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R. Paul Van Dam; Attorney General; Douglas W. Springmeyer; Annina M. Mitchell; Assistant Attorneys General; Attorneys for Appellee.
Steven Elmo Averett; Utah Legal Services, Inc.; Michael E. Bulson; Utah Legal Services, Inc.; Attorneys for Appellant.

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BRIEF

IN THE SUPREME COURT OF THE STATE OF UTAH

DOYCE ALLEN,

Petitioner,

v.

UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING,

Respondent.

Case No. 920197

Priority 14

BRIEF FOR RESPONDENT

ON CERTIORARI TO THE UTAH COURT OF APPEALS

R. PAUL VAN DAM
Attorney General
DOUGLAS W. SPRINGMEYER (#3067)
ANNINA M. MITCHELL (#2274)
Assistant Attorneys General
UTAH ATTORNEY GENERAL'S OFFICE
P.O. Box 1980
Salt Lake City, UT 84110-1980
(801) 538-4660

STEVEN ELMO AVERETT
Utah Legal Services, Inc.
455 N. University Ave., #100
Provo, Utah 84601
(801) 374-6766

MICHAEL E. BULSON
Utah Legal Services, Inc.
550-24th Street, #300
Ogden, Utah 84401
(801) 394-9431

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IN THE SUPREME COURT OF THE STATE OF UTAH

DOYCE ALLEN, Petitioner, v. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	Case No. 920197 Priority 14

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R. PAUL VAN DAM
Attorney General
DOUGLAS W. SPRINGMEYER (#3067)
ANNINA M. MITCHELL (#2274)
Assistant Attorneys General
UTAH ATTORNEY GENERAL'S OFFICE
P.O. Box 1980
Salt Lake City, UT 84110-1980
(801) 538-4660

STEVEN ELMO AVERETT
Utah Legal Services, Inc.
455 N. University Ave., #100
Provo, Utah 84601
(801) 374-6766

MICHAEL E. BULSON
Utah Legal Services, Inc.
550-24th Street, #300
Ogden, Utah 84401
(801) 394-9431

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IN THE SUPREME COURT OF THE STATE OF UTAH

DOYCE ALLEN, Petitioner, v. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	)	Case No. 920197 Priority 14

BRIEF FOR RESPONDENT

JURISDICTION

This is not an appeal from a final agency order. This case is before the Court on Doyce Allen's original petition for certiorari to review the decision of the Utah Court of Appeals in Allen v. Utah Dep't of Health, 829 P.2d 122 (Utah App. 1992) [Addendum A], which affirmed the final order of respondent Utah Department of Health, Division of Health Care Financing ["Division"]. Jurisdiction is proper under Utah Code Ann. § 78-2-2(3) (Supp. 1992).

DETERMINATIVE STATUTES AND RULES

The following statutes and rules are relevant to the determination of this case: 42 U.S.C. § 1396 (1992); 42 U.S.C. § 1396a(a)(10) (1992); 42 U.S.C. §1396a(a)(17) (1992); 42 U.S.C. § 1396a(a)(34) (1992); 20 C.F.R. §§ 416.1201, 416.1205, 416.1210 (1992); 42 C.F.R. §§ 435.831, 435.840-435.852 (1991); Utah Code

Ann. § 26-18-1 to -48 (1989 & Supp. 1992); Utah Admin. Code R455-1-1 to 455-1-48 (1991); and Utah Admin. Code R810-304-400, R810-304-403, R810-304-411 (1991). The full texts of these are set forth in Addendum B to this brief.

ISSUES PRESENTED/STANDARD OF REVIEW

Petitioner Doyce Allen misstates the issue before this Court. Because this is not an appeal of final agency action, the issue presented on certiorari is not whether the Division "erred in finding that [Allen] could not 'spend down' his assets to become eligible for Medicaid" (Brief of Petitioner at 1). Properly framed, the issues before this Court are:

1. Did the Utah Court of Appeals correctly conclude that federal law, specifically 42 U.S.C. § 1396a(a)(17) and (34) (1992), does not require the Division to use a "resource spend down" methodology in determining Allen's eligibility for Medicaid coverage under Utah's optional Medically Needy Program?

2. Did the Utah Court of Appeals correctly conclude that the use of a fixed asset limit does not violate the federal requirement in section 1396a(a)(17) that eligibility standards for Utah's optional Medically Needy Program be reasonable?

Whether an administrative agency's policy or rule conflicts with an authorizing statute is a question of law, on which this Court reviews the conclusions of the Utah Court of Appeals for correctness. See Landes v. Capital City Bank, 795 P.2d 1127, 1128 (Utah 1990); see also Heaton v. Second Injury Fund, 796 P.2d 676, 679 (Utah 1990).

679 (Utah 1990).

STATEMENT OF THE CASE

Allen's February 1991 application for payment of over $40,000 in incurred medical bills under Utah's Medicaid program for the "medically needy" was denied by the Division because his total nonexempt assets were $7,745.90 more than the $3,000 asset limit for his two-person household (R. 113). After this determination of ineligibility was affirmed through the administrative appeals process (R. 78-79; 94-99), Allen sought review of the Division's final order in the Utah Court of Appeals, which affirmed the agency's determination in Allen v. Utah Dep't of Health, 829 P.2d 122 (Utah App. 1992).

In his petition for certiorari, Allen claimed the Utah Court of Appeals erroneously held that 42 U.S.C. § 1396a(a)(17) (1992) does not require the Division to use a "resource spend down" methodology in determining whether an applicant with resources above the applicable limit is eligible for coverage under the optional Medicaid program for the "medically needy." This Court granted certiorari on June 22, 1992, to review the Utah Court of Appeal's decision on this question.

STATEMENT OF FACTS

Allen worked for many years as a truck driver for Intermountain Farmers Co-op until December 1988, when he retired at age 61 because of arthritis (R. 34, 36, 88, 98). While a fulltime employee there, he was covered by a group health insurance policy

issued by Blue Cross/Blue Shield (R. 98). After retirement, he continued group coverage as a former employee until June 30, 1990, when it expired (R. 5, 36, 98).[1] He worked part-time in an Intermountain Farmers Co-op store beginning in the spring of 1990 to save money for premiums on an individual health insurance policy when his extended coverage under Intermountain Farmers' group policy expired (R. 33, 68).[2]

Allen applied to Blue Cross/Blue Shield in June 1990 for coverage under such an individual health insurance policy, but his application was denied due to pre-existing medical problems, including heart disease and open heart surgery in 1980 (R. 5-6, 33-34, 37, 98). Allen inquired about health insurance coverage from other insurance companies, but chose not to pursue it and apply for coverage when told such a policy would cost from $400 to $600 per month with a $500 deductible (R. 37). In Allen's words, "So we figured that we had a year and a half to go [until Medicare coverage at age 65] and we hadn't been in the hospital for ten years, so we'd just have to chance it." (R. 37). According to Allen, money saved for health insurance premiums was instead kept as a "nest egg" (R. 68).

Thus, after July 1, 1990, Allen had no health insurance

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[1]Federal law, referred to as COBRA, requires large employers to continue group health insurance coverage of former employees for up to eighteen months after they cease working due to disability.

[2]Allen was not eligible for health insurance coverage through the federal Medicare program until he reached age 65 on January 24, 1992.

coverage (R. 6, 78). Allen ended his part-time employment at Intermountain Farmers Co-op in October 1990 (R. 102). On January 23, 1991, the day before his sixty-fourth birthday, Allen suffered a heart attack while in Arizona, where he lives several months of the year (R. 5, 7, 97, 98, 112). He was transported to Utah, where he lives the remainder of the year, and underwent heart-bypass surgery at Utah Valley Regional Medical Center (R. 98). Medical bills incurred as a result of his emergency treatment, air evacuation, and heart surgery exceeded $40,000 (R. 11, 98). On February 4, 1991, at the suggestion of the hospital, Allen applied for Medicaid coverage under the Medically Needy Program, retroactive to January 1, 1991 (R. 11, 88, 90, 145).

In January and February 1991, Allen's household had $967 in monthly income in Social Security benefits (R. 18, 25, 27, 106). On the first moment of those months, Allen and his wife owned, in addition to exempt household effects and an unencumbered house worth $65,000, a savings account containing $3,029.86, a checking account containing about $100, a Lincoln automobile valued at about $600, a 1983 Ford pickup truck worth about $2,500, and an unencumbered 1981 travel trailer valued at about $7,000 (R. 7-8, 31, 33, 50, 52-53, 98, 103, 105). The Division's Office of Family Support determined that, even after excluding as exempt the value of the pickup truck and the home, Allen exceeded the applicable $3,000 limit on nonexempt assets based on the cash in his savings account alone; therefore, it denied Allen's application (R. 14,

98, 113).[3]

After a formal hearing at Allen's request, Hearing Officer Cornelius Hyzer recommended that the determination of Allen's ineligibility due to excess nonexempt assets be affirmed:

> The applicant was unable to demonstrate his assets were below the asset limit and, therefore, he failed to meet his burden of proof. Many alternatives were explored to try to determine that a correct decision was made by the Office of Family Support. After careful review with the applicant of regulations requiring that his assets be determined as of the first moment of each month, the applicant understood that his savings account alone exceeded the limit. Therefore, the value ascribed to his motor vehicles and the travel trailer were not necessary to sustain a denial.

(R. 99). Upon further administrative review by the Division's director, the hearing officer's findings and conclusions were adopted, and the determination of ineligibility due to nonexempt assets in excess of the $3,000 limit was affirmed (R. 94-96). Allen's request for reconsideration was denied (R. 78), with the Division noting that there is no "resource spend down" rule that would allow Allen to become eligible for Medicaid by subtracting from the total nonexempt assets he held in January and February 1991 the amount of unpaid medical bills he had incurred in those months (R. 79).

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[3]Allen contended that the entire value of the unencumbered travel trailer was exempt as a "medical necessity," but this issue was never ruled upon at the administrative level because the cash available to Allen in his savings and checking accounts was alone sufficient to sustain the determination of ineligibility. (R. 79).

SUMMARY OF ARGUMENTS

Congress created optional Medicaid coverage for the "medically needy" in 1965, to be paid for with federal and state funds. It sought to encourage states to pay the uninsured medical bills of its citizens who, though poor, were less needy than the "categorically needy," whose incomes and resources are both below amounts essential for their maintenance. In section 1396a(a)(17)(D), Congress required states to provide this optional coverage to persons whose incurred medical bills are greater than the amount by which their monthly incomes exceed the income level considered essential. There is no express or implicit requirement that states provide this optional coverage to persons who also have accumulated substantial assets. Instead, this choice has been appropriately left by Congress to the state legislatures themselves, as has the setting of reasonable eligibility criteria for the medically needy program.

Consistent with Congressional objectives and the Medicaid statute, the Division determines who will receive assistance as "medically needy," based on the relative need of all who are potentially eligible. Need is measured by applicants' incomes and resources. It is reasonable for the Division to distribute scarce public funds by rendering ineligible all those who have accumulated substantial assets from which they could provide for the costs of their own medical care even if, like Allen, they do not actually do so. It is thus also reasonable for the Division to treat excess

income differently from accumulated resources, by not allowing an applicant to spend down excess resources against incurred medical bills even though it allows such a spend down of excess income because required by Congress to do so.

Contrary to Allen's representations to this Court and the mistaken belief of the dissenting judge on the Utah Court of Appeals, an applicant's eligibility is based on accumulated resources held at the first moment of the month for which Medicaid coverage is sought, not those held at the time of application for retroactive Medicaid coverage. Accordingly, it is not possible for a person to "spend down" excess resources by paying incurred medical bills **before** applying and thereby become eligible for retroactive Medicaid coverage. It is, therefore, reasonable for the Division not to allow "spend down" of excess resources at or after the time of application for retroactive coverage.

This Court should affirm the decision of the Utah Court of Appeals and decline Allen's invitation, under the guise of statutory interpretation of "implicit" Congressional purpose or intent, to rewrite the federal Medicaid statute and impose "resource spend down" as a method of determining who is eligible in Utah for optional Medicaid coverage as "medically needy."

ARGUMENTS

Introduction

The only issue before this Court is whether the Utah Court of Appeals correctly determined that federal law, specifically 42

U.S.C. § 1396a(a)(17) and (34), does not require participating states to use a "resource spend down" methodology when measuring the nonexempt assets held by an applicant for the medically needy program.

Allen advances four separate arguments for reaching the opposite conclusion about what federal law demands: 1) the Division's failure to use a "resource spend down" methodology in calculating eligibility for the medically needy program is inconsistent with the purposes of the Medicaid program, contrary to section 1396a(a)(17)(A); 2) Congressional intent to require a resource spend down methodology is implicit in the express requirement in section 1396a(a)(17)(D) that participating states allow applicants for the medically needy program to "spend down" their excess income; 3) Congressional intent to require a resource spend down methodology is implicit in the provision in Medicaid law, 42 U.S.C. § 1396a(a)(34) (1992), which creates a three-month retroactive application period; and 4) failure of the Division to adopt a resource spend down methodology creates an unreasonable eligibility standard, contrary to section 1396a(a)(17). In order to evaluate these claims, a basic understanding of the history and operation of the Medicaid program is necessary.

Overview of the Medicaid Program and "Income Spend Down"

Medicaid was established by Congress in 1965 as Title XIX of

the Social Security Act[4] "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." Harris v. McRae, 448 U.S. 297, 301 (1980). It is a program designed "to make medical services for the needy more generally available," S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1 at 2014 (1965) [hereinafter 1965 Senate Report, Addendum Item D]. To this end, Congress appropriates funds

> [f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the cost of necessary medical services . . . .

42 U.S.C. § 1396 (1992). Medicaid reimburses participating States a percentage of the cost of medical care provided to these types of eligible individuals and families. See Atkins v. Rivera, 477 U.S. 154, 156-57 (1986). The federal government reimburses Utah at a 75% rate, and the State pays the remaining 25% of the cost of the Medicaid program.

In order to obtain reimbursement, a participating state must develop a plan that complies with the Medicaid statute and federal implementing regulations, see 42 U.S.C. § 1396; Atkins, 477 U.S. at 157, and it must select a single agency to administer the plan. 42 U.S.C. § 1396a(a)(5) (1992). The state plan must be approved by the Department of Health and Human Services, the federal agency

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[4]Public Law No. 89-97, as amended, 79 Stat. 343 (codified at 42 U.S.C. §§ 1396 et seq. (1992)).

that oversees implementation of the Medicaid program. 42 U.S.C. § 1396 (1992); Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981).

A participating state must provide Medicaid coverage to "categorically needy" persons, 42 U.S.C. § 1396a(a)(10)(A)(i) (1992), but it may choose whether or not to provide Medicaid coverage to "medically needy" persons "who meet the income and resources requirements of the appropriate State plan. . . ." 42 U.S.C. § 1396a(a)(10)(A)(ii) (1992); see Schweiker v. Gray Panthers, 453 U.S. at 37.

The "categorically needy"--a group that includes dependent children as well as aged, blind, or disabled adults--receive both cash payments and Medicaid coverage; however, in order to be eligible for this assistance, their incomes and resources must both be below limits set by the Department of Health and Human Services. Significantly, a person applying for Medicaid coverage is not permitted to "spend down" excess resources against incurred medical bills in order to become eligible as "categorically needy." See 20 C.F.R. §§ 416.1201, 416.1205, 416.1210 (1992) [Addendum B].

