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March 28, 2016

To:
All members of the House Health and Human Services Reform Committee
Minnesota State Capitol, St. Paul, MN

From: Buddy Robinson, Co-Coordinator, Greater MN Health Care Coalition; and
Staff Director, MN Citizens Federation NE

RE: House File 3467 (Medical Assistance Estate Recovery)

We are writing to the House Health and Human Services Reform Committee in support of HF 3467, authored by Rep. Matt Dean, regarding Medial Assistance Estate Recovery.

Greater MN Health Care Coalition represents 3,000 members in east central, north east, and central Minnesota. We are strongly in favor of enactment of HF 3467, which is a companion to SF 2501, authored by Sen. Tony Lourey. We are glad that SF 2501 was approved by the Senate Health, Human Services and Housing Committee on March 14 after a hearing on that date. It will eliminate the estate recovery of non-long term care expenses for Medical Assistance enrollees from ages 55 to 64.

We want to comment on and clarify several points of information on this issue, based on our own direct research of relevant documents in state statutes, CMS communication (Centers for Medicare and Medicaid Services), and DHS Bulletins (MN Dept. of Human Services). We found that:

1. Sen. Lourey correctly stated at the March 14 hearing that existing law, for a long time, required this estate recovery. Minnesota State Statutes 256B.15, Subd. 1a have had a requirement, since 1995, that estate recovery claims "shall be filed" [paragraph (e)] for the "total amount paid for Medical Assistance" services [paragraph (a)], meaning all services, not just long term care (LTC), for people over age 55. (Chapter 207, Article 6, Sections 79 and 80). Prior to 1995 and going back to 1967, this recovery was limited to people over age 65.

2. Senator Lourey also correctly described on March 14 how the current crisis of exposure to estate recovery by people concerned about their assets evolved: When the ACA expanded Medicaid (Medical Assistance, or MA in Minnesota) income limits, it meant many more people enrolled in MA than before, including many previo*usly on MinnesotaCare who were now within the new, higher MA income limits.* As you know, there are no asset limits on MinnesotaCare; and the new ACA rules eliminated an assets limit for people getting onto Medicaid (MA). Also, many people with significant assets, usually in the form of real property, enrolled in MA without having been on MinnesotaCare before. Both groups were taken by surprise and deeply dismayed with the estate claims being put on their property and assets.

3. **CMS letter, Feb. 2014:** Something not fully discussed at the Senate hearing was the letter, to State Medicaid Directors, from the federal Centers for Medicare and Medicaid Services (CMS), dated Feb. 14, 2014 (SMDL #14-001, ACA#29). CMS wrote to Medicaid Directors in response to their requests for advice on dealing with Medicaid asset recovery in light of the ACA. On page 2 it states:

> states must also seek recovery, for Medicaid beneficiaries who were 55 years old and older….. for nursing facility services, home and community based services (HCBS), and related hospital and

prescription drug services, or, at state option, for any other items and services under the state plan (with the exception of Medicare cost-sharing)."

In other words, recovery of LTC expense is mandatory, **but recovery of non-LTC expense is a state option, as far as CMS is concerned.** Further, on page 3 it states:

> Due to the potential barrier to enrollment that future estate recovery may create for some individuals, CMS intends to thoroughly explore options and to use any available authorities to eliminate recovery of Medicaid benefits consisting of items or services other than long term care and related services in the case of individuals who are determined eligible for Medicaid benefits using the MAGI methodology.

(Note: MAGI stands for Modified Adjusted Gross Income, which is the category of enrollees in the new, higher "Medicaid expansion" income limit.)

In this paragraph, we see that CMS is telling states that estate recovery is undesirable, because it **can be a barrier for enrollment**; and that CMS intends to rectify that by **trying to find ways to eliminate the recovery for non-LTC services.** CMS is not explicitly urging states to "please don't exercise your option to do this," but it is nonetheless clear to states that CMS would rather they didn't, since it will likely be outlawed before long.

4. **DHS bulletin, Aug. 2014:** Something not mentioned at all at the hearing was the MN Dept. of Human Services' (DHS) action in Aug., 2014. DHS responded to the CMS letter by issuing its own bulletin on Aug. 13, 2014, "MA Estate Claim Recovery and Undue Hardship Waivers" (Bulletin # 14-21-03). On page 4, this bulletin stated DHS' current and unchanged rule, based on State Statute 256B.15:

> No Change: The county or state may recover from a deceased MA recipient's estate for those individuals who were 55 years of age or older when they received MA services provided for under chapter 256B of Minnesota statutes, regardless of income methodology. The recovery of MA costs in these estates applies to all MA services, not just LTC services. See HCPM Liens and Estate Recovery for a more detailed explanation of estate recovery and the lien process.

