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You call it IME, I call it PEME, Let's Call the Whole Thing ... WAIT, NO!

Texas legal service attorneys have an opportunity to improve Texas Medicaid long term care coverage to spare clients the problems arising from delays in eligibility. The issue is your clients' right to deduct incurred medical expenses - what you call IME – even if incurred pre-eligibility – which is why we call them PEME -- from current income in determining cost of care. They have this right under Federal law, affirmed in 2008 by the conservative Fourth Circuit.

The field is open for your action.

I. WHAT IS THE "PRE-ELIGIBILITY MEDICAL EXPENSE" (pre-eligibility IME or PEME) DEDUCTION AND WHY IS IT IMPORTANT?

A. What is "PEME" – pre-eligibility IME

The best way to appreciate PEME is to go back to basics.

First, in general, a recipient of Medicaid long term care is required to use all of his or her available income to pay for his or her own care. The assumption is that the person does not need the income, except for what they need for "personal needs," and all the rest must go for medical care.

Available income is monthly gross income less health insurance premiums (including Medicare, until there is State "buy-in") and a personal needs allowance. If the resident has a low income spouse there might also be a spousal allowance deduction and a family allowance deduction (if a minor or disabled child is living with the community spouse).

There is also a deduction for other medical expenses "not covered" under the Medicaid State Plan. "Not covered" expenses most commonly covers things like dental care,

podiatry, vision care and eyeglasses, and the like. Here is a typical "cost of care" or "patient pay" calculation for the first four months of eligibility of someone who has Medicare, an AARP Medigap policy, and a community spouse (but no children). They also had to get new eyeglasses in the third month.

Income/Expense	Month			
	March	April	May	June
INCOME				
SSA	$1,050	$1,050	$1,050	$1,050
Pension	$790	$790	$790	$790
Total income	***$1,840***	***$1,840***	***$1,840***	***$1,840***
DEDUCTIONS				
Medicare	$96	$96	$0	$0
Medigap	$78	$78	$78	$78
PNA	$70	$70	$70	$70
Spouse allowance	$995	$995	$995	$995
Other medical expenses			$230	
Total deductions	***$1,239***	***$1,239***	***$1,373***	***$1,143***
PATIENT PAY	**$601**	**$601**	**$467**	**$697**

"PEME" is just what the name says – medical expenses incurred prior to eligibility that have not been paid at the time of eligibility. Since at least the 1980s, the Centers for Medicare and Medicaid Services (CMS), including its predecessor, the Health Care Financing Administration (HCFA), have viewed expenses incurred prior to qualifying for Medicaid as "not covered" under the State Plan. As a result, Federal law, as interpreted by CMS, says State Medicaid programs ***must***, in determining a nursing home resident's patient pay amount, deduct unpaid medical expenses incurred ***prior*** to initial Medicaid eligibility.

The States are allowed to impose "reasonable limits" on the deduction, if approved by CMS in the State Plan, but the period for which they must allow the deduction cannot be less than three months (the so-called "retro period").

Texas' State Plan seems to recognize that the Texas Medicaid program is required to allow PEME deductions with the limitations that CMS has found to be reasonable:

¶ The compensation for services beyond "amount, duration and scope" are limited to Medicaid State Plan rates;

¶ Dental services are paid at 90 % of the ADA regional rate survey;

¶ DME expenses based on the Medicare fee schedule.

¶ There is no deduction for expenses incurred more than three months prior to the month of application

¶ There is no deduction for expenses incurred during a transfer of assets penalty period.

See Attachment #1. But it has not implemented the PEME deduction that these provisions suggest. The ***Medicaid Eligibility Handbook*** says there are no "[d]eductions ... for medical services received before the applicants' certification date."[1] § H-2100. Similarly, "Amended Page 6A" (also attached) of the application appears on its face to allow ***some*** deductions, but its language squares with neither the state plan nor the ***Handbook***; it says in pertinent part:

> INCURRED MEDICAL EXPENSES – Effective May 1, 1989, certain "incurred medical expenses" not covered by a third party can be deducted from the amount you pay the nursing home. These expenses are limited to Medicare and other general health insurance premiums, deductibles and coinsurance, and to medical care and services recognized by state law but not covered by the Medicaid State Plan.
>
> Deductions are not allowed for items covered by the nursing home vendor rate, such as diapers, dietary supplements or physical, speech or occupational therapy.
>
> Have you had any medical or dental expenses in the past year that you had to pay for because Medicaid, Medicare or private insurance did not pay? [Yes and no boxes]
>
> If "yes," please indicate below the type of bill (for example, health instance premiums, dentures, etc.), the date paid, and the amount.
>
> [Table provided with columns, "TYPE OF BILL," "DATE PAID," and "AMOUNT"]

B. **PEME in operation**

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1 I am told that Texas Medicaid understands that to mean the date the applicant qualifies for Medicaid financially, as well as medically.

