

Medicaid and Medicare New Developments

November 15, 2007 by Douglas Sea, Legal Services of Southern Piedmont

Health-miscellaneous

County share of Medicaid costs to be phased out over 3 yrs by 2007 Gen. Assembly:
from 15% to 11.5% 10/1/07, 7.5% 7/1/08, 0% 7/1/09

6% increase in SCHIP (Health Choice) enrollment approved by 2007 GA

NC Kids Care passed in 2007 GA (to cover kids between 200 and 300% of poverty);
proposal to be studied for a year. \$7 million appropriated to implement something 7/1/08.

SCHIP reauthorization still stuck in Washington battle, continuing resolution passed

Rating system for adult care homes passed 2007 GA

Special Assistance slight income limit increase effective oct 1 2007; expansion of the in-home portion of the program

Aids Drug Assistance Program: increase in income limit to 200% of poverty by 2007 GA

Medicaid eligibility-miscellaneous

The Deficit Reduction Act of 2005 (DRA) substantially increased documentation requirements to prove citizenship and identity effective July 1, 2006. However, DSS must assist in obtaining this verification, including requesting and paying for birth certificates if the applicant does not have one in his possession. Citizenship verification is not required for current or former SSI recipients, Medicare recipients, or Social Security disability recipients. MA-2504. Proof requirements eased somewhat effective 9/1/07.

To be Medicaid eligible, applicants must be residents of North Carolina. Effective January 1, 2006, a new statute tightened proof requirements for residency at application (current recipients are exempt). See N.C.G.S. 108A-55.3; Two different documents proving N.C. residence are generally required but sworn declarations may be accepted from those without these documents (e.g. homeless). Applicants incapable of stating intent and those who are institutionalized are exempted. See MA-2220

Medicaid disability appeals-new policy by Chief Hearing Officer in Spring 2007 not to consider new evidence submitted after tentative decision

2007 GA appropriated money for 2 new eligibility hearing officers and a new supervisor;
good news for more timely Medicaid eligibility hearing decisions

Mixed citizenship families-Social Security Number can no longer required for financially responsible person (spouse or parent) if not applying for self. ABD Manual Change Notice 26-05.

Medicaid eligibility-income and resources

Medicaid coverage for 18-20 yr old aged out foster care kids regardless of income and assets effective October 1 2007.

New Ticket to Work buy in Medicaid category for disabled persons with incomes under 150% of poverty who have returned to work- effective date postponed again to 7/1/08 by 2007 GA.

Individuals terminated from SSI due to earned income also may retain Medicaid eligibility under Section 1619(b) of the Social Security Act. A potential issue for litigation is DMA's refusal to consider the combined effect of the 1619(b) and "passalong" disregards of Social Security COLA's for former SSI recipients in determining income eligibility for Medicaid.

Effective July 2007, unlicensed vehicles are no longer exempt assets and licensed vehicle must be used for transportation of Medicaid applicant/recipient to be exempt.

Excess Home Equity Rule: For applications for Medicaid filed on or after November 1, 2007, if the equity value in the home exceeds \$500,000, the individual is ineligible for Medicaid to cover long term care or CAP services, unless the individual or his spouse or minor child or blind or disabled adult child lives in the home. Reverse mortgages and home equity loans may be used to reduce home equity but cash from loan or income from reverse mortgage are countable. Excess home equity rule does NOT apply to persons continuously receiving Medicaid LTC services since before November 1, 2007.

The excess home equity rule may be waived for demonstrated hardship. However, the request for waiver must be made within 12 days of notice of the right to do so. Definition of demonstrated hardship in MA-2242 not promulgated and could be challenged on appeal.

Medicaid manual deems income and assets of father of unborn child to pregnant woman even if not married. This violates federal law. Request to change manual pending.

The (d)(4) Special Needs Trust can be funded with income assigned to be paid to the trust rather than to the Medicaid applicant. This assignment may allow individuals to qualify for Medicaid who would otherwise be over the Medicaid income limit, for example from installment payments under a structured personal injury settlement. An assignment of income to a (d)(4) trust is not penalized under SSI and Medicaid transfer of asset rules. Three limitations on such a strategy: 1) whether the payer of the income will agree to the assignment; 2) whether the person establishing the trust has the authority to make the assignment (For example, some pension plans by their terms do not permit the beneficiary to be changed in this way). 3) Whether the Medicaid agency will agree that the income is not countable by Medicaid. Even Social Security benefits have been assigned to be paid to a trust under a court order establishing a (d)(4) trust. However, a

dispute likely to arise regarding whether such diverted income will be excluded under Medicaid rules, particularly for long term care budgeting. See, Matter of Kennedy, 779 N.Y.S.2d 346 (2004).