It is interesting that this bulletin reads "may recover" instead of "shall recover." We do not know whether or not DHS was routinely filing estate claims, prior to 2014, for all MA enrollees in the 55 to 64 age bracket, for all services – including and besides LTC expenses. It probably was not an issue for most enrollees – even if they knew about it -- since their assets were very low. We think it is significant that the DHS bulletin did not make any reference to CMS' comments about the undesirability of recovery for non-LTC expenses, nor mention any concern for problems that could arise from this. (Note: There have been, and still are, allowable hardship exceptions people can apply for in order to escape recovery.) **And, it is disturbing that DHS did not prioritize making enrollees aware of the recovery provisions.**

5. Whether or not DHS had been routinely filing estate claims all along for 55-64 year olds for all services -- not just LTC, we think the following points and **questions about DHS' behavior** are very important:

(A) The CMS letter of Feb. 2014, as mentioned above, indicated that: CMS was **not in favor** of estate recovery for non-LTC expenses for the people enrolled in Medicaid under the expanded ACA eligibility – *precisely because it would be a disincentive to enrollment*; and that CMS intends to issue rules forbidding that from happening; but that until then, it is purely a state option as to whether or not to recover non-LTC expenses.

Given all that, plus the MN state law requiring recovery of ALL expenses, we wonder why DHS didn't take the initiative to approach the legislature, and advise and request legislators to change the state statute? If they had, this issue could have been resolved before it deeply distressed many enrollees and blew up into a public spectacle. Our understanding is that Minnesota is one of only a handful of states which used the option of recovering non-LTC expenses. Some other states had a deliberate, open discussion and explicitly decided to not use the option for non-LTC expenses.

(B) The MA funds to pay for coverage for the increased income limit, "Medicaid expansion" enrollees is currently 100% federal funds, unlike for enrollees with the pre-ACA income limits, which contains federal and state match. Therefore, we assume it the case that any money recovered from estates of the "Medicaid expansion" enrollees would have to all be returned to CMS, and none kept by DHS.

Given that, we wonder why DHS was rigorous with placing estate claims on these people, since the state should not be able to keep any part of those recoveries? It would be helpful if legislators were to ask DHS officials **what they intended to do** with funds recovered from these peoples' estates.

An historical point is that back in 2011, DHS was given $30 million from UCare, which was a voluntary return of overpaid managed care capitations. UCare's CEO Nancy Feldman, and UCare's CPA audit (in MN Health Dept. Archives), clearly stated as such. The $30 million was incorrectly called a "charitable donation," but DHS was legally required to give the federal match of 50%, which is $15 million, back to CMS. Nevertheless, DHS resisted and argued with CMS for a year, until finally deciding to give CMS its share, just before DHS Commissioner Jesson was to appear before a Congressional Committee.

(C) In computing how much money to file for the estate claims, DHS uses, for people in managed care, the full amount of the monthly capitations paid by DHS to the HMOs which manage the person's MA services. For people on Fee For Service MA, however, DHS files claims for the amounts paid by DHS to medical providers, which represent the actual medical services given to the person. This presents a troubling inconsistency, and raises the following question: **Why did DHS choose to seek recovery from managed care MA enrollees for the full capitation amounts, rather than finding out, from its HMO contractors, the actual amounts that the HMOs paid for those enrollees' medical services?** We wonder if DHS' reluctance has something to do with the disputes over public disclosure of the amounts that the HMOs are paying to medical providers for MA enrollees' services.

6. **Budget Impact:** We realize that recovery from estates of "Medicaid expansion" enrollees technically impacts the state budget, in that the budget officially incorporates the federal contributions to MA expenses. However, it does not impact, as far as we know, **state tax revenue** for these expenses, since they are 100% federal and don't include state funds.

We hope that this information is useful to state legislators. We can explain any of the above comments further if requested.