At the time Medicaid was enacted, these "categorically needy" persons were considered by Congress as the "most needy in the country," thus making it "appropriate for medical care costs to be met, first, for these people." H.R.R. No. 213, 89th Cong., 1st Sess., 66 (1965) [hereinafter 1965 House Report, Addendum Item C]. Persons who would qualify as "categorically needy" except for incomes or resources over the fixed dollar limits could still

qualify for Medicaid coverage as "medically needy" in a state opting to provide such coverage, but this latter group was deemed "less needy" by Congress. Id.; see also 1965 Senate Report, at 2017.[5] The basis for distinguishing between these two subgroups of the poor in this country was explained in Schweiker v. Hogan, 457 U.S. 569, 590, 102 S.Ct. 2597, 2609 (1982):

> Congress has differentiated between the categorically needy--a class of aged, blind, disabled, or dependent person who have very little income--and other persons with similar characteristics who are self-supporting. Members of the former class are automatically entitled to Medicaid; members of the latter class are not eligible unless a State elects to provide benefits to the medically needy and unless their income, after consideration of medical expenses, is below state standards of eligibility.

Utah chose to participate in Medicaid with the adoption of the Medical Assistance Act in 1981. See Utah Code Ann. §§ 26-18-1 to -11 (1989 and Supp. 1992). The Division is the designated Utah agency responsible for administering the Medicaid program in accordance with federal and state law requirements. Utah Code Ann. § 26-18-3(1) (Supp. 1992); Utah Code Ann. § 26-18-2.1 (1989). The Utah Legislature has given the Division broad authority to develop policies to implement the Medicaid program and to develop eligibility standards consistent with federal requirements. Utah

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[5]If a state opts to provide medical assistance to the "medically needy," it may not provide Medicaid coverage that is greater in amount, duration, or scope than that provided to the "categorically needy." 42 U.S.C. § 1396a(a)(10)(B)(ii) (1992). This provision was included "in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy." 1965 House Report at 67.

Code Ann. § 26-18-4(1) (1989); Utah Code Ann. § 26-18-3(2) (Supp. 1992). The state has complied with conditions set by federal law by creating a state Medicaid plan, found at Utah Admin. Code R455-1-1 to -48 [Addendum B], which has been approved by the Secretary of Health and Human Services.

Federal law requires a state plan for medical assistance to

> (17) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent the the objectives of this subchapter, (B) provide for taking into account only such income and resources as are . . . available to the applicant or recipient . . . (C) provide for reasonable evaluation of any such income or resources, and (D) . . . provide for flexibility in the application of such standards with respect to income by taking into account . . . the costs . . . incurred for medical care or for any other type of remedial care recognized under State law.

42 U.S.C. § 1396a(a)(17) (1992). This provision underlies several of Allen's claims that the Division's failure to use a "resource spend down" method of determining his eligibility for Medicaid as a "medically needy" person is contrary to federal law.

Utah's Medically Needy Program

Unlike its neighboring states in the Intermountain West, Utah has elected to make the optional medically needy program available to some of its neediest citizens.[6] Utah Admin. Code R455-1-17 (1991). As required by federal law, 42 U.S.C. § 1396a(a)(34) (1992), a person can apply for Medicaid coverage under the program

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[6]In a state such as Colorado that offers Medicaid only to the categorically needy, Allen would be ineligible for any Medicaid coverage because his $967 monthly household income is too high, even if his assets were below the $3,000 limit.

retroactively to three months before the month of application. Utah Admin. Code 455-1-11 (1991). In FY 1991, this optional program payed the uninsured medical bills of over 5,000 eligible Utahns at a cost of $19.7 million in federal and state Medicaid funds. MEDSTAT H.C.F.A. 2082 Report for Utah (Dec. 20, 1991).

As noted above, the "medically needy" are persons who have characteristics of the categorically needy (i.e., as aged, blind, or disabled adults, or as dependent children), but who also have too much income or assets to meet the federal eligibility standards for those programs. Winter v. Miller, 676 F.2d 276, 277 (7th Cir. 1982). Eligibility for the optional medically needy program likewise depends on: a) the total of the applicant's nonexempt resources[7]; and b) the applicant's monthly income.

The applicable limit on allowable nonexempt resources, in this case $3,000 for a two-person household,[8] is set by the federal Social Security Administration. See 20 C.F.R. § 416.1205(c) (1992) [Addendum B]. For purposes of determining Medicaid eligibility during a specific calendar month, countable assets are those held on the first moment of that month. Utah Admin. Code R810-304-403

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[7]"Resources" are "cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could be converted to cash for his or her support and maintenance." 20 C.F.R. § 416.1201(a) (1992). Exempt resources include, among other things, a home, household goods, a vehicle, property essential for self-support, allotted Indian lands, life insurance, burial space and funds, and housing assistance. See 20 C.F.R. § 416.1210 (1992); Utah Admin. Code R810-304-411 (1991).

[8]Utah Admin. Code § R810-304-403 (1991) [Addendum B]; see R. 13, 98.

[Addendum B]. "The case is ineligible for the entire month if countable assets exceed limits on the first moment of the month. Id. Under these eligibility standards, a person like Allen with nonexempt assets above the fixed $3,000 limit, measured at the first moment of the months for which he seeks coverage, is ineligible for Medicaid. Utah Admin. Code. R810-304-403.

An applicant for the medically needy program whose nonexempt resources are below the fixed dollar limit must also meet the "income" eligibility criterion by having income below the applicable dollar limit, a figure set by the Social Security Administration based on federal poverty guidelines. See 20 C.F.R. § 416.1205(c) (1991). However, in calculating an applicant's income for a specific month, the Division is required by 42 U.S.C. § 1396a(a)(17)(D), quoted above, and implementing federal regulations to use an "income spend down" methodology.[9]

Under income spend down, an applicant must be allowed to

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[9]See, e.g., Atkins, 477 U.S. at 158; 106 S.Ct. at 2459 ("the spenddown mechanism of 42 U.S.C. § 1396a(a)(17)(D) "allows the medically needy to spend down "the amount by which their income exceeds" the eligibility level); Foley v. Coler, No. 83-C-4736, 1986 WL 20891 (N.D. Ill. Oct. 1, 1986) ("42 U.S.C. § 1396a(a)(17)(D) requires states to use income spend-down") [Addendum E]; Harriman v. Commissioner, No. 90-0046-B, 1990 WL 284515 (D. Me. Nov. 9, 1990) (42 U.S.C. § 1396a(a)(17)(D) "specifically requires the state to have an income spend-down rule") [Addendum F]; Ramsey v. Department of Human Servs., 301 Ark. 285, 783 S.W.2d 361, 363 (1990) ("Under the 'medically needy' procedure, applicants are permitted to 'spend down' their excess income for medical expenses."); Haley v. Commissioner of Public Welfare, 394 Mass. 466, 476 N.E.2d 572, 574 (1985) (42 U.S.C. § 1396a(a)(17) "provide[s] for application of the spend down principle to income eligibility determinations").

deduct <u>from income</u> any medical expenses incurred in that month that are not subject to payment by a third party.[10] 42 C.F.R. § 435.831(c) (1991); Utah Admin. Code R810-303-331 (1991). After such a set-off, an applicant will meet the income eligibility criterion if the incurred medical costs reduce income to or below the applicable monthly income standard. 42 C.F.R. § 435.831(d) (1991).

To see the federally mandated "income spend down" provision in operation, consider the following simplified hypothetical. Sara Johnson, disabled by emphysema, lives with her husband Sam, who earns minimum wage as a watchman at a small company with no health insurance benefits. She incurs $10,000 in uninsured medical bills in January 1991 during an emergency hospitalization for severe pneumonia, so she applies for the medically needy program. If Johnson has only $1,000 in total nonexempt cash and other assets on January 1, 1992, she satisfies the $3,000 resource eligibility criterion for her two-person household.

The income limit for that two-person household, an amount considered minimally necessary for basic life maintenance, is $430.

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[10]According to the legislative history, the "income spend down" provision was inserted into section 1396a(a)(17)(D) to insure that the measurement of an applicant's income in any month, as part of the Medicaid eligibility determination process, took into account the applicant's costs of medical care incurred during that month. 1965 House Report, at 68 [Addendum C]. There is no parallel language in the federal statute requiring states to set off an applicant's nonexempt resources held in any month, as part of the Medicaid eligibility determination process, against the costs of medical care incurred during that month.

If, like Allen and his wife, Johnson's countable income is $967 in January, she would be $537 over the income limit and thus ineligible as a "categorically needy" person. However, due to the federally mandated "income spend down" method of determining eligibility as a "medically needy" person, Johnson will be allowed to deduct from this countable income the amount of incurred medical bills, thereby bringing herself to the $430 income limit. She will thus be eligible in January under both the resources and income eligibility criteria for the Utah Medically Needy program, and Medicaid will cover all but $537 of the medical bills she incurred.[11]

If, on the other hand, Johnson incurred only $500 in medical bills in January she would not be eligible as "medically needy" under the income criterion of eligibility. Even after the "income spend down" methodology was applied to deduct her incurred medical expenses from her gross income ($967-$500), she would be ineligible because her net income of $467 would be $37 more than the $430 household income limit.

As previously noted, the federally mandated eligibility guidelines for Medicaid coverage do not allow a person to become

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[11]The amount of the income spend down, $537 in this hypothetical, remains the responsibility of Johnson to pay. But she need not actually pay the $537 toward a medical bill in Utah to become eligible for Medicaid under the Utah Medically Needy Program. In sharp contrast, the state plans in Massachusetts, Arizona, and North Carolina, discussed below at pages 23-26, required an applicant to actually expend assets on incurred medical bills in order to decrease resources to be counted in determining eligibility.

eligible as "categorically needy" by spending down excess resources against incurred medical bills. The eligibility standards for the medically needy program in Utah's approved state Medicaid plan likewise do not include a methodology for measuring available resources that permits the applicant to "spend down" excess nonexempt resources by setting them off against incurred medical bills.

Allen contends that federal law requires the Division to adopt such a resource spend down methodology and thereby provide Medicaid coverage through this optional program to persons with substantial nonexempt resources in excess of fixed resource limits. He has, however, failed to demonstrate any error by the Utah Court of Appeals in rejecting his statutory claims.

THE COURT OF APPEALS CORRECTLY DETERMINED THAT FEDERAL LAW, 42 U.S.C. § 1396a(a)(17) and (34) (1992), DOES NOT REQUIRE THE DIVISION TO USE "RESOURCE SPEND DOWN" WHEN DETERMINING ELIGIBILITY FOR OPTIONAL MEDICAID COVERAGE AS "MEDICALLY NEEDY."

1. Use of a fixed asset limit, without resource spend down, is consistent with the objective of the Medicaid statute, which is to help states provide medical assistance to persons least able to meet the costs of medical care from their own income and resources.

Allen's first argument is that the Division's failure to use a resource spend down methodology in determining eligibility is inconsistent with the legislative purpose and intent behind the Medicaid program. Section 1396a(a)(17) requires a state plan to use reasonable eligibility standards consistent with the objectives of the Medicaid statutes in Title XIX of the Social Security Act.

In the appropriations provision at the beginning of that title, Congress stated that it was appropriating funds for Medicaid

> for the purpose of enabling each State, <u>as far as practicable under the conditions in such State</u>, to furnish medical assistance [to dependent children and aged, blind, or disabled individuals] whose income and resources are insufficient to meet the cost of necessary medical services . . . .

42 U.S.C. § 1396 (1992) (emphasis added).

Nothing in Title XIX or its legislative history suggests that the financial assistance provided through Medicaid to the categorically needy or to the medically needy was intended by Congress to be national health insurance coverage for all persons whose income and resources are "insufficient" in the sense that they are less than incurred medical bills.[12] This Congressional "purpose" ascribed by Allen to Medicaid is created out of thin air.

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[12]Contrary to Allen's assertion at page 12, the mere creation of a public assistance program for categorically needy and medically needy does not, by definition, preclude limiting participation to those whose assets are below fixed dollar limits. <u>See</u> <u>Harriman</u>, 595 A.2d at 1057; <u>see</u> <u>also</u> <u>Ramsey</u>, 783 S.W.2d at 364 (federal Medicaid statute does not even permit states to use resource spend down methodology for medically needy applicants). Congress itself has dictated that a person with excess resources cannot spend down that excess against incurred medical bills to become eligible for Medicaid as "categorically needy." <u>See</u> 20 C.F.R. §§ 416.1201, 416.1205, 416.1210 (1992).

Furthermore, the fact that the federal statutory scheme and the state plan allow applicants to retain a certain amount of nonexempt resources and still be eligible for Medicaid as categorically needy or medically needy does not mean Congress impliedly intended that all persons with medical bills larger than their resources must be deemed eligible. Instead, allowing assets below the resource limit merely indicates Congressional intent that persons need not have zero in accumulated assets to be eligible for Medicaid, either as categorically needy or as medically needy.

Allen is really arguing, with no supporting authority, that Congress intended the optional medically needy program to be a national health insurance program paying the uninsured, catastrophic medical bills of all persons who otherwise qualify, notwithstanding the amount of assets they hold. If Congress had so intended, it could have compelled states that opt to provide medically needy coverage to use the "resource spend down" methodology of determining eligibility, one Allen is asking this Court to impose by judicial legislation. Congress could have restricted states in this manner by merely enacting statutory language like that in section 1396a(a)(17)(D), which compels the "income spend down" methodology of determining income eligibility, but it did not. See Hession, 544 N.E.2d at 757 (application of statutory construction rule, "express mention and implied exclusion," would lead to the conclusion that section 1396a(a) does not impose resource spend down methodology on states because it does not mention such a requirement among the express enumerations of what state Medicaid plans must contain).

Instead, Congress stated in the Medicaid statute its purpose to help a participating state provide medical assistance to as many of its needy citizens as possible, i.e., "as far as practicable under the conditions in such State[.]" 42 U.S.C. § 1396 (1992). In permitting the medically needy program to be optional, Congress left it up to each participating state to decide whether it could afford to provide medical assistance to any medically needy persons

at all. Congress also left it to each state choosing to provide this optional assistance to set its own income and resource eligibility standards, subject to the requirement in section 1396a(a)(17) that these standards be reasonable.

As the Utah Court of Appeals correctly concluded, although section 1396a(a)(17) permits a state to choose to provide Medicaid coverage to a larger group of needy citizens through the use of a "resource spend down" methodology of calculating resource eligibility, it does not compel a state do so. Allen, 829 P.2d at 126. Every court that has addressed this issue has reached the same conclusion. E.g., Harriman v. Commissioner, Medicare and Medicaid Guide ¶ 39,089 (D. Me. Nov. 9, 1990) (1990 WL 284515) ("The federal statute specifically requires the state to have an income spend-down rule. . . . But there is no similar requirement in the federal statute for a resource spend-down rule.") [Addendum Item F]; Harriman v. Commissioner, 595 A.2d 1053, 1055 n.2 (Me. 1991) (court adopts prior district court holding that resource spend down is permitted but not required by section 1396a(a)(17)); Foley v. Coler, No. 83-C-4736, slip op. at 9 (N.D. Ill. Oct. 1, 1986) (1986 WL 20891) ("42 U.S.C. § 1396a(a)(17)(D) requires states to use income spend-down but is silent regarding resource spend-down . . . . Resource spend-down is thus permitted, but not required, by the Medicaid statute and regulations") [Addendum Item E]; Hession v. Illinois Dep't of Public Aid, 129 Ill. 2d 535, 544 N.E.2d 751, 757 (1989) ("Simply stated, we perceive nothing in

section 1396a(a)(17) which precludes a State that participates in the Medicaid program from using the resource spend down methodology if it chooses to do so."), affirming Hession v. Illinois Dep't of Pub. Aid, 163 Ill. App. 3d 553, 516 N.E.2d 820, 823 (1987); Haley v. Commissioner of Pub. Welfare, 394 Mass. 466, 476 N.E.2d 572, 578 (1985) (federal Medicaid statute does not require resource spend down methodology);[13] see also Westmiller by Hubbard v. Sullivan, 729 F.Supp. 260, 263 (W.D. N.Y. 1990) ("Although the Medicaid Act does not expressly mention a resource spend-down, it is clear from other sections of the Act and from the legislative history that the states have discretion in utilizing such a [resource] spend-down in determining eligibility."); Matarazzo v. Aronson, No. CV91-0388251, 2 Medicare and Medicaid Law Rptr., para. 90. at 379-80 (Conn. Superior Court, June 30, 1992) (federal Medicaid law permits resource spend-down, but state statute prohibits it) [Addendum G].