The result is that a person who has medical or nursing home bills at the time he first qualifies for benefits now has a means to pay those bills.

That situation is a common one. An elderly woman in a nursing home runs through her liquid resources and finds that she no longer has enough to pay for her current care. Her husband applies for Medicaid, but miscalculates the community spouse resource allowance and loses one month of eligibility. She qualifies on March 1, but with an unpaid nursing home bill for one month of $7,250. Her patient pay amount is shown in the table above. Her husband would sorely rather not have to pay that bill out of his modest CSRA.

PEME requires Medicaid to deduct her "not covered" nursing home bills from her otherwise available income in determining her patient pay amount each month until the entire amount has been deducted. In this case, her patient pay would be deducted each month as follows, until paid in full:

I	II	III	IV	V
M/Y	Available income (after all other deductions)	Additional amount to be deducted	Patient payment	Unpaid balance
				$7,250.00
3/9	$601.00	$601.00	$0.00	$6,649.00
4/9	$601.00	$601.00	$0.00	$6,048.00
5/9	$467.00	$467.00	$0.00	$5,581.00
6/9	$697.00	$697.00	$0.00	$4,884.00
7/9	$697.00	$697.00	$0.00	$4,187.00
8/9	$697.00	$697.00	$0.00	$3,490.00
9/9	$697.00	$697.00	$0.00	$2,793.00
10/9	$697.00	$697.00	$0.00	$2,096.00
11/9	$697.00	$697.00	$0.00	$1,399.00
12/9	$697.00	$697.00	$0.00	$702.00
1/10	$697.00	$697.00	$0.00	$5.00
2/10	$697.00	$5.00	$692.00	$0.00
3/10	$697.00	$0.00	$697.00	$0.00
Check calculation:		$7,250.00		

(Columns: ***I:*** Month/year; ***II***: "Available income" as determined; ***III***: Amount to be deducted from available income to pay PEME; ***IV***: Resulting patient payment to nursing home for current bill; ***V***: Balance of unpaid medical bills.)

C. Why is PEME important?

PEME solves one of the most vexing problems of Medicaid – the delay that results from well-intentioned but non-expert people in trying to wend their way through the Medicaid maze – or morass, depending on just how bad your county is. The nursing home resident who misses two or three months of eligibility that he or she would have gotten had the representative appreciated all of the spend-down fine points can now get their pre-eligibility care paid for – to their relief, the relief of the nursing home, and to the welfare of everyone involved.

Everyone benefits from this rule. First, clients are relieved from pressure from nursing homes when their spend down for any reason fails to work as planned. Second, nursing homes have reasonable assurance of payment from people who would otherwise be judgment proof and need not be ogres in demanding payment from people who have little or nothing. Third, it gives the elder law attorney more leeway in assisting clients.

The three courts to look at this issue have all found that the Federal PEME rule valid. The first decision came in a Maryland state court class action challenging Maryland's failure to allow any deduction as a violation of Federal law (as well as the validity of a "reasonable limitation" put in the State Plan but not properly adopted as state policy).[2] The PEME requirement was applied in a Montana Supreme Court appeal of a denial of benefits where Medicaid declined to allow the deduction.[3] Maryland's attempt to expand the "reasonable limit" to include all pre-eligibility expenses was rejected by CMS and that rejection was approved by the Fourth Circuit.[4]

2

Smith v. McCann, Balt. Cnty Cir. Ct., No. 24-C-05-007421, Memorandum, 1-18-08 (available at my website:
http://www.ronmlandsman.com/content/uploads/Memorandum-1-18-2008.pdf.

3

Timm v. Dept. of Public Health and Human Services, 343 Mont. 11, 184 P.3d 994 (2008).

4

Maryland Department of Health and Mental Hygiene V. Centers for Medicare and Medicaid Services, 542 F.3d 424 (4th Cir. 2008).

II. WHAT IS INVOLVED IN PURSING INDIVIDUAL PEME CLAIMS AS PRELUDE TO A CLASS ACTION LAWSUIT?

Not to be too obvious, but to get the deduction, you have to ask for it. The request should be made with the application, if possible, but at the earliest possible time for anyone now getting Medicaid benefits who had an unpaid nursing home or other medical bill at the time of initial eligibility.

Before discussing administrative practice in a little detail, I will address the client and his or her interest in any of this. The client who is just seeking Medicaid now and has an unpaid nursing home bill has the most incentive to authorize counsel to pursue this claim. While making the claim is no guarantee that the nursing home will not discharge, or that it will permit re-admission if the resident is hospitalized for any reason, it is nonetheless a real benefit for the client to have the prospect of eliminating that liability. This is especially so if there is a spouse who might be exposed to a claim if they signed an admission agreement, but in any event might fund the pressure unsatisfying. For the resident who has been at a facility for many months, where it is clear the facility is not going to attempt discharge or non-re-admission, the pressure to pursue the claim may be weaker, but to the extent you pursue this claim without charge to that client, there is little reason not to permit you to pursue the claim.