Sincerely,

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMDL #14-001
ACA #29

February 21, 2014

RE: **Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules and Post-Eligibility Income Rules to MAGI Individuals**

Dear State Medicaid Director:

This letter provides guidance to states on how the long-term services and supports-related rules, including the estate recovery rules, in section 1917 of the Social Security Act (the Act), and federal regulations at 42 C.F.R. 435.700, et seq., apply to individuals who are eligible for Medicaid under Modified Adjusted Gross Income (MAGI) eligibility rules ("MAGI individuals") and receive coverage for long-term services and supports (LTSS). The vast majority of people in need of Medicaid-covered LTSS will qualify under eligibility categories related to age or disability. The MAGI rules do not apply to these categories, and states generally are not required to offer LTSS in the Alternative Benefit Plans (ABPs) that are available to MAGI individuals. However, some people who need LTSS may qualify for Medicaid under MAGI rules. In particular, MAGI individuals who are medically frail or otherwise meet one of the benefit plan exceptions listed in 42 C.F.R. 440.315 must be offered the option of a benefit plan that includes Medicaid state plan services. For most adult beneficiaries receiving state plan services, medically necessary nursing facility and home health services must be covered. Additionally, some states have chosen to include LTSS in their ABPs.

Section 1902(e)(14) of the Act directs that individuals whose Medicaid eligibility is determined using MAGI rules are not subject to an assets or resources test for purposes of determining Medicaid eligibility. However, a number of other statutory provisions are implicated when an individual seeks Medicaid coverage for LTSS. These provisions do not affect eligibility for Medicaid and they are not limited in their application based on the category under which a Medicaid LTSS applicant is eligible or the methodology applied to determine an applicant's eligibility. States have inquired as to whether the various Medicaid LTSS rules, including the estate recovery rules, will apply to MAGI individuals who are eligible for LTSS coverage. This guidance is intended to address these questions.[1]

[1] This letter does not change rules and policies expressed in existing guidance relevant to the application of section 1917's rules to non-MAGI individuals.

A. Section 1917 of the Act ("Liens, Adjustments and Recoveries, and Transfers of Assets")

Under section 1902(a)(18) of the Act, a state must comply with the provisions of section 1917. Section 1917, which is a long-standing provision that preceded enactment of the Affordable Care Act, contains several provisions that apply specifically in circumstances in which Medicaid applicants and beneficiaries seek LTSS coverage. The provision governs a state's authority and responsibility to seek recovery of LTSS expenditures from Medicaid LTSS beneficiaries or their estates, and prohibits LTSS coverage where individuals have engaged in certain financial transactions before seeking LTSS coverage or have interests in certain assets.

With some exceptions, described below, application of section 1917 is not limited based on the eligibility categories in which Medicaid beneficiaries who seek LTSS coverage are enrolled or the methodologies applied to determine their eligibility. As such, most of the rules of section 1917 will apply to MAGI individuals who request Medicaid coverage for LTSS.

1. Section 1917(a): Medicaid Liens

Section 1917(a)(1)(B) permits states to place liens, subject to certain exceptions, on real property owned by a Medicaid beneficiary who is an inpatient of a nursing facility, intermediate care facility for the developmentally disabled, or other medical institutions, where the individual is receiving Medicaid coverage for the institutional services where certain other conditions apply.

One of the other conditions is that the Medicaid beneficiary has to be required, as a condition of receiving services in the institution, to spend for costs of medical care all but a minimal amount of his or her income for personal needs. The rules for "post-eligibility treatment of income" (PETI) are contained in 42 C.F.R. 435.700 et seq., which identify discrete categories of individuals who are subject to the PETI rules. MAGI individuals are not described in these provisions, and as such, these rules may not be applied to MAGI individuals under the current regulations. As a result, MAGI individuals who receive coverage for LTSS may not have liens placed on their real property at this time (see below for a broader discussion regarding the PETI rules).

2. Section 1917(b): Estate Recovery

Under section 1917(b)(1)(A), states are required to seek recovery, for Medicaid beneficiaries whose real property may be subject to a lien authorized under section 1917(a)(1)(B), from the estates of such individuals for amounts equal to the medical assistance correctly paid on their behalf. Under section 1917(b)(1)(B), states must also seek recovery, for Medicaid beneficiaries who were 55 years old and older when they received medical assistance, from the estates of such individuals for amounts at least equal to medical assistance paid on their behalf for nursing facility services, home and community based services (HCBS), and related hospital and prescription drug services, or, at state option, for any other items and services under the state plan (with the exception of Medicare cost-sharing).

For the first group—those whose real property may be subject to a lien—the prior application of the post-eligibility income rules under 42 C.F.R. 700 et seq. is a contingency, as the group in section (b)(1)(A) is made up exclusively of individuals who are described in the lien provision of 1917(a)(1)(B). Therefore, a state may not recover from the estates of MAGI individuals under this authority.