Congress does not allow use of resource spend down to become Medicaid eligible as categorically needy. With regard to Medicaid eligibility as medically needy, Congress has left it to each participating state to determine how many needy citizens it can afford to provide medical assistance to out of the larger class of persons whose extraordinary uninsured medical expenses are greater

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[13]In Ramsey v. Department of Human Servs., 301 Ark. 285, 783 S.W.2d 361, 364 (1990), the Arkansas Supreme Court likewise held that federal Medicaid law does not require states to use a resource spend down methodology, but it went even further to conclude that states are not authorized by federal law to allow applicants to spend down resources to become eligible for Medicaid.

than their assets.[14] This flexibility granted by Congress is consistent with its express intent to encourage states to choose to assist as many of the "less needy" as practicable within local conditions, see 42 U.S.C. § 1396 (1992), including burgeoning state expenditures for mandatory "categorically needy" Medicaid coverage and state budgetary constraints in these recessionary times. The interpretation of section 1396a(a)(17) urged on this Court by Allen, which would dramatically increase the costs of the medically needy program by expanding eligibility through mandated "resource spend down," would eliminate this flexibility and would itself defeat the purposes of the medically needy program by discouraging states from offering this optional program to anyone.

As the Utah Court of Appeals correctly pointed out, the state supreme courts in Hession and Haley, in decisions mistakenly relied upon by Allen, ultimately concluded that their respective state Medicaid agencies were required by clear manifestations of state legislative intent, not Congressional intent, to use a "resource spend down" methodology of calculating an applicant's eligibility for the medically needy program. Allen, 829 P.2d at 126-28. In Hession, 544 N.E.2d at 757, the Illinois Supreme Court pointed out that Illinois statutes defined those eligible, required disregard of a fixed dollar amount of assets in determining Medicaid

[14]Here, that larger group of potentially eligible would consist of the 192,000 Utahns with no medical insurance, Deseret News, Feb. 1, 1992, at B1, as well as the uncounted numbers of Utahns who are underinsured for catastrophic health care costs.

eligibility, and specifically noted the special importance of preserving recipients' limited resources. Thus, the court phrased the issue before it as whether the lower "appellate court correctly concluded that the Illinois Public Aid Code (Code) requires the application of a resource spend down." Id.

Similarly, in Haley, 476 N.E.2d at 579, the court addressed whether the Massachusetts Legislature "intended to require the use of a resource spend down." The court identified numerous provisions in the state laws about the medically needy program that strongly evinced the state legislature's intent that its medically needy program use a resource spend-down methodology. Significantly, these included provisions allowing medically needy applicants to dispose of excess assets by actually paying incurred medical bills before applying for retroactive coverage[15] and to establish eligibility without depleting assets below an exempted amount. Furthermore, the state legislature had explicitly required a resource spend down methodology when applicants had assigned or transferred away assets before application in order to render themselves eligible for medical assistance. Id. at 578-79 & nn.8, 9. Based on these state statutory provisions, the court concluded

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[15]The court stated that under the Massachusetts scheme, without resource spend-down, a person aware of the Medicaid agency's asset limit could use his excess assets to actually pay incurred medical bills and then become retroactively eligible, while the person unaware of the policy or unable to actually spend excess assets on medical bills before applying would be found ineligible. Haley, 476 N.E.2d at 578-79 n.8. As discussed more fully at page 30-32, such a disparate result is not possible in Utah.

that use of resource spend down by the Massachusetts Medicaid agency was required by state law. Id. at 579-80.

Similar statutory provisions regulating eligibility for the medically needy program in North Carolina led the court there to likewise conclude that resource spend down, which allows applicants to set off accrued medical bills against assets held at the time of application, was implicitly required by state legislation permitting applicants for the program to actually spend those assets on medical bills before applying and thereby bring themselves under applicable asset limits. Kempson v. North Carolina Dep't of Human Resources, 100 N.C. App. 482, 397 S.E.2d 314, 316-18 (1990), aff'd by divided court, 328 N.C. 722, 403 S.E.2d 279 (1991)[16]; accord Walter O. Boswell Memorial Hospital, Inc. v. Yavapai County, 148 Ariz. 385, 714 P.2d 878, 882 (1986) (involving same provisions in a state created medical assistance program, not Medicaid).

Thus, in all the cases relied on by Allen, the state agency's failure to use resource spend down was considered contrary to express state legislative intent, as well as unfair to "blindsided" applicants who were unable (or unaware of the need to) use excess assets to actually pay medical bills before application. Haley, 476 N.E.2d at 578-79 & n.8; Hession, 544 N.E.2d at 757; Kempson,

[16]The Supreme Court of North Carolina was careful to point out that the North Carolina Court of Appeals' decision it was affirming, because of an equally divided court, nonetheless has "no precedential value." 403 S.E.2d at 279.

397 S.E.2d at 316-17; Walter O. Boswell Memorial Hospital, 714 P.2d at 881-82. See note 15, supra.

However, as Allen now concedes, Utah's legislature has enacted nothing on which to conclude that the Division's failure to allow resource spend down is contrary to state law or state legislative intent. Instead, the Utah Legislature has given the Division complete authority and broad discretion to administer and implement the Medicaid program, including authority to adopt policy and eligibility standards consistent with federal law. Utah Code Ann. § 26-18-3 (1991). The Utah Legislature could have, but has not, directed the Division to use a resource spend down methodology, a change which would necessarily expand the pool of potentially eligible persons and thereby increase the cost of offering any medically needy program. See Harriman, 595 A.2d at 1057 n.6. On the contrary, by continuing to fund the medically needy program without taking such preemptive action, the Utah Legislature has tacitly adopted the Division's policy of not using resource spend down.

As a matter of sound and humane public policy, it may be desirable for the government to make catastrophic health insurance coverage accessible to all Americans so no one must spend a life's savings to pay exorbitant costs of necessary medical care. Nonetheless, this is a matter for legislative consideration and action. The policy determination of whether to offer the optional medically needy program and how many needy persons Utah can afford

to subsidize has properly been left by Congress to the determination of the state legislature. As the Court of Appeals recognized, it is not for the courts to rewrite eligibility criteria for public assistance programs. Allen, 829 P.2d at 128 n.18; accord Harriman, 595 A.2d at 1057 (court not justified in imposing on Medicaid agency a resource spend down methodology where state legislature has clearly refrained from requiring one); Bemowski v. Comm., Dept. of Pub. Welfare, 582 A.2d 103, 106 (Pa. Cmwlth. 1990) (where state plan does not use resource spend down, "such a change in the eligibility criteria for . . . the medically needy category must be made legislatively or by regulation, not judicially").

For these reasons, this Court should conclude that failure to use a resource spend down methodology when measuring resources held by an applicant for the medically needy program is not inconsistent with Congress's objectives in creating the Medicaid program.

2. The federal requirement in section 1396a(a)(17)(D) that a state use income spend down does not impliedly require a state to use resource spend down since, in setting criteria for public assistance eligibility, it is rational to treat income differently from accumulated resources.

Characterizing resources as merely unspent income, Allen suggests that it is unreasonable for the Division not to use a resource spend down methodology since it is required by federal Medicaid law to use an income spend down methodology when determining eligibility for the medically needy program. However, as noted above, Congress itself has expressly required income spend

down in section 1396a(a)(17)(D), but has not required resource spend down. This is itself a strong indication of Congressional intent not to make resource spend down mandatory.

As the Arkansas Supreme Court recently explained in a decision rejecting a claim that states must use resource spend down, there are quantitative differences between the two that justify such disparate treatment. Income "is accrued day to day in return for labor. On the other hand, resources in place, or acquired, are viewed as wealth in hand that increases the recipient's well-being." Ramsey v. Department of Human Servs., 301 Ark. 285, 783 S.W.2d 361, 364 (1990).

As discussed more fully below under point 4, a state can reasonably conclude that persons able to put money away and accumulate substantial assets are in a better position to provide for their own health care costs. Harriman v. Commissioner, 1 Medicare and Medicaid Law Rptr., para. 318, at 1418 (D.Me. March 4, 1992) [Addendum H]. Indeed, Congress itself has already reached this same conclusion by declining to allow applicants for Medicaid coverage as categorically needy to use resource spend down and set off incurred medical bills against excess resources, even if their incomes are below poverty level income limits and even if they have incurred medical bills far greater than their excess resources. See 20 C.F.R. §§ 416.1201, 416.1205, 416.1210 (1992) [Addendum B]. It would be highly irrational for Congress to require states to provide optional Medicaid coverage to a "medically needy" person

through resource spend down when federal law does not allow resource spend down when determining if a person is eligible for mandatory categorically needy assistance.

If a state chooses to use resource spend down in its medically needy program, it is rendering eligible for public assistance all applicants with substantial assets if they also have even more substantial uninsured medical bills. Recognizing this, Congress has not statutorily required states to use resource spend down, since such a requirement would force some states to choose between providing coverage to this huge pool of potentially medically needy, or to no one at all.

Furthermore, there are considerable administrative problems (and attendant costs) not posed by income spend down that would accompany use of resource spend down. In most cases, it is simple to measure an applicant's regular monthly income stream, so income spend down is merely a computational matter. If an applicant has minimal nonexempt assets, the administrative burden on the state to evaluate them is slight. But if persons with substantial assets are to be eligible under a resource spend down methodology, the state will have to evaluate many more assets, including assets difficult to value like collectibles and stock not publicly traded. The state would also have to put in place a tracking system for assets to insure that they were not used repeatedly from month to month for resource spend down purposes.

These additional administrative burdens provide added support

for the conclusion that it is rational to draw the line between income and resources for purposes of applying the spend down rule when determining eligibility for the optional medically needy program. Harriman v. Commissioner, 1 Medicare and Medicaid Law Rptr., para. 318, at 1418 (D.Me. March 4, 1992) [Addendum H]. As the Harriman court noted, use of a fixed asset limit instead of resource spend down represents a choice by the state to spend scarce Medicaid dollars on needy persons with assets under that limit, instead of spending those dollars on the increased administrative costs entailed in using a resource spend down methodology:

> The State should not be compelled to use its limited budget to hire more people to apply a different rule where the alternative is to direct the funds to people in need even though not all people in need can be reached.

Id.

This Court should, therefore, reject Allen's argument that Congress impliedly required resource spend down when it expressly required income spend down.

3. Because an Applicant Cannot Spend Excess Assets to Pay Incurred Medical Bills before Applying for Retroactive Medicaid Coverage, the Three-Month Retroactive Application Period in Section 1396a(a)(34) Does Not Impliedly Require Use of Resource Spend Down.

Next, Allen contends that resource spend down is impliedly required by Congress's mandate, in section 1396a(a)(34), of up to three months of retroactive Medicaid coverage prior to the month of application. Relying on Kempson, 397 S.E.2d at 318, he claims that applicants for such retroactive coverage in Utah are "blindsided"

by the resource limit if they are either unable to (or unaware of the need to) spend their excess assets before applying for coverage. This is the same unfair scenario envisioned by Judge Bench in his dissent below, in which he states erroneously that an applicant "savvy enough to spend down his or her assets before applying for Medicaid would be eligible, while the applicant who applies for benefits before spending down is not eligible." Allen, 829 P.2d at 128-29 (Bench, J., dissenting). However, as counsel for Allen should know even if Judge Bench does not, it is impossible for this scenario to take place in Utah.

The applicants for medical assistance in Kempson were unfairly "blindsided" because state law setting out medically needy eligibility standards allowed them to actually use excess assets to pay accrued medical bills and thereby bring their total assets below the resource limit by the time of application for retroactive coverage. Kempson, 397 S.E.2d at 316-318. Under such a state eligibility system, which was also present in Haley, 476 N.E.2d at 578-79, and Walter O. Boswell Memorial Hospital, 714 P.2d at 882, it is patently unreasonable to not permit resource spend down at the time of application by those who were unable to (or were unaware of the need to) do so before application.

In contrast, under current Medicaid law and Utah's Medicaid eligibility standards, an applicant may not make himself eligible by using excess assets to pay incurred medical bills prior to applying for coverage. Allen's representations to the contrary at

pages 15 and 18 of his brief are simply not true.

Section 1396a(a)(34) requires a state to provide for retroactive Medicaid coverage for medical bills incurred up to three months before the month of application, but only "if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished." In accordance with this directive, eligibility is determined based on the resources held by an applicant at the first moment of the month for which he seeks Medicaid coverage. See Utah Admin. Code R810-304-403. Resources are not, as Judge Bench believed, measured as of the date a person applies for retroactive Medicaid coverage. Thus, Allen could not have spent down his excess resources after incurring his hospital bills and thereby rendered himself eligible for Medicaid coverage retroactive to January and February 1991 when he applied on February 4, 1991.

Because Utah's medically needy eligibility standards do not allow a "savvy" applicant to become eligible while an ignorant or unable applicant cannot, the federally mandated three-month retroactive application process does not impliedly require resource spend down.

4. It is Reasonable for the Division to Base Eligibility for Medicaid Coverage under the Optional Medically Needy Program on Need, as Measured by the Amount of an Applicant's Accumulated Resources.

Finally, Allen contends that the Division's failure to allow resource spend down is contrary to the requirement in section 1396a(a)(17) that a state's eligibility criteria be "reasonable."

As support for this argument, he refers the Court only to the 1965 Senate Report at page 2019 [Addendum D]. Significantly, that Report expressly acknowledges earlier in the same section, captioned "Determination of need for medical assistance," that "States may set a limitation on income and resources which individuals may hold and be eligible for aid." Id. at 2018. The subsequent language Allen apparently relies on, with emphasis added, is:

> The State may require the use of all the excess income of the individual toward his medical expenses, or some portion of that amount. In no event, however, with respect to this provision . . . may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan.

As the Utah Court of Appeals recognized, this section merely explains that section 1396a(a)(17)(D), i.e., "this provision," requires **income spend down** in determining whether one is eligible as medically needy. Allen, 829 P.2d at 126 n.10. The 1965 Senate Report emphasizes that states can require applicants to use all excess income (i.e., that above the applicable monthly income limit) toward medical bills, but states cannot require applicants to so use the protected amount of income (i.e., that below the applicable monthly income limit). The cited passage provides no support for a conclusion that it is unreasonable to exclude persons with substantial assets from participation in an optional program designed to encourage state assistance to the neediest citizens.

Indeed, it is eminently rational for the Division to delineate

who is most in need of medical assistance by taking into account the level of applicants' accumulated resources. Harriman v. Commissioner, 1 Medicare and Medicaid Law Rptr. para. 318, at 1418 (D.Me. March 4, 1992) [Addendum H]. In applying a fixed asset limit as an eligibility criterion for the Medically Needy Program, the Division has reasonably concluded that persons with assets above the resource limits are generally more able than those with assets below the resource limits to be able to meet the costs of their own medical care:

> [T]he State could rationally believe that [people with accumulated resources over resource limits] 'generally are better able to provide for their medical needs,' than people who have been unable to accumulate resources. In other words, people with accumulated resources, as a group, are likely to have greater flexibility in making alternative arrangements for their medical needs, whether it be by previous purchase of insurance, arranging for loans, family assistance, etc.