N.C. DMA defines “community spouse” as separated less than 12 months at the time of institutionalization. MA 2270 VI.A. Thus, community spouse income allowance is denied to a spouse who lives in the community if the couple was separated more than 12 months before the other spouse went into the nursing home. Nothing in 42 USC 1396r-5 or SMM 3260 supports this limitation on definition of community spouse if the couple is still married. DMA has declined to change its manual.

DMA provides no community spouse income allowance for applicants for the Community Alternative Program (CAP) but does provide a community spouse resource allowance in CAP cases.

If the community spouse will not provide his assets to the institutionalized spouse, federal law permits the nursing home resident to become Medicaid eligible by assigning to the state her rights to support. 42 U.S.C. Section 1396r-5(c)(3)(A); Morenz v. Wilson-Coker, 415 F.3d 230 (2nd Cir. 2005); State Medicaid Manual Section 3262.2D. This provision is absent from the N. C. Medicaid manual despite two N.C. statutes which arguably give DMA the authority to accept such an assignment or seek spousal support. See N.C.G.S. 108A-59; 108A-70(b).

Federal law requires the state to allow an undue hardship exception to spousal deeming for institutionalized persons. 42 U.S.C. 1396r-5(c)(3)(C); SMM 3262.2D. This provision is also absent from the N.C. Medicaid Manual.

A waiver of Medicaid disqualification due to an irrevocable trust is required by federal law in the case of "undue hardship." HCFA has developed the following definition of undue hardship: when application of the trust provisions would deprive the individual of medical care such that his life would be endangered or he would be deprived of other necessities of life. HCFA Transmittal No. 64, Section 3259.8 (Nov. 1994). However, DMA has not adopted any rule or manual language to implement this provision.

Interest and dividends no longer counted as income as of 11/1/07 but investments still countable assets.

Effective November 1, 2007, Medicaid manual excludes EITC and child tax credit refunds from assets for 9 months after receipt even if commingled with other assets.

Effective November 1, 2007 Medicaid manual excludes from countable income employer withholdings for certain cafeteria plans.

Effective November 1, 2007, clarifications to Medicaid manual re how to count income from self employment.

Medicaid eligibility-Transfer of Assets

Deficit Reduction Act (DRA) passed: Transfer of Asset changes to be effective 2/8/06

Undue hardship rule defeated four times in N.C. Rules Review Commission. Meanwhile implementation in NC of DRA was delayed.

2007 Legislature: new Transfer of Assets statute and compromise statute defining undue hardship both passed.

Fall 2007: drafts of manual circulated; some requested changes to policy and rule accepted but many problems remain.

11/1/07: Implementation of DRA T of A rules in N.C.

DRA gradually increases the look back period to sixty months for all transfers. If the “starting point” is before November 1, 2010, the look back period is 36 months (except for transfers to a trust or annuity). If the “starting point” is between November 1, 2010 and November 1, 2012, the look back period is always back to November 1, 2007. After November 1, 2012, the look back period is always sixty months.

The trigger date or ending date of the look back period is called the “starting point.” For applications filed on or after November 1, 2007, the “starting point” is the date the person is both admitted to the nursing home (or has requested CAP services) and has applied for Medicaid to pay the cost of nursing home care (or CAP services). For applications made before November 1, 2007, the “starting point” is the date she first applies for Medicaid for home health services.

For transfers made before November 1, 2007, the sanction period begins with the first day of the month in which the property is transferred. However, under the DRA, the beginning of the sanction period is postponed until the individual applies for and is “otherwise eligible” for Medicaid payment for long term care. DMA and CMS have interpreted this provision to require that the individual actually be receiving long term care in a facility or at home before the penalty can begin. MA-2240. This interpretation can create a never-ending “Catch 22” penalty if the nursing home won’t admit the individual until she becomes Medicaid eligible. A legal challenge to this interpretation of DRA is possible. This provision applies to all uncompensated transfers made on or after November 1, 2007.

For transfers made on or after November 1, 2007, the transfer of assets penalty will apply to the transfer of any countable or non-countable resource or income (including the applicant’s or recipient’s home, tenancy-in-common interests in real property, life estates, exempt automobiles, household goods, jewelry, etc.). MA-2240, IV.D. and V.C. For transfers made before November 1, 2007, transfers of most exempt assets other than the home are not penalized. This expansion of the rule to transfers of exempt assets could be challenged as inconsistent with the N.C. Administrative Procedures Act because no rulemaking process was followed. The policy also appears to conflict with the language of the new N.C. transfer

of assets statute, G.S. 108A-58.1, which does not authorize penalizing transfer of any exempt assets except for tenancies in common, income producing property, and life estates. See also, CMS State Medicaid Manual, Section 3257B4.