If you work with, or are on good terms with, or in any event have professional connections to nursing homes or their lawyers, they might be able to line up residents who are interested in pursuing claims. However, my own experience is that few have been interested, mostly because of a fear of retaliation by the state Medicaid agency.

You should of course get a retainer agreement with the resident or an appropriate representative.

As to compensation, those nursing homes that have been willing to pursue these claims have been willing to agree to pay a contingent fee of 1/3 of whatever we obtain from Medicaid. I assume state ethics rules vary, but in Maryland there is no problem in getting paid by a third party so long as the client consents to the arrangement.

Maryland has not been aggressive in challenging my relationship to clients, nor has it sought to depose any of the class representatives, but you should be aware that doing so would be part of an aggressive defense and you might want to caution the client to that effect.

Attached please find a sample letter that can be used to make a claim on behalf of a nursing home resident in your State. The claim could be made for:

-- someone who is just now applying for Medicaid, with the deduction to begin with the first month of eligibility, current or retro. It need not be sent in with the application. If you have pending case that presents the claim, you can send it in at any time, but of course the sooner the better.

-- someone who has been a nursing home resident for a while and who still has a legally enforceable nursing home bill. (Arguably, you could make a claim now for someone whose nursing home claim was still good when they first qualified for benefits, but again that might not be the most attractive class representatives.) It should be sent to the local department that handled the case and would normally handle the annual re-certification.

As the sample letter makes clear, these are fairly simple and clear cut claims. You should include the bills covering the entire unpaid amount. If the client does not have, and the facility cannot provide, copies of the actual bills, a computer-generated statement of unpaid charges under nursing home letterhead should be sufficient. If there are non-medical charges, such as beauty shop or haircut, you might deduct them and make a claim for the appropriate balance.

If the local department rejects the request (for example, by issuing a notice of eligibility that shows a patient pay determination without a deduction for the PEME), or fails to act on it within the regulatory time limit (no more than 45 days under Federal law), you should then request administrative relief by appeal for a so-called "fair hearing" before an ALJ on the claim for the PEME deduction. Again, this will be very much a function of local practice, but in Maryland the ALJs are pro-State and rarely if ever will rule against the State on a Federal law claim, but given the larger goal of securing state-wide relief, that is all to the good.

I understand that practice at this point deviates significantly. There is usually some action after the ALJ acts. In some States, the ALJ opinion is a "recommended decision" for the State Medicaid administrator, who adopts it as his or her own, or rejects it. In others (this is Maryland, with which I am familiar), there is an intermediate board of review that can affirm or reverse and usually does so in single sentence orders, but which becomes the decision of the Secretary. Again, like ALJs, but if anything more so, it reflects agency policy and will not reverse the agency based on a Federal law claim.

-- Ron M. Landsman
June 22, 2011

Attachments listed on following page.

ATTACHMENTS

1. Texas [Medicaid] State Plan, Supplement 3 to Attachment 2.6-A, Page 1 -- "Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid."

2. "Amended Page 6A" of Texas Medicaid application form

3. Sample letter making PEME claim

PAGE 321 of plan

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

In determining the amount of monthly income an institutionalized client must pay toward the cost of his care, Texas uses the following limits:

- Covered services beyond the amount, duration, and scope of the Medicaid State Plan that are medically necessary are limited to the Medicaid State Plan rates;
- Services available from Medicaid providers, but recipient elects a non-Medicaid provider is zero;
- A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application;
- A deduction for incurred medical expenses for dental services is based on the American Dental Association, West South Central Region, Survey of Fees at the 90th percentile. If an item is not listed on the Survey of Fees, the item is cleared through a Texas Health and Human Services dental consultant;
- A deduction for incurred medical expenses for durable medical equipment is based on the Medicare fee schedule for durable medical equipment. If an item is not listed on the schedule, the item is cleared through a Medicare contact at the CMS Regional Office; and
- Expenses incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

STATE Texas
DATE REC'D 8-25-09
DATE APPV'D 11-12-09
DATE EFF 8-1-09
HCFA 179 09-21
A

SUPERSEDES: NONE - NEW PAGE

AMENDED PAGE 6A

SECTION 9–THIRD PARTY RECOVERY–Have you received (or do you expect to receive) funds as a result of a lawsuit/personal injury settlement or an accident liability claim?

SECCIÓN 9–RECUPERACIÓN DE TERCEROS. ¿Recibió (o espera recibir) dinero como resultado de una demanda o arreglo por una lesión corporal, o por una reclamación de responsabilidad civil en un accidente? .... ☐ Yes Sí ☐ No

If "No," continue to the next page./Si contesta "No", pase a la página siguiente.