Id. (quoting Schweiker v. Hogan, 457 U.S. at 590).

The facts in this specific case demonstrate the reasonableness of the Division's conclusion about the general class of persons to which Allen belongs, i.e., those who have accumulated assets in excess of resource limits. Allen and his wife owned their own $65,000 home and held over $10,000 in cash and other assets, in addition to other property exempted from consideration. When Allen's group health insurance coverage ended in June 1990, he could have protected himself for $400-600 per month for the eighteen months until he would gain Medicare coverage. Persons with meager or no accumulated assets have no such option. But

Allen decided to hold onto his "nest egg" and risk being without health insurance, despite a history of heart disease and prior open heart surgery. Although his nest egg and all his other assets may now be at risk for payment of his catastrophic uninsured medical bills, his predicament results from his own gamble, not from an unreasonable or unlawful method of determining his Medicaid eligibility.

Finally, quoting from the dissent below, Allen asserts it is unreasonable not to permit resource spend down because an applicant who is "savvy enough to spend down his or her assets before applying for Medicaid would be eligible, while the applicant who applies for benefits before spending down is not eligible." Allen, 829 P.2d at 128-29 (Bench, J., dissenting). As discussed above under points 1 and 3, this admittedly unfair result is not possible under the Utah Medicaid program, although it was possible under the state eligibility standards examined in Haley, Kempson, and Boswell Memorial Hospital. In short, a "savvy" Allen could not have spent his excess assets in January and February 1991, prior to applying for Medicaid, and thereby made himself eligible for coverage for those months. 42 U.S.C. § 1396a(a)(34) (1992); Utah Admin. Code § 455-1-11 (1991).

Because it is reasonable for the Division to establish eligibility standards for a public assistance program that take into account an applicant's accumulated resources, this Court should reject Allen's argument that failure to use resource spend

down contravenes section 1396a(a)(17).[17]

CONCLUSION

For the foregoing reasons, this Court should reject Allen's claims and affirm the Utah Court of Appeals' holding that federal law does not require the Division to use a resource spend down methodology when determining eligibility for Utah's optional Medically Needy Program.

RESPECTFULLY SUBMITTED this 30th day of September, 1992.

R. PAUL VAN DAM
ATTORNEY GENERAL

Douglas W. Springmeyer by AMM
DOUGLAS W. SPRINGMEYER
Assistant Attorney General

Annina M. Mitchell
ANNINA M. MITCHELL
Assistant Attorney General
Attorneys for Respondent

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[17]Allen also mentions, for the first time on appeal, an unsupported claim that the Division's failure to allow him to spend down his excess resources against incurred medical bills constitutes an unreasonable overvaluation of his available resources, contrary to section 1396a(a)(17)(C). (Brief of Petitioner) at 17-18. Although this belated, alternative "unreasonableness" argument should not even be addressed, Espinal v. Board of Educ., 797 P.2d 412, 413 (Utah 1990), it lacks merit for the same reasons set forth by the Division in point 4.

<u>MAILING CERTIFICATE</u>

I hereby certify that I mailed four (4) copies of the foregoing Respondent's Brief, with first-class postage prepaid, on this the 30th day of September, 1992, to the following:

Steven Elmo Averett, Esq.
Utah Legal Services, Inc.
455 N. University Ave., #100
Provo, Utah 84601

Michael E. Bulson, Esq.
Utah Legal Services, Inc.
550 24th Street, #300
Ogden, Utah 84401

[signature]

ADDENDA

ADDENDUM A

FILED

MAR 17 1992

Mary T Noonan
Clerk of the Court
Utah Court of Appeals

This opinion is subject to revision before
publication in the Pacific Reporter.

IN THE UTAH COURT OF APPEALS

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Doyce Allen, Petitioner, v. Utah Department of Health, Division of Health Care Financing, Respondent.	)	OPINION (For Publication) Case No. 910287-CA F I L E D (March 17, 1992)

Original Proceeding in this Court

Attorneys: Steven Elmo Averett, Provo, for Petitioner
R. Paul Van Dam and J. Steven Mikita, Salt Lake City, for Respondent

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Before Judges Bench, Billings, and Russon.

BILLINGS, Associate Presiding Judge:

Petitioner Doyce Allen (Allen) appeals from a final order of respondent Utah Department of Health, Division of Health Care Financing (DHCF) denying him Medicaid benefits. We affirm.

FACTS

On January 23, 1991, Allen suffered a heart attack while in Arizona. He was subsequently transported to Utah where he underwent heart bypass surgery, resulting in medical costs exceeding $40,000.00. At the time of his heart attack, Allen had no health insurance and was ineligible for Medicare assistance because he was not sixty-five years old.

Allen applied for Medicaid benefits on February 4, 1991, seeking retroactive coverage to include medical bills incident to his heart surgery in January, 1991. Utah Medicaid guidelines require that Allen's assets be less than $3,000.00, on the first of each calendar month, to qualify for medical assistance. In both January and February, Allen owned a savings account in the

amount of $3,029.86, a checking account in the amount of $100.00, a Lincoln automobile valued at approximately $600.00, a 1983 Ford pickup truck valued at approximately $2,500.00, and a 1981 travel trailer valued at approximately $7,000.00.

On February 19, 1991, the Office of Family Support denied Allen's Medicaid application, finding his resources exceeded the $3,000.00 limit. Allen requested a formal hearing, after which a DHCF hearing officer sustained the denial on the ground that Allen's "savings account alone exceeded the limit." On April 29, 1991, the DHCF issued a Final Agency Action and Order on Review, adopting the findings and conclusions of the hearing officer. Allen then filed a Request for Reconsideration which was denied.

On appeal, Allen alleges the DHCF erred in denying his Medicaid application because: (1) The savings account funds are designated for burial expenses and, thus, exempt from consideration for Medicaid eligibility; (2) the travel trailer, modified to accommodate his wife's disabilities, is a medical necessity or personal effect and, thus, exempt from consideration for Medicaid eligibility; and (3) he should have been permitted to "spend down" his assets, by applying them to medical bills, in order to become eligible for Medicaid.

I. THE SAVINGS ACCOUNT AS A BURIAL FUND

Allen contends that his $3,029.86 savings account should not be included for purposes of Medicaid eligibility because it is exempt as a burial fund.[1] In support of this claim, Allen points to a statement in his will directing that the savings account be used "to bury Doyce Allen and Lilly Allen." Allen alleges the will is properly before this court on appeal because it was submitted to the DHCF with his Request for Reconsideration. The DHCF responds that it is inappropriate for us to consider Allen's will as part of the record on review because it was never introduced as evidence at Allen's formal administrative hearing.

A review of the record reveals that a copy of Allen's will was first presented to the DHCF as an attachment to a letter from Allen's counsel, dated June 3, 1991, requesting a transcript of

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1. Under the Utah Administrative Code, "a $1,500 burial or funeral fund exemption for each eligible household member" is permitted only if these funds "are separately identified and not commingled with other funds. They must be clearly designated so that an outside observer can see that these funds are specifically for the client's burial expense." Utah Code Admin. P. R810-304-411(9)(e)(1) (1991).

Allen's administrative hearing. The DHCF did not receive the will until June 10, 1991[2], after the hearing officer's Recommended Decision, the DHCF's Final Agency Action and Order on Review, and the DHCF's Response to Request for Reconsideration had already been signed and dated. Because there is no indication that Allen's will was ever included as evidence before the DHCF, it is not properly a part of Allen's record on appeal.

However, even if we were to consider the general language in Allen's will, the result would not be different. Allen clearly and unequivocally testified the account was to pay for insurance premiums, not burial expenses. Allen did not specify the account as a burial fund on his original Medicaid application. During his formal administrative hearing, Allen did not argue or present any evidence indicating his savings account was designated for burial expenses. In fact, when the hearing officer specifically asked if the savings account might be a burial fund, Allen replied that "we earned it last summer for our insurance premiums, and they didn't go through, so we had this money for a nest egg, you might say. You have to have a little bit of something in case--."[3] Therefore, considering only the savings

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2. Allen argues the will "was submitted at a time when the record was still open," pointing out that the letter to which the will was attached was mailed on June 3, 1991. The letter, nevertheless, clearly bears a "Received June 10, 1991" stamp.

3. Allen testified that, after the DHCF denied Medicaid benefits, Allen, in fact, did not maintain the account as a burial fund. The following exchange occurred at the administrative hearing:

> HEARING OFFICER: What did you do with the $3,000 in February which you pulled out of the savings account?
> MR. ALLEN: Well, we paid bills that was accrued during our heart attack deal here, and transportation to and from.
> HEARING OFFICER: So, that money was spent on medical things?
> MR. ALLEN: Bills again.

Contrary to his argument, Allen apparently neither considered nor used the savings account as a fund "separately identifiable" which was set aside "specifically" for burial expenses.

account for purposes of affirming on appeal[4], Allen's savings account alone surpassed the $3,000.00 Medicaid limit.

II. MEDICAID "SPEND DOWN"

A. An Overview of the Medicaid Program

Allen alternatively argues that he should have been permitted to spend his assets on medical bills in order to qualify for Medicaid. We look to both federal and Utah Medicaid regulations to resolve this question.

In 1965, Congress established the Medicaid program as Title XIX of the Social Security Act.[5] Medicaid is a cooperative federal-state program providing federal funds to assist individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396 (1992). States choosing to participate in this optional program are reimbursed for a portion of their costs in providing medical treatment to needy persons. See Atkins v. Rivera, 477 U.S. 154, 156-57, 106 S. Ct. 2456, 2458 (1986); Weber Memorial Care Ctr., Inc. v. Utah Dept. of Health, 751 P.2d 831, 832 (Utah App.), cert. denied, 765 P.2d 1278 (Utah 1988).

Participating states must develop a plan that complies with all federal Medicaid regulations. See 42 U.S.C. § 1396; Atkins, 477 U.S. at 157, 106 S. Ct. at 2458; Weber Memorial, 751 P.2d at 832. Each state must also select a single agency "to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5) (1992). In determining eligibility for its program, a state must provide benefits to the "categorically

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4. Allen also argues that his travel trailer, equipped with oxygen, and his truck, both used to transport Allen and his wife to a warmer climate during winter because of his wife's ill health, should be excluded from Medicaid eligibility consideration because they are exempt either as personal effects or medical necessities. See Utah Code Admin. P. R810-304-411(4), (5)(b) to (d) (1991). Furthermore, Allen asserts that, because his wife requires the truck and travel trailer for health reasons, neither vehicle is "available" to him, as contemplated by federal statutory Medicaid requirements. See 42 U.S.C. § 1396a(a)(17)(B) (1992). We find it unnecessary to reach these issues in view of our determination that Allen's savings account alone exceeded the Medicaid eligibility limit.

5. Pub. L. No. 89-97, as amended, 79 Stat. 343 (codified at 42 U.S.C. §§ 1396, et seq. (1992)).

needy"[6] but may provide benefits to the "medically needy"[7] at its discretion.[8]

B. The Concept of "Spend Down" in Federal Medicaid Statutes

When a "medically needy" applicant's income or resources exceed the applicable state's Medicaid eligibility limits, the "spend down" rule may apply. Under this rule, the applicant may be able to "spend down" excess income or assets, by applying them to outstanding medical bills, to become eligible for Medicaid.

In determining whether the federal Medicaid program requires states to adopt the "spend down" rule, courts have focused on the following portion of the Medicaid statutes:

> (a) A State plan for medical assistance must
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> . . . .
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> (17) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are . . . available to the applicant or recipient . . . (C) provide for reasonable evaluation of any such income or resources,

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6. See 42 U.S.C. § 1396a(a)(10)(A)(i).

7. See 42 U.S.C. § 1396a(a)(10)(A)(ii).

8. The United States Supreme Court explained this distinction in Schweiker v. Hogan, 457 U.S. 569, 102 S. Ct. 2597 (1982):

> Congress has differentiated between the categorically needy--a class of aged, blind, disabled, or dependent persons who have very little income--and other persons with similar characteristics who are self-supporting. Members of the former class are automatically entitled to Medicaid; members of the latter class are not eligible unless a State elects to provide benefits to the medically needy and unless their income, after consideration of medical expenses, is below state standards of eligibility.

Id., 457 U.S. at 590, 102 S. Ct. at 2609.

> and (D) . . . provide for flexibility in the application of such standards with respect to income by taking into account . . . the costs . . . incurred for medical care or for any other type of remedial care recognized under State law.

42 U.S.C. § 1396a(a)(17) (1992)(emphasis added). Courts recognize section 17(D) as the "income spend down rule," finding that state plans must permit a Medicaid applicant to "spend down" or deplete excess income to comply with a state's eligibility standards.[9]

The question in the present case, however, is whether the federal Medicaid regulations also require states to allow an applicant to "spend down" excess resources in the same manner. Allen contends that the federal Medicaid program requires states to implement "resource spend down" because it is necessary to fulfill the purpose of the Medicaid program and is reasonable. The DHCF responds that federal Medicaid regulations mandate "income spend down" but merely permit states to incorporate "resource spend down" within their plans at their discretion.

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9. See, e.g., Atkins, 477 U.S. at 158, 106 S. Ct. at 2459 ("the spenddown mechanism of 42 U.S.C. § 1396a(a)(17)" allows the medically needy to spend down "the amount by which their income exceeds" the eligibility level); Foley v. Coler, No. 83-C-4736, 1986 WL 20891 (N.D. Ill. Oct. 1, 1986)("42 U.S.C. § 1396a(a)(17)(D) requires states to use income spend-down"); Harriman v. Commissioner, No. 90-0046-B, 1990 WL 284515 (D. Me. Nov. 9, 1990)(42 U.S.C. § 1396a(a)(17)(D) "specifically requires the state to have an income spend-down rule"); Walter O. Boswell Memorial Hosp., Inc. v. Yavapai County, 148 Ariz. 385, 714 P.2d 878, 881 (Ct. App. 1986)("Federal regulations implementing [42 U.S.C. § 1396a(17)] expressly require deduction of incurred medical bills from income for purposes of determining eligibility."); Ramsey v. Department of Human Servs., 301 Ark. 285, 783 S.W.2d 361, 363 (1990)("Under the 'medically needy' procedure, applicants are permitted to 'spend down' their excess income for medical expenses."); Haley v. Commissioner of Pub. Welfare, 394 Mass. 466, 476 N.E.2d 572, 574 (1985)(42 U.S.C. § 1396a(a)(17) "provide[s] for application of the spend down principle to income eligibility determinations"); Kempson v. North Carolina Dept. of Human Resources, 100 N.C. App. 482, 397 S.E.2d 314, 316 (1990)(The "explicit reference to income [in 42 U.S.C. § 1396a(a)(17)(D)] has been interpreted by the courts to mean that 'income spend-down' is allowed by the statute."), aff'd, 328 N.C. 722, 403 S.E.2d 279 (1991).

Courts considering the issue agree with the DHCF, finding the express statutory mandate is limited to "income spend down."[10] Courts conclude that federal Medicaid regulations permit, but do not require, states to employ "resource spend down."[11] We agree and conclude "resource spend down" is not mandated by federal law.

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10. Legislative history accompanying section 1396a(a)(17) points to only "income spend down" as a mandatory federal requirement. See S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Admin. News 1943.