There is no penalty if the asset (not just the home) was transferred to the applicant's spouse, child under the age of 21, or to his or her blind or disabled child of any age. DMA says the child must be disabled by SSA standards. Who determines disability if that person is over income for SSI and not insured for soc security? Presumably need to appeal the T of A sanction and let state hearing officer apply SSA disability standard.

For annuities purchased by the applicant or spouse on or after November 1, 2007, the state of N.C. must be named the remainder beneficiary. The application of this provision of the DRA to annuities purchased by the spouse could be the subject of legal challenge. See 42 U.S.C. 1396p(c)(1)(G). Copies of annuity contracts must be provided to DSS. Failure to meet these requirements is treated as a transfer of assets. Purchase of single premium endowment life insurance policy now penalized.

The purchase of a promissory note, loan, or mortgage on or after November 1, 2007 also may be treated as a transfer of assets unless the repayment terms meet certain criteria.

DMA has imposed some restrictions on the definition of "good and valuable consideration received" for the transfer which appear to conflict with N.C. contract law, N.C.G.S. 108A-58.1(f)(2), the N.C. Administrative Procedures Act, and federal law. For example, the manual states that personal service contracts are compensation only if a written contract existed prior to services being rendered and only if the recipient is not in a nursing facility. MA-2240, IX.H. In contrast, N.C. contract law does not require a personal services contract to be in writing and does allow a person who is institutionalized to enter into a valid personal services contract.

DMA dropped requirement that personal service contracts be notarized. MA-2240, IX.J.

Requirement for negotiability of purchased mortgages dropped by DMA in final version. MA-2240 IX.B.

DMA dropped requirement that purchase of promissory notes be secured to avoid T of A penalty. Also DMA appears to have removed requirement that promissory note be negotiable for notes purchased after 11/1/07 but must have regular payments to be paid back within life expectancy of recipient. MA-2240 IX.B.

The purchase after 11/1/07 of a life estate in the home of another also may be penalized if certain requirements are not met, including that the purchaser live in the home for one year after purchase. MA-2240 IX.C.

November 1 Manual change adds factors to look at when rebuttal made to show intent not for purpose of qualifying for Medicaid that will make it difficult for some to overcome including whether recipient consulted with an attorney before making the gift

and whether a person providing evidence of intent benefited from the gift. MA-2240 XIII.C.

DMA appears to have dropped requirement that protective services determine person has been defrauded or exploited. Other evidence can be accepted. MA-2240 XIII.C. also changed standard from substantial evidence to greater weight of evidence per Dillingham.

Increase of denominator for T of A sanction period calculation to \$5000 effective July 1 2007.

Rounding down is no longer permitted under the DRA for transfers made after November 1, 2007. This means that fractional portions of a month are now included in computing the penalty period so that an individual may be penalized for a portion of a month.

A new manual provision was added November 1, 2007 based on changes in state and federal law allowing a waiver of the transfer of assets disqualification in the case of "undue hardship." MA-2245. This provision applies to transfers both before and after November 1, 2007.

The DRA and N.C.G.S. 108A-58.2 have adopted the following definition of undue hardship: when application of the transfer provisions would deprive the individual of medical care such that his life would be endangered OR he would be deprived of other necessities of life. However, DMA's manual provision has added further restrictions and particular documentation requirements beyond what is authorized by either the state or federal statute and without promulgating these additional requirements as rules. See, MA-2245 IV.

DSS must notify applicants of the right to claim undue hardship. The individual must request an undue hardship exception within 12 days of notice of the sanction. An additional 12 day period is given to provide evidence of the hardship. A denial of undue hardship, like the transfer sanction itself, is appealable for a local and then a state hearing.

The November 1, 2007 policy change requires the county DSS to request bank statements and other financial documentation for the entire look back period from applicants for CAP or Medicaid coverage of nursing home care to verify that an illegal transfer has not taken place. In the past DSS could accept applicant statement. However, DSS must assist in obtaining this information and must accept alternative documentation that provides a reasonable picture of the look back period. MA-2240 VIA.

Problems with the content of DMA's transfer of asset decision notices could be used as an argument for extending the time period for appeal. See MA-2240 XIV.