If "Yes," please provide the name, address and telephone number of the attorney who represented you in these proceedings:
Si contesta "Sí", por favor dé el nombre, dirección y teléfono del abogado que lo representó en este caso:

Name of Attorney/Nombre del abogado	Telephone No./Teléfono
Address (Street or P.O. Box, City, State, ZIP)/Dirección (Calle o Aptdo. postal, Ciudad, Estado, Código postal)	

If "Yes," and you were NOT represented by an attorney, give the name of someone (insurance company, court, etc.) who has information about the settlement:
Si contesta "Sí" y NO lo representó un abogado, dé el nombre de alguien que tenga información sobre este arreglo (una compañía de seguros, una corte, etc.):

Name/Nombre	Telephone No./Teléfono
Address (Street or P.O. Box, City, State, ZIP)/Dirección (Calle o Aptdo. postal, Ciudad, Estado, Código postal)	

For Long-Term Care Facilities and Home and Community-Based Waiver Programs ONLY

SOLO para Centros de Atención a Largo Plazo y Programas Opcionales de Servicios en el Hogar y en la Comunidad

INCURRED MEDICAL EXPENSES–Effective May 1, 1989, certain "incurred medical expenses" not covered by a third party can be deducted from the amount you pay the nursing home. These expenses are limited to Medicare and other general health insurance premiums, deductibles and coinsurance, and to medical care and services recognized by state law but not covered by the Medicaid State Plan.

Deductions are not allowed for items covered by the nursing home vendor rate, such as diapers, dietary supplements or physical, speech or occupational therapy.

DEUDAS POR GASTOS MÉDICOS. A partir del primero de mayo de 1989, ciertos "gastos médicos efectuados" por el cliente y no cubiertos por un tercero se pueden reducir de la porción que dicho cliente paga al centro para convalecientes. Estos gastos se limitan a las primas, los deducibles y los coaseguros de Medicare y de otros seguros médicos generales, y a la atención médica y servicios de salud reconocidos por la ley del estado, pero no cubiertos por el plan estatal de Medicaid.

No se permiten reducciones en artículos cubiertos bajo la tarifa que cobra el centro para convalecientes, como pañales, suplementos alimenticios o terapia física, del habla u ocupacional.

Have you had any medical or dental expenses in the past year that you had to pay for because Medicaid, Medicare, or private insurance did not pay?
En el último año, ¿tuvo que pagar algún gasto médico o dental porque no lo pagó Medicaid, Medicare ni ningún seguro privado? ☐ Yes Sí ☐ No

If "Yes," please indicate below the type of bill (for example, health insurance premium, dentures, etc.), the date paid, and the amount.
Si contesta "Sí", indique a continuación el tipo de cuenta (por ejemplo, prima de seguro médico, dentaduras postizas, etc.), la fecha del pago y la cantidad.

TYPE OF BILL (Submit copies of bills, statements, receipts) TIPO DE CUENTA (Mande copias de los cobros, los estados de cuenta y los recibos)	DATE PAID FECHA DE PAGO	AMOUNT CANTIDAD

SUBMIT COPIES OF ALL BILLS, STATEMENTS AND RECEIPTS.
MANDE COPIAS DE LOS COBROS, LOS ESTADOS DE CUENTA Y LOS RECIBOS

June 21, 2011

CASEWORKER
MEDICAID AGENCY

Re: **[Applicant]**
[Medicaid number]
Claim for pre-eligibility medica expense deduction

Dear [case worker]:

I am writing on behalf of [name of client], representative for [Applicant].

Enclosed please find bills for medical services received by [Applicant] prior to her initial qualification for Medicaid. I ask that you deduct these charges from her income in determinating her income to be applied to her cost of care. Since expenses exceed the first month's income, her applied income for that month should be reduced to $0.

The amount not deducted for the first month should be carried forward to the next month, and so forth until the entire charge has been deducted. The deduction should be made effective with her first month of eligibility, [Date, Year], and then continued to the next month and every month thereafter until an amount equal to the entire bill has been deducted.

This deduction is required under Federal Medicaid law. 42 USC § 1396a(r)(1)(A)(ii); 42 C.F.R. §435.725(c)(4)(ii).

I respectfully request that you make your determination of the amount of the deduction within the time required for action on an application, 45 days, as required by Texas regulation and Federal law. 42 C.F.R. § 435.911(a)(2). Please provide an appropriate notice stating the basis for the decision, ***id.*** § 435.912. If you are unable grant this request, I will ask for an administrative hearing under the Texas Medicaid regulations.

Thank you.

Yours truly,

[Attorney]
Attorney for [Name of Client]

Enclosures:
1. Bill from [X] nursing Home, through [Dates].