11. See, e.g., Foley, 1986 WL 20891 ("42 U.S.C. § 1396a(a)(17)(D) requires states to use income spend-down but is silent regarding resource spend-down . . . . Resource spend-down is thus permitted, but not required, by the Medicaid statute and regulations"); Harriman, 1990 WL 284515 ("The federal statute specifically requires the state to have an income spend-down rule. . . . But there is no similar requirement in the federal statute for a resource spend-down rule."); Hession v. Illinois Dept. of Pub. Aid, 129 Ill. 2d 535, 544 N.E.2d 751, 757 (1989)("Simply stated, we perceive nothing in section 1396a(a)(17) which precludes a State that participates in the Medicaid program from using the resource spend down methodology if it chooses to do so."); Hession v. Illinois Dept. of Pub. Aid, 163 Ill. App. 3d 553, 516 N.E.2d 820, 823 (1987)("section 1396a(a)(17) of the Act permits a state plan to utilize resource spend down in determining an applicant's eligibility for medical assistance benefits"), aff'd, 129 Ill. 2d 535, 544 N.E.2d 751 (1989); Harriman v. Commissioner, 595 A.2d 1053, 1055 n.2 (Me. 1991)(court adopts prior holding of district court in this case that federal Medicaid statute "only permits, and does not require, a state to use an asset spend-down"); Bemowski v. Department of Pub. Welfare, 136 Pa. Commw. 103, 582 A.2d 103, 106 (1990)(the provision of medical benefits "to the medically needy by participating States is optional and may be excluded entirely from a State's Medicaid program").

But see Ramsey, 783 S.W.2d at 364 (court finds "no authority in any category for a 'spend-down' of excess resources that is similar or identical to the expressly authorized 'spend-down' of excess income"); Kempson, 397 S.E.2d at 317 (court stops short of holding "resource spend down" discretionary, stating that, although "§ 1396a(a)(17)(D) only mentions income in instructing states to provide flexibility in their program application standards, we note that § 1396(a)(17)(C) instructs that a state's plan must 'provide for reasonable evaluation of any such income or resources'").

C. Utah's Medicaid Program

Since Utah may implement "resource spend down" at its discretion, we must determine whether the Utah Medicaid plan has, in fact, adopted "resource spend down" in determining Medicaid eligibility. Utah courts have never addressed Medicaid "spend down" issues.

Utah chose to participate in the Medicaid program with the adoption of the Medical Assistance Act in 1981.[12] Utah has complied with federal requirements by creating a state plan[13], which has been approved by the Secretary of Health and Human Services, and designating the DHCF as the agency responsible for Medicaid administration.[14] Utah's statutes describe the DHCF's responsibilities, in pertinent part, as follows:

> [T]he division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay.

Utah Code Ann. § 26-18-2.3(1) (1989).

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12. See Utah Code Ann. §§ 26-18-1 to -11 (1989 and Supp. 1991).

13. See Utah Code Admin. P. RR455-1 to -48 (1991). Utah has elected to provide assistance to the "medically needy." See Utah Code Admin. P. R455-1-17 and R455-1-20 (1991). Assets Utah has designated as exempt from Medicaid eligibility determination, including the burial fund discussed earlier, are listed at Utah Code Admin. P. R810-304-411 (1991).

14. "[T]he Division of Health Care Financing . . . shall be responsible for implementing, organizing, and maintaining the Medicaid program . . . in accordance with the provisions of this chapter and applicable federal law." Utah Code Ann. § 26-18-2.1 (1989)(emphasis added); see also Utah Code Ann. § 26-18-3(1) (Supp. 1991)("The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.")(emphasis added).

> (2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

Utah Code Ann. § 26-18-3 (Supp. 1991)(emphasis added).

> The department may develop standards and administer policies relating to eligibility under the Medicaid program.

Utah Code Ann. § 26-18-4(1) (1989).

Allen points to no Medicaid statute, regulation, or rule indicating that the Utah legislature has adopted "resource spend down" in determining Medicaid eligibility. Rather, Allen posits a more delicate argument which goes beyond literal statutory language. Specifically, Allen contends that Utah will not be following the federal requirement to use "reasonable standards" in determining Medicaid eligibility unless it applies "resource spend down."

Furthermore, Allen observes that Utah's Medicaid plan designates certain assets as exempt in determining eligibility for the "medically needy."[15] Allen, thus, argues that Utah has tacitly adopted a policy of allowing "medically needy" Medicaid applicants to maintain a level of income and resources for the necessities of life while still qualifying for Medicaid.

In support of these claims, Allen cites cases from other jurisdictions which, he argues, require "resource spend down" because, like Utah, they exempt certain assets from Medicaid eligibility determination. We read these cases differently. Courts in these jurisdictions have found a state mandate for "resource spend down" based on a specific legislative directive within their Medicaid plans, not just on the practice of allowing exemptions.

In Haley v. Commissioner of Public Welfare, 394 Mass. 466, 476 N.E.2d 572 (1985), the Supreme Judicial Court of Massachusetts closely examined both federal and its own state Medicaid laws to determine if "resource spend down" was mandated or simply permitted. The court, first, determined that, although the federal statutes did not require "resource spend down," it was a reasonable method of calculating resources and "consistent with the goals of Title XIX." Id., 476 N.E.2d at 578. Therefore, the court concluded that it "must determine

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15. See Utah Code Admin. P. R810-304-411 (1991).

independently whether the Legislature intended to require the use of a resource spend down." Id. at 579. The court found a statute "explicitly appl[ying] a resource spend down," id. n.9, as evidence of "the legislature's determination to ensure an individual's retention of a certain level of resources." Id. at 579. The court, thus, held that the Massachusetts Medicaid plan required "resource spend down."

The Supreme Court of Illinois performed an analysis similar to that of the Haley court in Hession v. Illinois Department of Public Aid, 129 Ill. 2d 535, 544 N.E.2d 751 (1989). After concluding that the federal Medicaid statutes permit, but do not require, "resource spend down," the court turned its attention to the Illinois Medicaid plan. The court recognized that the plan included a provision whereby $1,500 in assets is exempt from Medicaid eligibility determination. However, the court, relying upon a specific Illinois statute, also stated: "In establishing an assistance program for these individuals, the legislature has noted that it is of special importance that their incentives for continued independence be maintained and that their limited resources be preserved." Id., 544 N.E.2d at 757 (citing Ill. Rev. Stat. 1987, ch. 23, par. 5-1). Based on this clear manifestation of legislative intent, the court held that the Illinois Medicaid plan required "resource spend down."

Utah does not have such a saving, "resource spend down" provision in its Medicaid plan, nor any statement of policy expressing a desire to preserve the resources of potential beneficiaries.[16] Utah's statutes, particularly those outlining

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16. In fact, one commentator states:

> It is not only conceivable, but a fact that some unprepared applicants' assets are reduced beyond the poverty level to bankruptcy because medical bills in that month exceed those resources which the applicant cannot preserve under the Utah Exemptions Act. It [is] to the applicant's advantage to put forth any plausible argument that a particular value should be counted as income rather than asset, if the reverse would result in excess assets. Excess assets mean a denial of Medicaid eligibility; excess income means that the applicant will be required to shoulder more of [his or] her health care costs for that month.

Ken Bresin, Utah's Medicaid Program: A Senior's Eligibility Guide for Private Practitioners, 14 J. Contemp. L. 1, 9 (1988) (emphasis added)(footnote omitted).

the DHCF's authority[17], seem to evince a legislative concern for economy and efficiency in the Medicaid program, not the preservation of applicants' assets. Jurisdictions requiring "resource spend down," on the contrary, appear concerned about preserving the limited assets of Medicaid applicants.

We, unlike our colleague in dissent, cannot say it was unreasonable for the DHCF to choose not to adopt "resource spend down" in an otherwise completely optional state benefit plan. The expressed legislative concern is for economy and efficiency in implementing a Medicaid program, and we cannot see how this line-drawing offends the legislative delegation of power.

Utah's statutory scheme is more similar to that of Maine, recently reviewed in Harriman v. Commissioner, 595 A.2d 1053 (Me. 1991). In Harriman, the Supreme Judicial Court of Maine recognized that its state plan does not include "resource spend down." "If the assets of applicants exceed the specified dollar limit, they are ineligible for assistance under the medically needy program, regardless of the amount of their medical expenses." Id. at 1056. Noting that "[t]he overall effect was to restrict as much as possible the number of eligible Medicaid recipients," the court stated: "For whatever reason--whether to achieve cost containment or to comply only with the federal mandate or through simple oversight--the legislature stopped short of enacting an asset spend-down." Id. at 1057 (footnote omitted).

We, therefore, conclude there is nothing in the Utah Medicaid plan or its regulations that requires the utilization of "resource spend down."[18] Allen had $3,029.86 in his savings

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17. See, e.g., Utah Code Ann. § 26-18-2.3(1) quoted above.

18. We agree with most courts which have considered the issue and believe the adoption of "resource spend down" is good public policy. See e.g., Foley, 1986 WL 20891 (a state resource spend-down provision furthers the general purpose of the Medicaid program); Harriman, 1990 WL 284515 ("Clearly, if the goal of Medicaid is to assist individuals who are medically needy--defined as having insufficient income or resources to meet the cost of necessary medical services--the sensible solution is the spend-down rule."); Hession, 516 N.E.2d at 823 (a state's adoption of resource spend down "would be in conformity with the purpose and spirit of the Act"); Kempson, 397 S.E.2d at 318 ("Our review of the case law reveals a pattern where Medicaid applicants are blindsided by this eligibility requirement simply because it is so illogical. Applicants who otherwise qualify are (continued...)

account at the time he applied for Medicaid. The DHCF, thus, correctly determined he was ineligible for Medicaid benefits as Utah has not adopted a "resource spend down" system.

Judith M. Billings,
Associate Presiding Judge

I CONCUR:

Leonard H. Russon, Judge

BENCH, Presiding Judge (concurring in part and dissenting in part):

I concur with part I of the main opinion and dissent from part II.

Whether a "medically needy" applicant may have been eligible for Medicaid by spending down his or her assets is a policy decision delegated in Utah to DHCF by Utah Code Ann. § 26-18-4(1) (1989). We review for reasonableness an agency's policy based on a legislative grant of discretion to interpret a statute. See Morton Int'l, Inc. v. Auditing Div. State Tax Comm'n, 814 P.2d 581 (Utah 1991).[1]

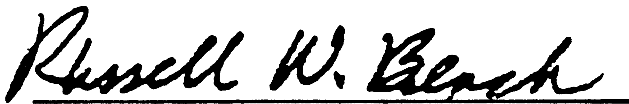
18.(...continued)
denied coverage because they have several hundred dollars above the reserve asset limit while at the same time they are liable for tens of thousands of dollars worth of medical bills.").

Nevertheless, a determination of the eligibility criteria for Medicaid benefits is not one for the courts to make.

1. I disagree with the majority's interpretation of Utah Code Ann. § 26-18-2.3(1) (1989) as an expression of intent to limit coverage. The Legislature's concern for economy and efficiency in the administration of the program simply does not have any logical relationship to the intended coverage of the program.

I do not believe the policy adopted by DHCF is reasonable since eligibility is determined by when the medically needy applicant applies for benefits. Under DHCF's policy, the applicant who is savvy enough to spend down his or her assets before applying for medicaid would be eligible, while the applicant who applies for benefits before spending down is not eligible. Because that agency policy is not reasonable, I would allow Allen to spend down his assets before his eligibility is determined.

I would therefore reverse and remand the case for further proceedings.



Russell W. Bench,
Presiding Judge

ADDENDUM B

Federal medical assistance percentage to 105 percent of the Federal share of medical expenditures for 1965 will obviate certain inequities in the various formulas and will enable a few States which might not otherwise do so to receive some additional Federal funds as an incentive for an improved program.

Provisions relating to the availability of Federal sharing in the cost of medical assistance for persons 65 years of age or older who are patients in mental or tuberculosis hospitals specify that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that the additional funds being received are being used to extend and improve the mental health program of the States. Comparable provisions appear in title II, part 3 of the bill, and are explained more fully in that part of this report relating to title II.

The provisions of title IV, section 405 of the bill, described elsewhere in this report are designed to assure that the additional Federal funds which are to accrue to the States under the operation of the formula described above, shall be used directly in the public assistance program and may not be withdrawn from the program by the States.

The bill sets forth provisions comparable to those which are in other of the public assistance titles of the Social Security Act describing the procedure by which the State submits its estimates of the funds it will need and receives payments under its approved plan, and the procedures to be followed in the event it should become necessary to question the continued receipt of Federal funds under the new title. There is also a new provision limiting payments made under the new title to States making a satisfactory showing of efforts toward broadening the scope of care and services made available under the plan. This showing must be such that the Secretary is reasonably convinced the program of medical assistance will have such liberalized eligibility requirements and comprehensive care and services, including needed social services to achieve independence or self-care that by July 1, 1975, assistance and services needed will be available to substantially all individuals who meet the State's eligibility standards with respect to income and resources. This provision was included in order to encourage the continued development in the States of a broadened and more liberalized medical assistance program so that all persons who meet the State's test of need, whose own resources, and the resources available to them under other programs for medical care, including those established for Federal matching under this bill, are insufficient, will receive the medical care which they need by 1975.

(h) Miscellaneous provisions

Title XIX would under the provisions of your committee bill become effective January 1, 1966. No payments may be made to a State under title I, IV, X, XIV, or XVI with respect to aid or assistance in the form of medical or other types of remedial care for any period for which such State receives payment under title XIX or for any period after June 30, 1967. Thus, under the provisions of your committee bill, a State is permitted to implement title XIX at any time it wishes commencing January 1, 1966, but must do so by July 1, 1967, if it wishes to receive Federal participation in vendor payments for medical care. When a title XIX plan has gone into effect pursuant to the bill, all vendor medical payments made on or after the effective date

(and administrative costs on or after the effective date, which are related to vendor medical payments) will be accounted for under title XIX, and not under the other titles.

The bill also makes technical and conforming amendments.

(i) Cost of medical assistance

As the accompanying table shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to $238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions in the bill which permit States to receive the additional funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed $200 million. Since the new title would be effective only for the last 6 months of the fiscal year ending June 30, 1966, expenditures in that fiscal year are not expected to exceed $100 million.

Public assistance: Increased Federal funds available for medical payments under title XIX [1]

[In thousands of dollars]

State	Increase available under title XIX [1]	State	Increase available under title XIX [1]
Total	$238,006		
Alabama	1,045	Missouri	350
Alaska	5	Montana	27
Arizona	19	Nebraska	1,511
Arkansas	3,906	Nevada	263
California	20,411	New Hampshire	1,931
Colorado	2,689	New Jersey	5,559
Connecticut	3,922	New Mexico	1,634
Delaware	8	New York	46,580
District of Columbia	344	North Carolina	2,890
Florida	684	North Dakota	3,809
Georgia	363	Ohio	2,871
Hawaii	898	Oklahoma	14,752
Idaho	477	Oregon	1,291
Illinois	18,395	Pennsylvania	3,098
Indiana	2,136	Rhode Island	2,437
Iowa	5,315	South Carolina	2,133
Kansas	5,808	South Dakota	148
Kentucky	262	Tennessee	324
Louisiana	3,950	Texas	1,237
Maine	781	Utah	3,028
Maryland	141	Vermont	330
Massachusetts	16,614	Virginia	159
Michigan	3,715	Washington	2,290
Minnesota	27,578	West Virginia	2,260
Mississippi	317	Wisconsin	17,031
		Wyoming	280

[1] Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

B. Child Health Amendments

1. Summary of Committee Action

Your committee believes that the proposals embodied in part 1, title II of its bill will help to improve the health care of many low-income preschool and school age children and youth.

Your committee's bill would—

under the age of 21—whether or not they are attending school or taking a program of vocational training—who would otherwise be within the scope of eligibility of a dependent child as defined under title IV of the Social Security Act. This provision was included in order to provide assurance that children under the age of 21 will have their medical needs met if they are either a member of a family receiving a money payment under title IV of the Social Security Act or a member of a family which has the need and other characteristics described under title IV.