PACE (Program for All-inclusive Care for Elderly-managed care for at home who need NF level of care) NOT subject to T of A rule or excess home equity rule

Effective with transfers occurring on or after November 1, 2007, the transfer of assets penalty for home health services (other than CAP) can occur only if a portion of the sanction period remains after first being applied to institutionalization or a request for CAP services. MA-2240. The sanction period runs continuously once it begins. The penalty can still begin with in-home services for transfers prior to November 1, 2007.

November 2007 manual change: returned asset or funds spent for benefit of Medicaid applicant are counted as assets for the entire period they were not in the name of the applicant, which is likely to result in Medicaid ineligibility for the entire period. If a portion of the uncompensated value is returned, similar but more complex rules apply. MA-2240, XII.E. This provision applies even to transfers made before November 1, 2007. This provision could be challenged as inconsistent with the CMS State Medicaid Manual, Section 3258.10C.3, both as to money spent for the benefit of the Medicaid applicant and as to returns of a portion of the asset or equivalent value, particularly if the portion returned is an exempt asset (e.g. life estate).

Implementation of certain T of A changes by DMA without rulemaking may be illegal under NC Administrative Procedure Act. Draft rule for NCAC has been circulated but not formally proposed.

Medicaid estate recovery

Significant changes to estate recovery provisions, including creating pre-death liens, that were scheduled to take effect on July 1, 2007, were repealed by the General Assembly in 2007. Also in 2007, G.S. 108A-70.5(b) was amended to remove some Medicaid services from the list subject to estate recovery, e.g. prescriptions, physician services, Medicare premiums, home health services.

DMA's rules to implement the estate recovery statute appear at 10 NCAC 50D .0101, et seq. Proposals to significantly amend these rules are being considered by DMA.

Estate recovery may be waived or postponed upon a showing of undue hardship. The definition of undue hardship has been somewhat changed under a Medicaid State Plan Amendment effective July 1, 2007. The new definition exempts an estate from a Medicaid claim if property in the estate is the sole source of income for an heir with income below 200% of poverty OR if recovery would force the sale of the residence of an heir who lived there at least 12 months prior to the Medicaid recipient's death and who has income below 200% of poverty and assets of less than \$12,000 (not including the home). Other changes to this definition are being considered. Repeal of 2005 amendments defining undue hardship for estate recovery means old rules still in effect except as amended by this SPA.

A request for an undue hardship waiver must be made within 30 days of notice of estate recovery. It is unclear under the rules and N.C.G.S. 28A who must receive the notice or how specific the notice must be to trigger the 30 day deadline, particularly when no estate administrator has been appointed.

The state cannot collect from the estate if there is a surviving spouse, minor child, or adult disabled child. Current N.C. published rules improperly limit the exemption for disabled adult children to those who live on the property and who became disabled before age 21. Under federal law, estate recovery is flatly prohibited if there is an adult disabled child. DMA has corrected most estate recovery notices to make this exemption clearer. However, the definition of “disability” and how disability is determined are still unclear.

DMA has defined “cannot reasonably be expected to return home” to include all institutionalized recipients under age 55 not expected to come home within six months of admission, even if the individual has in fact returned home. This expanded definition of “permanently institutionalized” appears to be inconsistent with both state and federal law.

Medicaid Services

For non-Medicare recipients, the limits on the number of prescription drugs were increased May 1, 2006 to eight per month. The pharmacist may allow up to eleven prescriptions per month if needed. DMA may allow even more than eleven prescriptions if the recipient participates in a program called FORM to manage medication use.

GA increased limit on doctor visits for adults to 30 per year effective 7/1/07.

The N.C. Supreme Court limited the scope of emergency services that may be covered for undocumented immigrants in Diaz v. Div. of Soc. Ser., 360 N.C. 384 (2006).

All personal care services require prior approval beginning 10/1/07.

Medicaid coverage for orthotics and prosthetics for adults survived proposed elimination in 2007 GA.

Sliding scale cost-sharing (monthly deductibles) for CAP-DD and CAP-C for children whose parents’ income would make them ineligible for Medicaid but for CAP required by 2007 GA beginning 7/1/2008 if approved by CMS; details not yet known.

Increase in rates for PCS 10/1/07.

MUST scheduled to take effective January 1, 2008; new system for prior approval of institutional level care to replace FL2. Due process concerns.

Community Support Services: 2007 GA, CMS, DMA all cracking down because of huge expenditures for this service. Prior approval now required sooner, rates reduced, audits ongoing, new service definitions coming 12/07, CMS proposed regs would limit definition of rehab services even for children.

Large numbers of terminations and reductions by Value Options of mental health and CAP-DD services with no finding of medical improvement, due process problems, and inadequate information to make decision.