For the second group—those who were 55 years old or older when they received medical assistance and are described in 1917(b)(1)(B)—the rule is not limited in its application to individuals who were subject to post-eligibility income rules, or to individuals who received services to which the post-eligibility income rules apply (i.e., institutional services and HCBS). MAGI individuals who were 55 years old or older when they received medical assistance are therefore not exempt from the estate recovery provision in section 1917(b)(1)(B), although all of the estate recovery limitations and exceptions described in other parts of section 1917(b), including those described in section 1917(b)(2), and the exception in situations of undue hardship described in section 1917(b)(3)(A), apply.

Due to the potential barrier to enrollment that future estate recovery may create for some individuals, CMS intends to thoroughly explore options and to use any available authorities to eliminate recovery of Medicaid benefits consisting of items or services other than long term care and related services in the case of individuals who are determined eligible for Medicaid benefits using the MAGI methodology.

In the meantime, states have some existing authority to limit the scope of recovery for Medicaid beneficiaries. They may limit recovery based on the eligibility categories in which the beneficiaries are enrolled; for example, a state may limit estate recovery to the services under section 1917(b)(1)(B)(i) for people enrolled in the new adult group – that is those relating to LTSS. Furthermore, in view of the federal government's unique trust responsibility for the American Indian/Alaska Native (AI/AN) population, the State Medicaid Manual provides specific exemptions from estate recovery that are applicable to this population. In addition to complying with these manual provisions, states may also want to take into consideration other situations in which estate recovery would present undue hardship to the AI/AN population when establishing exemptions as permitted in section 1917(b)(3)(A) and noted above.

3. Section 1917(c): Transfers of Assets

Section 1917(c) prescribes certain rules where individuals who are seeking Medicaid coverage for LTSS have transferred assets for less than fair market value before, and subsequent to, applying for Medicaid. Specifically, this provision requires that, if an institutionalized individual, or the spouse of an institutionalized individual (or, at state option, a non-institutionalized individual or the spouse of a non-institutionalized individual) disposes of assets for less than fair market value on or after the individual's "look-back" date, the individual is ineligible for medical assistance for institutional services (or other LTSS). A penalty period based on the number of months equal to the amount transferred for less than fair market value divided by the average monthly cost to a private patient of nursing facility services in the state is applied. Exceptions, such as where an individual makes a transfer to a spouse or for a purpose other than to qualify for Medicaid, do apply. In the absence of an exception, however, the penalty period applies.

An "institutionalized individual" is defined in section 1917(h)(3) to include an inpatient of a nursing facility or other medical facility in which payment is being made based on the level-of-care provided in a nursing facility, and an individual receiving any service under section 1915(c) who is eligible under section 1902(a)(10)(A)(ii)(VI). The latter group, sometimes referred to as the "217" group (after the group's corresponding regulatory cite, 42 C.F.R. §435.217), is composed of individuals who are only eligible for Medicaid based on the application of institutional deeming rules (and who meet the level of care necessary for a HCBS waiver and are receiving at least one waiver service).

Non-institutionalized individuals are defined in section 1917(h)(4) to include recipients of personal care services, home health services, and, at state option, other non-institutional LTSS services available under the state plan to individuals who need LTSS. The word "assets" is defined in section 1917(h)(1) to include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or individual's spouse is entitled to but does not receive because of action by the individual, the individual's spouse, or others acting on their behalf.

As noted above, section 1902(e)(14) provides that individuals whose Medicaid eligibility is determined using MAGI rules may not have any "any assets or resources test" applied for purposes of determining Medicaid eligibility. The directive applies only to Medicaid *eligibility* determinations for MAGI individuals. By contrast, section 1917(c) applies to *coverage* for certain services—nursing facility services and other LTSS—in circumstances where Medicaid applicants have transferred assets for less than fair market value. Considering this, and the fact that, outside of the reference to the 217 group in the definition of institutionalized individuals, the application of the transfer rules in section 1917(c) is not limited by the eligibility category in which a Medicaid beneficiary is enrolled or the methodology by which the individual's eligibility is determined, we have concluded that the transfer rules should apply to MAGI individuals who meet the definition of "institutionalized individuals," and to "non-institutionalized individuals" in states that have opted to apply the transfer rules to non-institutionalized individuals.

This provision applies only to individuals who receive Medicaid funding for LTSS. All of the limitations and exceptions to the transfer rules described in section 1917(c)(2) would apply.

4. Other Provisions of section 1917

Section 1917 contains several other rules that are relevant in the context of coverage for LTSS.