The Secretary would be prohibited from approving any plan which imposed a residence or citizenship requirement that goes beyond those now in title I and title XVI as they relate to the medical assistance for the aged program. In addition, the Secretary is directed not to approve any State plan for medical assistance if he finds that the approval and operation of the plan will result in a reduction in the level of aid or assistance provided for eligible individuals under title I, IV, X, XIV, or XVI. An exception is provided allowing States to reduce such aid to the extent that assistance now provided under titles I, IV, IX, XIV, and XVI is to be provided under title XIX. The reason your committee recommends the inclusion of this provision is to make certain that States do not divert funds from the provision of basic maintenance to the provision of medical care. If the Secretary should find that his approval of a title XIX plan would result in a reduction of aid or assistance for persons receiving basic maintenance under the public assistance titles of the Social Security Act (except as specified above) he may not approve such a plan under title XIX. Your committee recognizes the need and urgency for States to maintain, if not improve, the level of basic maintenance provided for needy people under the public assistance programs. The provision is intended to prevent any unwarranted diversion of funds from basic maintenance to medical care.

(g) Financing of medical assistance

Your committee bill provides for payments under title XIX, beginning with the quarter commencing January 1, 1966. States with approved plans would receive an amount equal to the Federal medical assistance percentage of the total amount expended during a quarter as medical assistance under the State plan. This percentage is described below. The amount expended as medical assistance for purposes of Federal matching include expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under one of the Federal-State public assistance programs. This may include payment of premiums for those individuals covered under agreements between the State and the Secretary, and also for other money payment recipients who are eligible under part B of title XVIII. In addition, expenditures for other insurance premiums for medical or any other type of remedial care or the cost thereof are matchable as medical assistance. (The definitions of assistance in the public assistance titles of the Social Security Act would also be amended to include similar provisions.)

In addition, the States are to receive 75 percent of so much of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan as are attributable to the compensation of skilled professional medical personnel and staff directly supporting such personnel of the State agency or the local agency administering the plan in the political subdivision. This provision was included in order to provide adequate Federal financial support for the staffing of the State and local public welfare departments by such skilled professional medical personnel and staff directly supporting such personnel as may be necessary. Such staff will include physicians, medical administrators, medical social work personnel, and other specialized personnel necessary to assure an adequate number of persons to do a quality job as well as the clerical staff, directly associated with the professional staff, and the necessary travel and other closely related expenditures. It is very likely that some people in need of medical assistance will need related social services in order to receive the full benefits of the program. Under the 1962 public welfare amendments, States may receive 75 percent Federal sharing in the cost of services provided to persons receiving aid under titles I, IV, X, XIV, and XVI to former recipients of assistance under these titles and persons likely to become recipients of aid under these titles. Thus adequate provisions are already available to help the States finance the provision of social services to those receiving medical assistance or the cost of training staff to provide such services and no such provision is included in the new title.

In addition, the States are to receive one-half of all other expenditures found by the Secretary to be necessary for the proper and efficient administration of the State plan.

The Federal medical assistance percentage is determined in accordance with a formula described in the bill. It provides that a State whose per capita income is equal to the national average per capita income shall receive 55 percent Federal matching. States whose per capita income is below the national average shall receive correspondingly higher proportions of Federal funds up to a maximum of 83 percent. States whose per capita income is above the national average shall receive correspondingly lower percentages but not less than 50 percent. The medical assistance percentages for Puerto Rico, the Virgin Islands, and Guam shall be 55 percent. The method of determining the Federal medical assistance percentage and the frequency of its determination and promulgation are (after the initial promulgation for the period January 1, 1966, to June 30, 1967) already specified in the law.

There is a special provision for adjustment of the Federal medical assistance percentage for any State which might not otherwise receive full advantage from the title XIX formula. It is provided that during the period from January 1, 1966, through June 30, 1969, the Federal medical assistance percentage under title XIX for any State shall not be less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965. The computation is made by determining the amount of Federal payments made to each State for fiscal year 1965 under all of the public assistance titles, which would not have been payable except for the making of vendor medical payments. This amount of Federal payments is compared with the total amount of vendor medical expenditures under the public assistance plans (whether below or above the matching ceilings under the Federal statutory formulas) to give the Federal share of medical expenditures by the State during fiscal year 1965. The raising of the

mittee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) Scope and definition of medical services

"Medical assistance" is defined under the bill to mean payment of all or part of the care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406 (b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

Your committee bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

Inpatient hospital services.
Outpatient hospital services
Other laboratory and X-ray services.
Skilled nursing home services.
Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

In the opinion of your committee, these are the most essential items of service which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in titles I and XVI—for some institutional and some noninstitutional services.

Other items of medical service which the States may, if they wish include in their plans are:

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
Home health care services.
Clinic service.
Private duty nursing service.
Dental service.
Physical therapy and related services.
Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.
Other diagnostic, screening, preventive, and rehabilitative services.
Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The States must pay the reasonable cost of inpatient hospital services for the number of days of care provided under the plan.

Among the items of medical services which the States may include is medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Under this provision, a State may if it wishes, include medical and remedial services provided by osteopaths, chiropractors, optometrists and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

If a State chooses to provide eyeglasses as a service under the plan, your committee believes that the individual recipient should be free to select either a physician skilled in diseases of the eye or an optometrist to provide these glasses. Many small communities do not have qualified ophthalmologists but do have optometrists who are competent to provide, fit, or change eyeglasses.

In addition to the items specifically listed, the Secretary is authorized to define any other medical care or any other type of remedial care recognized under State law which he believes might be provided by the States and in which the Federal Government will participate financially.

The State plan may not include any individual who is an inmate of a public institution, except as a patient in a medical institution; nor may it include any individual under the age of 65 who is a patient in an institution for tuberculosis or mental diseases.

Under title XIX, it will be possible for States to give medical assistance to persons 65 years of age and older who are in mental and tuberculosis institutions and to otherwise eligible persons of any age with a diagnosis of psychosis or tuberculosis and who are receiving care in other medical institutions. Under the bill, if the plan includes medical assistance for patients in institutions for mental diseases or tuberculosis, various requirements are specified for inclusion in the State plan with respect to these individuals and various other fiscal and other provisions are included. These are identical with those included in title II, part 3 of the bill and are explained elsewhere in this report.

Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance, e.g., by attaining a specified age. This avoids the administrative inconvenience of having to segregate bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles.

(f) Other conditions for plan approval

Title XIX requires that the Secretary approve any plan which fulfills the plan requirements specified and described above and which does not contain certain other conditions. Under these provisions, a State plan may not include an age requirement of more than 65 years. Effective July 1, 1967, States may not, under the provisions of your committee bill, exclude any individual who has not attained the age of 21 and is, or would, except for the provisions of section 406(a)(2) be a dependent child under title IV. Thus, States will include within the scope of their plan all children

that income may be set aside for the future needs of the children. Other pertinent provisions for the disregard of income are found in the Economic Opportunity Act and the Food Stamp Act of 1964.

Your committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, your committee bill requires that the States standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be $2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than $2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similiar charge, nor of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. Your committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, your committee's bill provides that the States make provisions, for individuals 65 years or older, of the cost of any deductible imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under your com-

uals. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of your committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. Your committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

(c) Eligibility fo medical assistance

Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to the less needy than those who would be eligible for aid under the various other categories of public assistance.

. Under your committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various cate-

gories of assistance except that their income and resources are s cient to meet their needs for maintenance, the medical assistance gi such individuals shall not be greater in amount, duration, or sc than that made available for persons who are recipients of money p ments. This was included in order to make sure that the most ne in a State receive no less comprehensive care than those who are as needy.

Under the bill, if a State extends the program to those persons receiving assistance under titles I, IV, X, XIV, and XVI, the de mination of financial eligibility must be on a basis that is compara as among the people who, except for their income and resources, wo be recipients of money for maintenance under the other public ass ance programs. Thus, the income and resources limitation for aged must be comparable to that set for the disabled and blind must also have a comparability for that set for families with child who, except for their income and resources, would be eligible AFDC. The scope, amount, and duration of medical assistance av able to each of these groups must be equal.

(d) Determination of need for medical assistance

Your committee bill would make more specific a provision now the law that in determining eligibility for and the extent of aid un the plan, States must use reasonable standards consistent with objectives of the titles. Although States may set a limitation on come and resources which individuals may hold and be eligible for a they must do so by maintaining a comparability among the vari categorical groups of needy people. Whatever level of finan eligibility the State determines to be that which is applicable for eligibility of the needy aged, for example, shall be comparable to t which the State sets to determine the eligibility for the needy blind a disabled; and must also have a comparability to the standards u to determine the eligibility of those who are to receive medical assi ance as needy children and the parents or other relatives caring them.

Another provision is included that requires States to take into a count only such income and resources as (determined in accordar with standards prescribed by the Secretary) are actually availal to the applicant or recipient and as would not be disregarded (or aside for future needs) in determining the eligibility for and t amount of the aid or assistance in the form of money payments f any such applicant or recipient under the title of the Social Secur Act most appropriately applicable to him. Income and resources tak into account, furthermore, must be reasonably evaluated by the Stat These provisions are designed so that the States will not assume t availability of income which may not, in fact, be available or ove evaluate income and resources which are available. Examples of i come assumed include support orders from absent fathers, which ha not been paid or contributions from relatives which are not in reali received by the needy individual. The provisions also are designed assure that whatever is applicable under titles I, IV, X, XIV, a XVI for the disregarding of income or for setting aside of income sh also be applicable in evaluating the income of the individual who applying for medical assistance under title XIX. Titles I and X no provide for the disregarding of certain income and title IV provid

have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

Your committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, your committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs." After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program), or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(b) State plan requirements

(1) Standard provisions

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, your committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, your committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

Your committee bill provides that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State-supervised, the same State agency shall supervise the administration of title XIX. This provision was included because of the need to have the same agency which is most familiar with the administration of assistance (including medical care) to various groups of needy or nearly needy people also administer the medical assistance program. This is an agency with long experience and skill in determination of eligibility. Responsibility can be arranged by a welfare agency for actual provision of medical care by or through a health agency under suitable contractual relationships as some States have done under the MAA program.

Moreover, your committee recognizes that there are other State agencies with responsibilities for the provision of medical care or for various types of rehabilitative services in the States. In order to make certain that there is no duplication of effort and that maximum utilization will be made of the resources available from such other agencies, your committee bill provides that the State's plan must include provisions for entering into cooperative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the States.

Your committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the plan relating to the aged under title I or title XVI, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individ-

along with the matching Government contribution, have utilized data from the experience under the Federal Employees Health Benefits Act of 1959 for persons aged 65 and over, the experience under the Connecticut 65 program, and various information obtained by the National Health Survey conducted on a periodic basis by the Public Health Service of the Department of Health, Education, and Welfare.

The cost estimates have been made on a conservative basis—as seems essential in a newly established program of this type for persons aged 65 and over, most of whom have not previously had such insurance. It is believed that the $6 total per capita income of the system (from the premiums of the individuals and the matching Government contributions) will be fully adequate to meet the costs of administration and the benefit payments incurred, as well as to build up a relatively small contingency reserve. It is believed that there will be no need to draw upon the advance appropriation that is provided from general revenues.

Two cost estimates have been presented in regard to the possible per capita cost. Under the low-cost estimate, the benefits and administrative expenses will, on an accrual basis, represent about 75 percent of the contribution income, whereas under the high-cost estimate, the corresponding ratio will be almost 100 percent.

In an individual voluntary-election program such as this, it is impossible to predict accurately in advance what proportion of those eligible to participate in the program will actually do so. Accordingly, the cost estimates have been presented on two bases—an assumed 80 percent participation and an assumed 95 percent participation. Both of these estimates assume that virtually all State public assistance agencies will "buy in" for their old-age assistance recipients.

(2) *Short-range operations of supplementary health insurance benefits trust fund*

Table D presents estimates of the operation of the supplementary health insurance benefits trust fund for the first 2 years of operation, 1966-67. As indicated previously, four sets of estimates are given, under different assumptions as to low-cost and high-cost estimates and low and high participation. A significant balance in the trust fund develops in 1966, because of the lag involved in making benefit payments, since there are the factors of administrative processing and of the deductible that must be met first before any benefits are payable. In this respect, it will be noted that the income from premium payments by individuals will go into the trust fund beginning in the early part of July 1966, and the matching Government contributions will go into the trust fund simultaneously.

Under the low-cost estimates, the trust fund is estimated to have a balance of about $300 to $350 million at the end of 1966, and between $600 and $700 million at the end of 1967. On the other hand, under the high-cost estimates, the balance in the trust fund at the end of 1966 will be between $200 and $250 million, and will remain at substantially this level during 1967.

TABLE D.—*Estimated progress of supplementary health insurance benefits trust fu*

[In millions]

Calendar year	Contributions		Benefit payments	Administrative expenses	Interest on fund	Balance fund at e of year
	Participants	Government				
	Low cost estimate, 80-percent participation					
1966 [1]	$275	$275	$195	$65	$5	$[illegible]
1967	560	560	765	75	15	[illegible]
	Low-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$230	$80	$5	$[illegible]
1967	665	665	905	90	20	[illegible]
	High-cost estimate, 80-percent participation					
1966 [1]	$275	$275	$260	$85	$5	$[illegible]
1967	560	560	1,025	95	10	[illegible]
	High-cost estimate, 95-percent participation					
1966 [1]	$325	$325	$310	$100	$5	$2
1967	665	665	1,220	110	10	2

[1] Contributions would be collected only during the last 6 months of 1966, and benefit payments wou likewise be payable only during that period Administrative expenses shown include both those for t full year 1966 and such expenses as incurred in 1965

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a co tingency reserve during fiscal year 1966-67 (to be used only if needed and to be repayable).

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS PROGRAM

(a) *Background*

The provision of medical care for the needy has long been a respons bility of the State and local public welfare agencies. In recent years the Federal Government has assisted the States and localities in carry ing this responsibility by participating in the cost of the care provide Under the original Social Security Act, it was possible for the State with Federal help, to furnish money to the needy with which they coul buy the medical care they needed. Since 1950, the Social Securit Act has authorized participation in the cost of medical care provide in behalf of the needy aged, blind, disabled, and dependent children— the so-called vendor payments. This method of providing care ha proved popular with the suppliers of medical care, the agencies admin istering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provision of law under which the States administer the State-Federal program o medical assistance for the needy. The most significant enactment wa in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching t enable the States to provide medical care in behalf of aged persons wh

ADDENDUM C

For A, B, and D Medicaid, exclude cash payments from federal, state, or local government programs if the purpose of the payment is so the client can pay for medical or social services. This includes payments for vocational rehabilitation. Exclude these payments only for one calendar month following receipt. Do not confuse this exemption with reimbursements for medical or social services; money received as reimbursement must be counted as a resource the first month following receipt.

R810-304-419. When to Deem Assets.

Spouses have a legal responsibility to financially support one another. Parents have a legal responsibility to financially support their children until they are *emancipated**. Because of this legal responsibility, assets from a spouse or parent are counted as available to the eligible spouse or child. This process is called deeming. Because the asset is available, include it in the countable assets.

419.1 Non-Nursing Home Cases

Deem only from spouse to spouse or parent to unemancipated child. Deem only among people who live together.

419.12 F and C Cases

Do not deem from a parent or spouse who gets SSI.

419.2 Clients Who Are Residents of Medical Institutions

Do not deem to a resident of a medical institution. However, there may be persons in medical institutions who are not treated as medical institution cases. These cases will be set up using policy for clients who are not residents of medical institutions: deeming may apply. Examples are:

1. F or C Cases — Persons who are temporarily living apart from their parents or children are not considered residents of medical institutions.

