed Rulemaking proposing several changes to the regulations relating to post-eligibility determinations for institutionalized individuals. Among the changes proposed were changes relating to deduction of incurred medical expenses. 50 Fed.Reg. 10992. With respect to this proposed change, HCFA stated:

> [W]e would amend the regulations to allow States greater flexibility in determining allowable medical deductions from the patient's income when establishing his or her contribution to the cost of care. When considering the individual's allowable medical expenses, there are two types which would fit the general category of "noncovered" medical expenses, i.e., medical expenses incurred by the recipient for which title XIX will not be making any payment. These are:
> (1) Medical expenses for services which are recognized under State law, but not covered at all under the State plan; and

> (2) Medical expenses for services which exceed State plan limitations on amount, duration or scope.
> For example, assume a State's plan does not cover dentures, but will pay for up to two dental services per month. An institutionalized individual with income to be considered towards cost of care sees the dentist several times one month which results in charges for five dental services in that month. In the same month, the individual incurs a charge for dentures.
> Under this proposal, States may deduct none, some, or all of the cost of the dentures from this individual's income. However, the State must deduct some amount for the three dental services expenses which exceed its State plan limit on those services.

50 Fed. Reg. 10993. The regulation proposed in 1985 would have required that the States deduct expenses for services that exceeded plan limitations on amount, duration or scope, but would have made the deduction for expenses for services not covered at all optional.

In 1988, HHS issued its final regulations. 53 Fed.Reg. 3586-01. A large volume of comments had been received from States and from others, which were discussed at length. The position relating to deduction of medical expenses covered in the plan but beyond amount, duration and scope limits was revised based on comments received in response to the Notice of Proposed Rulemaking. It was determined that this deduction would also be made optional. In the comments to the proposed rule, the Agency discussed its reasons for permitting states to make this deduction optional.

> On the basis of numerous comments against the proposal to require States to deduct from an individual's income medical expenses that are covered in the State plan, but beyond amount, duration and scope limits, we are revising our position on this issue. Several States said that our proposal requires them to subsidize indirectly services for which they have chosen not to pay. They believe that it also increases Medicaid program costs because recipient income that is used for noncovered medical expenses is not applied to the cost of institutional care. The result is higher payments by the State Medicaid program to a facility to compensate for smaller amounts of income from recipients. . . .

> After careful consideration of the numerous comments on this issue, we have come to the conclusion that requiring States to deduct medical expenses for services included in the State plan, but which exceed State plan limits, would be inconsistent with our intent to provide States with greater flexibility. Moreover, the comments convince us that these services fall into the same category as services not covered under the plan, in that no payment is made for them. We believe that it is reasonable to treat these services in the same way as services not covered under the State plan. Consequently, we are not requiring that States deduct these services, but are making these deductions optional.

53 Fed. Reg. at 3588.

The regulators then went on to discuss other comments that had been received. In discussing a request from commenters that the regulations be revised to place limits on deductions for expenses incurred during a period of ineligibility, the Agency stated:

> 3. Comment: 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.
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> 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 reimbursement rate, subject to reasonable limits imposed by the State.

53 Fed. Reg. at 3589.

Congress took action to prevent the changes in the regulations from becoming effective. The Medicare Catastrophic Coverage Act of 1988 added the language that now appears as section (r)(1)(A). As stated previously, it incorporated the prior regulatory language in the statute. The intent expressly stated by Congress was to overrule the proposed regulation allowing states to eliminate the deduction for "uncovered medical costs" and to reinstate the previous rule. H.R. Conf. Rep 100-661, 1988 U.S.C.C.A.N. 923, 1044. The passage relating to the provision at issue here states:

> With respect to the deduction for incurred medical expenses, the conference agreement requires that, with respect to any Medicaid-eligible individual in an institution (regardless of whether the individual has a spouse in the community), States must take into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles, or coinsurance, and, subject to reasonable limits a State may establish, necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan. 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 toward the cost of nursing home care. However, a recent HCFA regulation, 53 Fed.Reg. 3586 (Feb. 8, 1988), altered this rule to allow States 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 (April 8, 1988). As under the previous regulation, States will have the ability to place "reasonable limits" on a resident's expenditures for medical or remedial care. The conferees wish to emphasize that these limits must ensure that nursing home residents are able to use their own funds to purchase necessary medical or remedial care not covered by the State Medicaid program, while minimizing opportunities for providers to take financial advantage of either the program or the residents. For example, it would be reasonable for a State to provide that only uncovered services prescribed by a physician may be deducted. It would also be reasonable for States to impose specific dollar limits for specific services or items,

> provided that these limits reflect annual increases in the cost of medical care services and supplies. However, it would not be reasonable for States to set an overall dollar limit, such as $50 per month, for all noncovered services. Similarly, it would not be reasonable for States to impose a limit on the number of medically necessary services or items that an individual could deduct in any month. In providing these examples of "reasonable limits" for deductions of uncovered medical expenses incurred by nursing home residents, the conferees do not intend any approval of comparable limitations in the "spenddown" process for medically needy programs.

1988 U.S.C.C.A.N. 1044. There is nothing in the Committee report that reveals any intent specifically relating to the question of whether pre-eligibility expenses are expenses "not covered" by a State plan.

Plaintiffs also refer to another statement in the legislative history that appears in a House Committee Report that accompanied the original bill. The bill that eventually became the Medicare Catastrophic Coverage Act of 1988 was initially introduced in 1987 as H.R. 2470. It was referred to the House Committee on Energy and Commerce, which reported favorably on the bill on July 1, 1987. H.Rep. 100-105(II), reprinted in 1988 U.S.C.C.A.N. 857. In that report, the Committee, describing the deductions from the income to be attributed to an institutionalized spouse, said that there would be deducted "amounts for incurred expenses for medical care for the institutionalized spouse not paid for by Medicaid, Medicare, or another liable third party." 1988 U.S.C.C.A.N. at 895. Plaintiffs argue that this demonstrates Congress's intent to include in the deduction all medical expenses "not paid for" by Medicaid.

There are multiple reasons why this argument is fallacious. First, the language of the bill that is the subject of this commentary is not the same language that appears in the statute that was eventually enacted. Section 214 of H.R. 2470, as the bill existed at the time of this report in 1987, described the deduction as follows: "Amounts for incurred expenses for medical or

remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party." The commentary that plaintiffs cite deals with completely different language that expressly phrases the deduction in terms of payment, not coverage. The language that eventually became law was, as stated above, the same language that previously appeared in the regulations, and was not inserted until many months later as section 303 of an amended H.R. 2470.

The context in which the quoted language appears also indicates that it does not have the significance that plaintiffs attribute to it. The original bill, as it related to Medicaid,[4] was concerned primarily with provisions relating to impoverishment of the community spouse. The primary focus of the passage in which the language appears was the community spouse allowance, which was the subject of extensive discussion. 1988 U.S.C.C.A.N. at 888-902. There is absolutely no indication that the drafters of the original bill gave any thought to the distinction at issue here, and the indications from reviewing the entire report are all to the contrary. H.R. 2470 was drafted before HCFA engaged in the final rulemaking to which Congress reacted in inserting the language that is at issue here. Accordingly, no significant weight can be attached to the statement quoted by plainitffs.

B. AGENCY INTERPRETATION OF THE STATUTE

Another potential source for the court to consider in determining the meaning of the statute is the interpretation of the statute by the administrative agency charged with its implementation. In this case, there are various pronouncements by CMS concerning the statute that have been made since the provision in question was enacted in 1988. Plaintiffs rely heavily

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[4] The greater part of the bill, by far, concerned Medicare.

upon these statements, arguing that they are entitled to deference. Defendants also make extensive reference to CMS's pronouncements, arguing that they are contrary to the purpose of the statute, and illogical. To assess the weight of these statements, it is necessary to review them in some detail.