Annuities, promissory notes, and life estate interests

Like the broader rules of section 1917(c), the rules imposed to these transactions are generally not limited to individuals who qualify under particular eligibility categories or have their eligibility determined under a particular methodology. Therefore, states should apply the rules relating to these transactions to MAGI individuals in the same way the rules are applied to non-MAGI individuals.

Trusts

Section 1917(d) outlines the Medicaid rules for evaluating trusts that are established with the assets of a Medicaid applicant or beneficiary. Generally, a revocable trust funded by a Medicaid applicant's or beneficiary's assets is considered an available resource to the individual, while irrevocable trusts are considered asset transfers that require determinations of whether fair market value was received in exchange. Certain trusts that meet specific criteria in section 1917(d)(4) (e.g., special needs trusts and pooled trusts) are generally exempt from these standard rules, even if irrevocable, and are instead generally evaluated under cash assistance program rules (e.g., SSI rules), although these trusts are not in all circumstances exempt from the transfer rules.

The trust rules are not limited in their application to the eligibility categories under which Medicaid applicants are eligible or the methodologies used to determine their eligibility. Thus, states will have to confirm whether a MAGI individual who requests coverage for LTSS established a trust using his or her assets on or after the individual's look-back date, and evaluate such trusts under existing rules. As with non-MAGI individuals, under section 1917(d)(5), states must also waive application of the trust rules for MAGI individuals where the application of the rules will result in an undue hardship.

Home Equity Rule

Section 1917(f) provides that, in determining eligibility for medical assistance for nursing facility services or other LTSS, the individual may not be eligible for such assistance if the individual's home equity exceeds, for 2014, $543,000, or, at state option, $814,000 (i.e., the state's home equity limit cannot be lower than $543,000, but it may be as high as $814,000). Section 1917(f) directs that the figures be increased from year to year based on the percentage increase in the consumer price index for all urban consumers.

Under section 1917(f)(2), the home equity-related limitation on medical assistance for nursing facility services and other LTSS does not apply if the spouse of the individual, or a child of the individual who is under the age of 21 or has a disability, is living in the home. Under section 1917(f)(4), the limitation is also waived in cases of demonstrated hardship.

The home equity rule is not limited in its application by the eligibility category in which an individual is enrolled or the methodology on which the individual's eligibility is based. Therefore, states must deny LTSS coverage to MAGI individuals whose home equity exceeds the limit identified in the Medicaid state plan, subject to the exceptions identified in section 1917(f).

B. Post-Eligibility Treatment of Income

A state Medicaid agency is required to reduce its costs using available beneficiary income for coverage of institutional services and home and community-based waiver services provided to most Medicaid beneficiaries. The state's costs are reduced generally by the amount of available income the institutionalized Medicaid beneficiary or waiver enrollee has after deductions for the

personal needs of the individual, the maintenance needs of the individual's spouse or family, and certain other expenses are made. The process by which the individual's available income is calculated is referred to as the post-eligibility treatment of income (PETI).

Section 1902(a)(17) of the Act is the general authority for the post-eligibility income calculation process. The specific method of the calculation is established in 42 C.F.R. 435.700, et seq., for categorically needy Medicaid enrollees, and 435.832 for medically needy individuals. Regarding categorically needy Medicaid enrollees, 42 C.F.R. 435.725 (for SSI states) and 435.733 (for 209(b) states) identify the specific categories to which the post-eligibility rules apply. These categories all apply the financial methodologies of the SSI and AFDC cash assistance programs to determine eligibility for Medicaid beneficiaries enrolled in them.

Because of the connection in the post-eligibility regulations between the cash assistance programs and the discrete categories to which the regulations direct their application, we have concluded that the scope of the current post-eligibility regulations does not capture Medicaid beneficiaries whose eligibility is based on MAGI methodologies. We believe, however, that the statute provides us the authority to expand the reach of the post-eligibility regulations to include MAGI individuals who receive coverage for LTSS, and because there are equity reasons to consider the application of these rules to the MAGI-eligible people receiving LTSS, we are considering rulemaking in this case.

We intend to work closely with states to conform their rules and procedures in accordance with the instructions in this letter. Questions regarding the lien or estate recovery rules should be directed to Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at (410) 786-0325. For all other issues addressed in this letter, please contact Eliot Fishman, Director of the Children and Adults Health Programs Group, at (410) 786-9535.

Sincerely,

/s/

Cindy Mann
Director

cc:

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