2. All Cases — Persons are not considered residents for the month they enter the medical institution

419.3 All Cases

Exemptions for deemed assets are applied based on the type of asset (home, burial funds, tribal funds, certain lump sum payments etc.), and the category of assistance to which it is being applied. Emancipated: A child is emancipated by:

1. turning 18 years old, or

2 getting married, or

3. getting a court order which says that the child is emancipated.

R810-304-421. Lump Sum Payments — All Cases.

Remember that most lump sums count as income in the month they are received. Count as an asset any balance which remains the month after receipt. All SSA and SSI lump sums are exempt for 6 months after receipt.

421.1 Lump Sum Received on Sales Contract

1. Exempt lump sum payments received on a sales contract for the sale of an exempt home if the money is committed to replacement of the property sold within thirty days and the purchase is completed within ninety days.

a. If a period longer than ninety days is required to complete the actual purchase, the District Director may grant an extension in writing, using Form 689, Policy Decision.

2. If the property is not replaced within 90 days and no extension has been granted, consider the total payment received as an asset.

421.2 Proceeds Other Than or In Addition to a Lump Sum

1. Proceeds of a sales contract other than or in addition to a lump sum shall be exempt if applied to the purchase of replacement property. The same conditions of time and commitment as for a lump sum apply (see Sec. 421.1).

2. If proceeds from the contract are not to be used to replace property, consider the balance remaining on the sales contract as an asset.

3. Availability (at any amount which would result in excess assets) is a factor. This means that if the balance remaining on a sales contract can be discounted to an amount which (in conjunction with any other countable assets) exceeds the asset level, the client is ineligible.

Example:

Assume a single individual has no other countable assets, but has a balance remaining on a sales contract of $5,000. We would ask a financial institution or other knowledgeable source if a market exists to assign the balance remaining to a buyer for the one-person asset limit. If the market exists, then the balance remaining on the sales contract would make the client ineligible.

421.3 Insurance Settlements for Destroyed Property

Exempt lump sum insurance payments for destroyed property if the available money is used within ninety days to replace the destroyed property, and the destroyed property was exempt at the time of loss.

1. The District Director may grant an extension beyond ninety days, using Form 689, Policy Decision.

R810-304-425. Income Producing Property.

425.1 F And C Cases

When a client owns property and has the legal right to sell it without interference, the property is available and we will count it in determining eligibility.

425.2 A. B and D Cases

1. Exempt income producing property when:

a. The equity in the property is less than $6,000 and

b. The property produces a net annual return of at least 6 percent of the equity.

Equity value more than $6,000 counts as an asset only if the 6 percent net annual return is met. If it is not, then the entire equity amount shall count.

2. If the client has the legal right to sell his share of the property, and if such equity is includable as an asset, and this results in the asset level being exceeded, close the case or deny the application.

3. The actual availability (whether a market exists to sell the property) is not a factor in counting the property as an asset.

R810-304-431. Transfer of Excess Assets.

431.1 F and C Medicaid

Take no sanction on the transfer of any asset.

431.2 A, B, and D Medicaid — Clients Who Are Not Residents of Medical Institutions

Take no sanction on the transfer of any asset if the client is not a resident of a medical institution.

431.3 A, B, and D Medicaid — Clients Who Are Residents of Medical Institutions

431.31 Apply no sanction for the transfer of the following assets:

1. If the property was transferred prior to July 1, 1988 and the property was transferred more than 24 months prior to the date of application. Also, apply no sanction for the transfer of an asset which would have

these types of contracts are merely promising these items when needed (a plot, a casket, a marker, etc.) and are considered to be a part of the contract or plan. They are not evaluated separately. They are considered for exemption under Section 411, (9).

9. Burial/Funeral Fund — All Cases

Allow a $1,500 burial or funeral fund exemption for each eligible household member. Compute this burial or funeral fund exemption as follows:

a. First, subtract the value of any irrevocable burial trust from the $1,500 burial or funeral fund exemption. If the irrevocable burial trust is valued at $1,500 or more, it will reduce the burial or funeral fund exemption to zero. If that is the case, do not go on to steps b. and c. The amount of the irrevocable burial trust which exceeds $1,500 is not counted as an asset.

b. Second, for A, B and D categories only, reduce the remaining burial or funeral fund exemption by the total face value of any exempt whole life insurance policies. If the face value of these policies exceeds the remaining burial or funeral fund exemption, it will reduce the burial or funeral fund exemption to zero. If that is the case, do not go on to step c. The amount of face value which exceeds the remaining burial or funeral fund exemption level is not counted as an asset. This step does not apply to F and C categories as life insurance is already counted.

c. If after subtracting the value of the irrevocable burial trusts and face value of exempt whole life insurance policies there is still a balance in the burial or funeral fund exemption, reduce the remaining exemption level by the cash value of any burial contract, funeral plan, and/or funds set aside for burial.

d. In A, B, and D cases only, subtract the cash value of non-exempt life insurance policies.

e. If these reductions result in an exemption greater than $1,500 then the difference is to be added to the other countable assets.

(1) Any interest which is accrued on an exempt burial contract, funeral plan, or on funds set aside for burial are exempt from consideration as an asset or as income.

Funds set aside for burial: funds which are separately identified and not commingled with other funds. They must be clearly designated so that an outside observer can see that these funds are specifically for the client's burial expense.

(2) If a person ever removes the principle or interest from an exempt burial contract, funeral plan, funds set aside for burial, or a life insurance policy and uses the money for a purpose other than for their burial expenses, the amount withdrawn from the account must be counted as income. The amount remaining in the fund is still exempt.

If a client has a previously unreported resource which he claims is to be used for burial:

(a) and the resource is clearly designated as being for burial, evaluate it for exemption back to when it was either designated or intended for burial. However, the date cannot be before November 1, 1982 and cannot be any earlier than 2 years prior to the date of application.

(b) and if the case is A, B, or D case and the resource is not clearly designated as being for burial, it can be designated for burial retroactively back to the first day of the month the client intended to set it aside for burial. However, the date cannot be before November 1, 1982 and cannot be any earlier than 2 years prior to the date of application.

10. Land or Accounts Held in Trust — All Cases

Exclude ownership of beneficial interest in any land or account which is held in trust by the United States, a state, or in a tribal account.

11. Per Capita Tribal Payments

Exlude all per capita payments or any asset purchased with per capita payments made to a tribal member by the Secretary of the Interior or the tribe

12. Alaska Native Claims Settlement Act — All Cases

Exclude shares received as payment under the Alaska Native Claims Settlement Act (Public Law 92-203).

13. Income Producing Property — A,B, and D Cases

Exclude income producing property from assets when the individual's equity in the property does not exceed $6,000 and the property produces a net annual return of at least 6 percent of the equity. Count any equity value in excess of $6,000 only if the 6 percent net annual return* is met. If it is not then count the entire equity amount.

Net annual return: The income produced after subtracting mortgage payments or other payments necessary to generate income.

14. Retroactive Social Security Benefits — All Cases

Exempt lump sum retroactive benefits received from the Social Security Administration (SSA and SSI) for 6 months after the month of receipt.

15. Student Benefits

All Cases

Do not count monies from certain sources to undergraduate students as assets These sources include

a. Educational loans, grants or scholarships that have funds guaranteed by the U.S Commissioner of Education, including.

— Pell Grants (Formerly BEOG)

— Supplemental Educational Opportunity Grant (SEOG)

— National Direct Student Loans (NDSL)

— Guaranteed Student Loans

— State Student Incentive Grants (SSIG)

b. Payments to participants of a service learning program, such as College Work Study or University Year for Action (UYA).

A, B, and D Cases

Count any monies which remain after the school period covered from an educational grant, loan, or scholarship as an asset.

16. Pension Funds — A, B and D Cases

Do not count money held in a retirement fund under a plan administered by an employer or union, an individual retirement account (IRA), or Keogh account owned by a spouse or parent ineligible for A, B, or D medical.

a. Count as an asset any available money withdrawn from the pension starting the month after it is withdrawn.

17. Uniform Gifts to Minors Act (UGMA) — All Cases

Do not count any asset, or the interest from the asset, which is held within the rules of the Uniform Gift to Minor's Act (UGMA). Count any money from the asset given to the child as unearned income

Uniform Gift to Minors Act: An irrevocable gift of money or property to a child under the age of 21. The gift can be made to only one child, with only one custodian. The gift is verified on a specific form which includes a statement that the custodian holds the asset for the child under the Utah UGMA rules

18. Cash Payments Given to Help Pay for Medical or Social Services.

When it appears that a trust has been established to allow the beneficiary to qualify for Medicaid, submit the trust document and all other pertinent information to the State APA Office for a decision on the availability of the trust.

Restricted Access: Only the court or the trustee, who is not the beneficiary, or the beneficiary's spouse or parent, can invade the principle of the trust.

409.67 Trusts Set Up to Pay For Medical Expenses Related to Organ Transplants

Send a copy of all trust set up to pay expenses related to organ transplants to the State APA Office for a decision regarding the availability of the trust.

409.68 When Availability is Not Clear

When you cannot determine whether all or part of a trust is available, submit it and all other pertinent documents to the State APA Office for a decision.

R810-304-411. Exempt Assets.

Allow the following exemptions for medical assistance cases other than Indigent Medical cases. See Section 807 for exemptions specific to Indigent Medical cases. If an asset is not treated in that section, use the F or C policy.

1. One Home and Lot — All Cases

Exclude one home, including a mobile home, and lot owned or being purchased and occupied by the client.

a. F and C Cases — The lot on which the home stands shall not exceed the average size of residential lots in the community where it is. Count the equity value of property exceeding an average size lot.

b. A, B and D Cases — Exempt the home and all contiguous property.

Exempt a life estate in a home if the owner of the life estate continues to live in the home.

2. One Home and Lot of a Person Who is A Resident of a Medical Institution — All Cases

When a person who owns a home, or life estate in a home, becomes a resident of a medical institution, the home or life estate becomes countable unless:

a. The person's stay in the medical institution will be short term. A stay is short term if a doctor says that the client is likely to return home within 6 months of admission. Anyone in a medical institution more than 6 months after admission is long term, or

b. The person states that he intends to return home. It does not matter whether the person actually returns home within 6 months. There is no time limit to this exemption. The statement of intent must be in writing from the client or his representative, or

c. The person has a spouse, dependent child, or relative* who lives in the home.

3. Water Rights — All Cases

Exclude water rights attached to a house and lot.

Relative: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister

4. Household Goods and Personal Effects

F and C Cases

Exclude the contents of the home that are essential to daily living. However, individual items with an value over $1,000 must be counted against the asset limit.

A, B, and D Cases

Exclude household goods and personal effects only to the extent they do not exceed $2,000.

a. In developing this $2,000 limit, if there are no single items with a value (as can be currently sold) of $500 or more, then do not consider the $2,000 exempt amount to be exceeded.

b. If there are single items with a value of $500 or more, then consider all other household goods and personal effects to have a value of $1,000. Add the single item(s) of $500 or greater value to $1,000, and then count the amount in excess of $2,000 towards the household's asset level.

5. Vehicles

F and C Cases — Exclude the equity value up to $1,500 of one car or other motor vehicle used to provide transportation for the assistance unit. Count any equity value in excess of this amount towards the household's asset limitation.

A, B, and D Cases — Exclude one vehicle, regardless of value if:

a. It is necessary for employment; or

b. It is used at least four times per calendar year for obtaining medical treatment; or

c. It is modified for use by a handicapped person.

d. It is needed due to climate, terrain, distance or other such factors to provide transportation for essential daily activities.

If no vehicle is excludable for one of the above reasons, one vehicle may be exempt if its fair market value does not exceed $4,500. If its fair market value exceeds $4,500, then count the amount in excess towards the asset limit.

Count the equity value of all other vehicles towards asset limits.

6. Irrevocable Burial Trust — All Cases

a. Exempt the value of an irrevocable burial trust fund such as a pre-arranged funeral plan.

b. Additionally, only the value of an irrevocable burial trust is used to reduce the burial/funeral fund exemption (see Sec. 411, (9)).

7. Life Insurance

A, B, and D Cases

a. Whole life insurance policies are exempt if the total face value of all such policies does not exceed $1,500 per individual. If their total face value exceeds $1500 for any individual, count the cash value of all that individual's policies against the asset limit. Up to $1,500 of the cash value can be exempt if it is used as a burial/funeral fund (See 411-9 below). Term insurance policies have no cash value, are not resources, and are not used in any way in determining countable assets.

b. Whole life insurance which is exempt must be deducted from the exemption level of burial/funeral funds (see Sec. 411, (9)).

Note: The cash value shown on the insurance policy table includes some interest. Often the interest paid on the cash value is greater than that used to compute the table. Therefore, the table may not show the true cash value. This is especially likely in cases of policies that have been held for a long time. When there is countable cash value that, combined with other assets, puts the assets close to the limit, you should obtain a current statement of the cash value.

F and C Cases

Count the cash value of life insurance policies.

8. Burial Spaces — All Cases

a. Exempt burial spaces and any items related to repositories used for the remains of the deceased, for any member of the client's immediate family. This includes caskets, concrete vaults, crypts, urns, grave markers, etc. Also, if a client owns a grave site, the value of which includes opening and closing, the value of these services is also excluded.

b. A burial contract or funeral plan may include many of the items exempted in this section. However,

b. The likely cost of making the asset available exceeds its value.

If 2a or 2b applies, explain this in the case log and do not count the asset. Otherwise, require the client to take all reasonable steps to make the asset available. The asset is exempt while these steps are being taken.

For applicants, such steps must begin before the application is approved. For ongoing cases, such steps must begin before any more assistance is issued, provided 10 day notice can be given. If such steps are not taken, or if the client does not follow through with the process, close or deny the case.

409.4 Transfer of Title

1. Vehicles — including motor vehicles, trailers, etc.

Unless you have reason to question ownership of a vehicle, accept the bill of sale or other legal document as proof of ownership. When questioning ownership, remember that until the Department of Motor Vehicles issues a new certificate of registration and certificate of ownership, the transfer of title is incomplete.

If transfer is incomplete, legal ownership is retained by the original owner and the vehicle is available to him alone, and not to the new owner.

If transfer is complete, legal ownership is with the new owner.

2. All Other Property with a Title Document.

When the client states property has been sold, but the title document has not been transferred, contact the State APA Office to determine the availability of the property. Send all documents related to the property and the transfer. Be sure to include any conditions attached to the transfer.

If the State APA Office determines that the asset is not available because title has not been transferred, follow the rules in Sec. 409.3.

409.5 Divorce Decrees

Review divorce decrees on a case-by-case basis.

1. Before a divorce is final:

The filing of a divorce petition does not change the ownership or availability of assets unless there is a court order specifically dealing with the assets. Unless there is such a court order, base availability on the ownership prior to the filing of the divorce petition.

If there is a question of an asset's availability after viewing the court order, contact the State APA Office.

2. After a divorce is final:

a. When there is no title document, a divorce decree can transfer legal title of personal property. But be sure to check for conditions attached to the transfer: liens, conditions concerning remarriage, etc. These conditions may restrict the sale of the asset. If so, see Sec. 409.2-2.

b. In cases of property where there is a title document, be sure the title has been transferred. Again, be sure to check for conditions attached to the transfer. If title has not been transferred, see Sec. 409.4.

409.6 Trusts

The rules which follow are guidelines to help you determine the availability of trust funds. Sometimes you will have to get more information or a legal opinion about trust funds. This can occur even when you have complete documentation. In these cases, be sure to send a copy of the trust agreement to the State APA Office for a decision about the availability of the trust.