In 1994, HCFA adopted a final regulation relating to the medical expenses that could be deducted in the spenddown process. 59 Fed.Reg. 1659. This action took into account comments that had been made in response to proposed rules issued in 1983. 48 Fed.Reg. 39959. As revised in 1994, the regulations relating to deduction of incurred medical expenses provide that the states are required to deduct only current medical expenses, medical expenses incurred within three months prior to the month of application, and current payments on older bills. The revised regulation requires states to deduct expenses incurred within the three month retroactive period for all medical and remedial services recognized under state law, whether or not such services are included within the state plan and whether or not the expenses exceed state limitations on the amount, duration and scope of such services.

In the same rulemaking, HCFA also discussed a separate proposal that had been made in the 1983 Notice of Proposed Rulemaking to allow states to limit deductible medical expenses to services covered under the state plan. *See* "Provision E - Allow States to Limit Deductible Medical Expenses to Services Covered Under the State Plan." 59 Fed. Reg. at 1670. There were a number of comments from different sources concerning this proposal. The agency determined not to adopt this proposal, stating that "offering the states this administrative option would reduce a person's Medicaid eligibility or the amount of medical assistance provided." *Id.* Further, referring to the 1988 legislation, the agency stated that "it would be inconsistent with

the direction taken by Congress in the post-eligibility process to allow a similar limitation in the spenddown process." 59 Fed.Reg. at 1670.

There also was a response to a comment from several states concerning the proposal that states may not place "amount, duration and scope limits on covered services in the spenddown process." The response stated:

> Under existing regulations, which have not been revised, States may place reasonable limits on the deductible amount of expenses not included in the State plan but may not limit the deduction of expenses included in the State plan. (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 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.) The basic requirement in section 1902(a)(17) is that incurred expenses recognized under State law be taken into account in the spenddown process. We believe that this is in keeping with the thrust of this requirement to require the deduction from income of expenses recognized under State law when the State has also included the expenses in the State plan, even though the State limits the amount of such expenses it pays for. We, therefore, allow States to limit the deductions only for incurred expenses recognized under State law that are not included in the State plan.

59 Fed. Reg. at 1671.

The first explicit statement by the agency concerning the application of the statutory language "expenses not covered in the State plan" to expenses incurred while an applicant was not eligible for benefits was a 1995 letter from HCFA Region V (Def. Ex. 1). That letter essentially equated "not covered by" with "not payable by" Medicaid in the context of expenses not payable by Medicaid because a recipient was ineligible due to a prohibited transfer of resources. The agency reasoned that because the Medicaid statute prohibits payments for

services incurred during such a period of ineligibility, these expenses are literally services "not covered" by the Plan, citing the language from the 1994 rulemaking quoted above as defining "covered expenses" as expenses for which Medicaid will pay if furnished by a Medicaid provider. Acknowledging that this result created a "loophole," the letter concluded that it was compelled by the literal language of the post-eligibility regulations.

On March 19, 2004, CMS disapproved a State Plan Amendment submitted by Louisiana that would have precluded the deduction in the post-eligibility process of expenses incurred prior to eligibility. (Pl. Ex. 4). It concluded that the limit was not reasonable within the meaning of section 1902(r)(1(A). It stated that the intent of section 1902(r)(1)(A) "is to afford an institutionalized individual with income an opportunity to pay uncovered medical expenses for medical and remedial care." By enacting the section, which reversed proposed regulations that would have authorized a limit of the type proposed by Louisiana, Congress "specifically rejected this approach." Furthermore, it reasoned, the proposal undercut the purpose of requiring states to deduct incurred expenses for purposes of the spenddown.

The agency view concerning the statute is also explained in the letter dated April 25, 2005, in which CMS disapproved SPA 05-06. (Def. Ex. 5). Its reasoning was largely identical to the March 19, 2004 letter. It stated that limits imposed by the State "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 Decision of the Administrator rejecting Maryland's exceptions to the disapproval contains a discussion concerning the reasons for the rejection of SPA 05-06 that expands upon the discussion set forth in the letter rejection, and makes CMS's position more explicit. One part of CMS's reasoning revolves around the relation between the spenddown process and the