300 new CAP-DD slots added by 2007 GA

Restrictions on family members being paid CAP-DD caregivers adopted in 2007.

CAP-AIDS repealed

Money Follows the Person Grant awarded to NC in Spring 2007. Implementation date and plan unknown.

New EPSDT policy instructions issued 8/17/07: significantly expands access to services for recipients under 21.

Medicare Part D

CHANGES TO NC RX: Effective 1/1/08, NC RX no longer will assist with Part D premiums. Instead a card will be issued that can be used at participating drug store for \$300-\$400 in deductible and copay costs. Asset limit removed. Income limit 200% of poverty. Recipients of partial LIS no longer eligible. Must be 65 or older.

CMS Mailings about reenrollment period in November. Part D open enrollment period 11/15-12/31/07.

3 month extension to pay premiums for those who lose LIS Jan 1.

Plan termination for failure to pay premium illegal when SSA error in failing to withhold premium.

Medicare Miscellaneous

Challenge to MQB budgeting for Medicare recipient with spouse not on Medicare won in Superior Court; appeal likely.

1/1/2007 significant increase in Part B premium for those w/incomes over 80K/yr (160K for couples).

Cost-Sharing for Part A and Part B

On October 1, 2007 the Centers for Medicare & Medicaid Services (CMS) announced Part A and Part B premiums and deductibles for 2008.

Hospital Deductible: \$1,024 / benefit period

Hospital Coinsurance:

- Days 0-60: \$0
- Days 61-90: \$256 / day
- Days 91-150: \$512 / day

Skilled Nursing Facility Coinsurance

- Days 0-20: \$0
- Days 21-100: \$128 / day

Part A Premium (for voluntary enrollees only)

- With 30-39 quarters of Social Security coverage: \$233 / month
- With 29 or fewer quarters of Social Security coverage: \$423 / month

Part B

- Deductible: \$135 / year
- Standard Premium: \$96.40 / month

Part B Income-Related Premium

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$82,000	Less than or equal to \$164,000	\$0.00	\$96.40
Greater than \$82,000 and less than or equal to \$102,000	Greater than \$164,000 and less than or equal to \$204,000	\$25.80	\$122.20
Greater than \$102,000 and less than or equal to \$153,000	Greater than \$204,000 and less than or equal to \$306,000	\$64.50	\$160.90

Greater than \$153,000 and less than or equal to \$205,000	Greater than \$306,000 and less than or equal to \$410,000	\$103.30	\$199.70
Greater than \$205,000	Greater than \$410,000	\$142.90	\$238.40

In addition, the monthly premium rates to be paid by beneficiaries who are married, but file a separate return from their spouse and lived with their spouse at some time during the taxable year are:

Beneficiaries who are married but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$82,000	\$0.00	\$96.40
Greater than \$82,000 and less than or equal to \$123,000	\$103.30	\$199.70
Greater than \$123,000	\$142.00	\$238.40

Medicare Advantage Eligibility

- Must be enrolled in Medicare Parts A & B; enrollees are still in the Medicare program,
- Must continue to pay the Part B premium (\$96.40 / month in 2008),
- Must live in the plan's service area,
- Must not have end-stage renal disease (ESRD) at time of enrollment.

Standard Part D Cost-Sharing for 2008

On April 2, 2007 CMS issued information about Part D cost-sharing for 2008:^[2]

Base Beneficiary Premium	\$27.93
Deductible	\$275.00
Initial Coverage Limit	\$2,510.00
Out-of-pocket Threshold	\$4,050.00
Total Covered Part D Drugs to Get to Catastrophic Limit	\$5,726.25
Catastrophic cost-sharing: Generic/ Preferred Drug	\$2.25
Other	\$5.60

Low-Income Subsidy Co-Payments (LIS)

Full Benefit Dual Eligibles w/incomes ≤ 100% Federal Poverty Level	
Generic/Preferred Drugs	\$1.05
Other	\$3.10
Above Catastrophic Limit	\$0.00

Full Benefit Duals with Incomes

>100% Federal Poverty Level &

Other *Full-Subsidy* Eligible Beneficiaries

Generic/preferred drugs

\$2.25

Other

\$5.60

Above Catastrophic Limit

\$0.00

***Partial Subsidy* Eligible Beneficiaries**

Deductible

\$56.00

Co-insurance to ICL

15%

Generics above catastrophic limit

\$2.25

Others above catastrophic limit

\$5.60

CMS has also announced the elimination of the 2008 late enrollment penalty for any beneficiary who qualifies for the low-income subsidy and who enrolls in a drug plan through December 31, 2008.