409.61 Definitions

1. Trust: A right of property held by one party for another.

2. Trustee: The person who holds the legal title to property for the benefit or use of another.

3. Beneficiary: The person for whose benefit the trust is created. Although this person does not hold legal title, he does have an ownership interest.

The beneficiary can receive money from the trust directly or through the trustee.

409.62 Availability to the Trustee

1. The entire trust is available as an asset if the client is the trustee and has the legal ability to

a. Revoke the trust, and

b. Use the money for his own benefit.

2. The entire trust is available if:

a. The trust was created by the client or his spouse, and

b. The client or his spouse has the right to dissolve the trust, and

c. He can use the money for his own benefit

3. In all other cases, the trust is not available to the trustee.

409.63 Availability to the Beneficiary — All Cases

If the client is the beneficiary and access to the trust is not restricted, the full value of the trust is an available asset. If access is restricted, see 409.64 and 409.65 below.

409.64 Trusts Set Up for Purposes Other Than to Qualify for Medicaid — Created by the Client or His Spouse — All Cases

1. With the exception of burial trusts, these rules apply to all trusts, including irrevocable trusts.

2. Potential payments in the budget month from the trust are an available asset if the client or his spouse set up the trust. The value of the asset is the maximum amount that the trustee can disburse to the client when exercising his full discretion under the terms of the trust. It does not matter whether disbursement is actually made. The potential disbursement can include both income and principle of the trust.

409.65 Trusts Set Up for Purposes Other Than to Qualify for Medicaid — Created by Someone Other Than the Client or His Spouse

For A, B, and D Cases

If the client's access to the trust principle is restricted*, the principle is not an available asset. This is true even when the trust:

1. Can be revoked by someone other than the beneficiary, and

2. Provides a regular payment from the principle to the beneficiary.

Payments made to the client from the trust are income.

For F and C Cases

The principle is an available asset if there is access to the principle to meet the needs of a household member. It does not matter if access is restricted. If the only way to access the trust is by approval of the court, require the client to petition the court to release the funds in the trust. Follow the procedures in Sec. 409.3.

When disbursement is limited to specific and limited needs or the principle cannot be invaded, the trust may not be available. (See 409.68.)

For example, when disbursement of funds of a trust set up from an insurance settlement is legally limited to payment of medical bills arising from an accident, the trust is not available. However, forward information about the trust to ORS. In this case, there is TPL coverage ORS must pursue.

409.66 Trusts Set Up for the Purpose of Qualifying for Medicaid

An SSI recipient must meet Medicaid asset limits. When these limits are exceeded, close the case or deny the application.

403.3 Deeming of Parental Assets to D and B Children

When a D or B unemancipated child is a Medicaid recipient and lives with his parents, count his parents' assets. It does not matter whether either parent is eligible. In this situation, follow the rules below:

1. Apply all asset exclusions of the D or B program to the parent's assets.

2. From the value of the parent's countable assets, deduct the one person $1,900 or two person $2,850 asset limit depending on whether there are 1 or 2 parents in the home. Do not allow the $25.00 exemption for each additional household member.

3. When more than one child is D or B, divide the parents' countable assets equally between each eligible child.

4 Allow each eligible B or D child the $1,900 limit in total countable assets.

Example:

The Blakes have five children living at home. Tom (age 17) and Tim (age 16) are SSI recipients. Neither Tom nor Tim have any assets of his own. Mr. and Mrs Blake have a $5,000.00 savings account. Of this $2,850.00 is exempt as a parental asset exclusion. This leaves a countable asset of $2,150.00 ($5,000.00 - $2,850.00 = $2,150.00). Of this $1,075.00 is deemed to each eligible D or B child ($2,150.00 divided by 2 equals $1,075.00). In this example neither child's assets exceed $1,900.00. Both are eligibile based on their assets.

R810-304-405. Real Property.

Real property includes items which may be fixed or permanent, such as land, houses, buildings, and trailer homes.

R810-304-407. Personal Property.

Personal property is an item other than real property. Some examples are:

1. Liquid assets such as savings and checking accounts, stocks, water stock, bonds, mutual fund shares, promissory notes, mortgages, insurance policies, trust funds, and agreements in escrow.
2. Motor vehicles, including automobiles, trucks, motorbikes, snowmobiles, etc.
3. Boats, campers and trailers.
4. Implements, instruments, and tools.
5. Livestock.
6. Merchandise and inventory.
7. Time shares and time share agreements.

Liquid Assets: Assets in cash or payable in cash on demand.

R810-304-409. Availability of Assets.

409.1 Joint Accounts

1. When an account is jointly held by a client and someone who is not eligible, count all the funds as an asset for the client if he can legally withdraw funds from the account. If more than one of the account holders is eligible, divide the funds equally among them.

If the client claims that the asset does not belong to him, allow him to refute it. He can refute it by providing 2 things:

a. His statement about the ownership of the funds. The statement should include the reason the joint account was set up and who made the deposits to and withdrawals from the account, and

b. Supporting statements from the other account holders.

If the asset belongs to someone else, the money must be removed or access must be restricted. If this is not done, count all the funds as an asset for the entire time access was not restricted. If access is restricted, do not count the asset back through the entire period the client is able to refute his ownership.

Example: In October you discover Mr. Jones had a savings account in his name and that of his father. Mr. Jones has been a joint owner of this account since January when first started receiving assistance. He proves that all deposits and withdrawals have been made by his father and are his father's money. Mr. Jones has his name removed from the account in October. Exempt the asset back to January.

2. When the assets of an A, B, or D SSI recipient are combined with those of an F or C family unit, such as in a savings account, decide the portion of the asset available to the F or C household as follows:

a. If the asset is jointly owned, divide the value equally among the owners.

Account: A contract of deposit of funds between depositors and a financial institution. This includes checking and savings accounts, certificates of deposit, share accounts, etc.

b. If you can identify exempt funds, such as a lump sum SSI payment which is exempt for 6 months after receipt, do not count them until after the exempt period has expired.

409.2 Joint Ownership of Assets

If property is owned by more than one person, determine the client's share. Plural ownership can exist in different forms.

In Utah these are:

1. Joint-tenancy.
2. Tenancy-in-common.
3. Not specified. The property is simply recorded in the names of 2 or more persons. Ownership is tenancy-in-common unless stated to be otherwise.

In all 3 cases, each owner has the legal right to sell only his share of the property. Unless there is a condition of ownership specifically prohibiting sale of any part of the asset without permission of the other owners, the client's share is an available asset. If there is such a condition, see Sec. 409.3.

However, when other owners refuse to sell the property, the fair market value of the client's share may be reduced. In such a case, allow the client to refute the determination of his equity by providing a statement from a knowledgeable source documenting the fair market value of the client's share based on the particular circumstances of the case.

The laws on plural ownership may differ for property located in other states. If you have a case with property in another state under plural ownership, contact the State APA Office.

409.3 When Legal Factors Hinder Making an Asset Available

1. If legal factors hinder making the asset available, it is exempt until it can be made available. (See 2 below). For example, a condition of ownership may prohibit selling the asset without the consent of both parties. In this case, the asset is exempt until the condition of ownership is changed or both parties consent to the sale.

2. If an asset is not legally available but can be made available by client action, the client must take steps to make it available. There are 2 exceptions. These are:

a. It is doubtful that reasonable actions will succeed. This should be confirmed by a knowledgeable source, such as a lawyer or financial institution.

5. Subtract medical insurance premiums and payments for medical services, see section 309.32.

6. If the client is a resident of a nursing home, the client must pay the rest of the income to the nursing home. If the client is a resident of another kind of medical institution, the client must spend down to the district office.

R810-303-375. Changes In Circumstances — Residents of Medical Institutions.

See Sec. 209.2 for a definition of a medical institution See Sec. 365.1 for a definition of a resident of a medical institution.

375.1 Client Responsibility

The client is responsible to report within 10 days any change in income or circumstances which may affect eligibility.

375.2 Date of Income Change

Consider the date of receipt of income as the date of change.

R810-303-377. Residents of Medical Institutions and Veteran's Administration (VA) Benefits.

A VA benefit recipient may be eligible for increased benefits when they enter a medical institution. These increased benefits are called Aid and Attendance. Also, potential VA recipients may become eligible for VA benefits when they enter a medical institution. Potential recipients include a veteran, or the spouse, parent, or child of a veteran.

When you identify a recipient or potential recipient who has entered a medical institution, take one of these actions:

1. Notify ORS.
2. If the client or his family wishes to apply directly to the VA, they may do so. Notify ORS.
3. If the OCO worker wishes to apply directly with the VA, you may do so. Notify ORS.

To notify ORS, use VA Form 21-8416a (Request for Information Concerning Unreimbursed Family Medical Expenses). This form is the minimum that you must send to ORS. If you have more information or a copy of the complete application, send it too. Send the form as soon as possible after application. The VA will pay only from the date this form is received by them.

If the client is in a nursing home, tell the nursing home operator to immediately report any increased benefits. Control for the increased benefits on Form 62 or Form 69.

If you have any questions about application for increased veteran's benefits, you may call the ORS Veteran's Benefits Coordinator at 538-4534.

377.1 Treatment of Lump Sum VA Benefits

Break any lump sum payment into Aid and Attendance and regular pension

1. Tell ORS of the Aid and Attendance amount. ORS will collect any Aid and Attendance for the time period that the client recieved Medicaid.
2. Consider the remainder of a VA lump sum payment as income in the month received. If the client is a resident of a nursing home and it is too late to be correctly reflected on the APA file, use the Form 417A to notify the nursing home and HCF.

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R810-304. Medicaid: Asset Standards.

R810-304-400. Asset Standards.
R810-304-403. Asset Limits.
R810-304-405. Real Property.
R810-304-407 Personal Property
R810-304-409. Availability of Assets.
R810-304-411. Exempt Assets.
R810-304-419. When to Deem Assets.
R810-304-421. Lump Sum Payments — All Cases
R810-304-425. Income Producing Property.
R810-304-431. Transfer of Excess Assets.
R810-304-441. Third Party Liability (TPL) — All Cases.
R810-304-443. Eligible Aliens and Counting The Assets of Sponsors — All Cases.
R810-304-461. Whose Assets to Count — Clients Who Are Not Residents of Medical Institutions
R810-304-465. Whose Assets to Count — Clients Who Are Residents of Medical Institutions.

R810-304-400. Asset Standards.

1. This section describes asset* standards for all Medicaid clients.
2. An Asset is available when the client owns it, or has the legal right to sell it or dispose of it for his own benefit. (See Sec. 409.)
3. The assets of a ward controlled by a legal guardian are available to the ward. This is true even if the ward is not living with the guardian. If the asset is a trust, follow the rules on trusts. (See Sec. 409.6.)
4. Do not count money as an asset in the same month it is counted as income.

R810-304-403. Asset Limits.

Base asset levels on the same number of persons included in the Basic Maintenance Standard (BMS)

Number In BMS	Asset Level
1 person BMS	$2,000
2 person BMS	$3,000
Each additional person in the BMS	add $25

Use section 329 to set the number of persons in the BMS.

Close the case or deny the application when the countable value of all assets is more than the asset limits.

403.1 The Value of Assets

Judge assets by their equity value. An exception is made for vehicles in A, B and D cases. (See Sec 411-5.)

1. Equity value is the current market value less any debts owing on the asset.
2. Current market value is the item's selling price on the open market as set by current standards of appraisal.

Assets: Any real or personal property that has money value. (See Sec. 405 and 407)

403.11 F and C Cases

For both applications and open cases, if asset levels are met at any time in a month, they are met for the entire month.

403.12 A,B, and D Cases

For both applicants and open cases, use assets held on the first moment of a calendar month to compute eligibility for that month. The case is ineligible for the entire month if countable assets exceed limits on the first moment of the month.

1. However, when the asset level is exceeded and a checking account is part of it, look at checks written prior to the first moment of the month which had not cleared as of the first moment.
2. Do not count such checks in the asset computation.

Subtract these checks from the checking balance

403.2 SSI Recipient

with the requirements of 42 CFR 435 940 through 435 960

(b) Attachment 4 32A describes, in accordance with 42 CFR 435 948 (a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested

R455-1-80. Section 5: Personnel Administration.

5 1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U S Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F All requirements of 42 CFR 432 10 are met

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F

R455-1-82

5 3 Training Programs, Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers

R455-1-83 Section 6. Financial Administration.

6 1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements The requirements of 42 CFR 433 32 are met

R455-1-84

6 2 Cost Allocation

The Medicaid agency meets the requirements of 42 CFR 433 34, paragraphs (c) through (e) with respect to the submittal and content of a cost allocation plan

R455-1-85

6 3 State Financial Participation

(a) State funds are used in both assistance and administration

X State funds are used to pay all of the non-Federal share of total expenditures under the plan Effective Date April 12, 1974

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State

R455-1-86. Section 7: General Provisions.

7 1 Plan Amendments

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in any phase of State law, organization, policy or State agency operations

R455-1-87

7 2 Nondiscrimination

In accordance with title VI of the Civil Rights Act of 1964 (42 U S C 2000d et seq), Section 504 of the Rehabilitation Act of 1973 (29 U S C 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin, or handicap

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations These methods for title VI are described in Attachment 7 2A

R455-1-88

7 3 State Governor's Review

The Medicaid agency will provide opportunity for the Office of the Governor to review amendments any new State plan and subsequent amendments and long-range program planning projections or other periodic reports thereon Any comments made will be transmitted to the Health Care Financing Administration with such documents

I hereby certify that I am authorized to submit this plan on behalf of UTAH STATE DEPARTMENT OF HEALTH, dated August 20, 1980, signature by James O Mason, M D , Dr P H

1987 II-42

R455-1A. Utah State Medicaid Plan Attachments.

R455-1A-100 Attachments Utah State Medicaid Plan
R455-1A-102 State Agency
R455-1A-200 Attachments Utah State Medicaid Plan Coverage and Eligibility
R455-1A-300 Attachments
R455-1A-400 Attachments Utah State Medicaid Plan Standards for Institutions
R455-1A-700 Attachments Utah State Medicaid Plan Nondiscrimination

R455-1A-100. Attachments: Utah State Medicaid Plan.

1A Attorney General's Certification

I certify that THE UTAH STATE DEPARTMENT OF HEALTH is the single State agency responsible for

X Administering the plan

The legal authority under which the agency administers the plan on a Statewide basis is Utah Code Annotated Section 63-35-10, Section 55-15a-3 and Senate Bill 332 (1979 General Session)(statutory citation) dated May 21, 1980, signed by Utah State Attorney General Robert B Hanson

1A1 State of Utah Office of the Governor

May 2, 1979 SUBJECT Single State Agency — Title XIX Program

Effective May 8, 1979, the Utah Health Agency is hereby designated as the single State Agency for the Title XIX program As the single State Agency they will be responsible for the total Title XIX program including certification of facilities, utilization review and payment of claims Eligibility for Title XIX programs will continue to be a responsibility of the Department of Social Services Scott M Matheson, Governor

1A2 Reorganization of State Health Functions 1979 General Session — Enrolled Copy S B No 332

AN ACT RELATING TO THE ORGANIZATION OF A STATE HEALTH AGENCY BY THE GOVERNOR WITHIN THE DEPARTMENT OF SOCIAL SERVICES PROVIDING FOR THE FUNCTIONS

Attachment 4 19E specifies, for each type of service the definition of a claim for purposes of meeting these requirements

R455-1-62

4 19(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447 15

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 447 53

R455-1-63

4 19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials

R455-1-64

4 19(h) The Medicaid agency meets the requirements of 42 CFR 447 203 for documentation and availability of payment rates

R455-1-65

4 19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population

R455-1-66

4 19(j) The Medicaid agency meets the requirements of 42 CFR 447 205 for public notice of any significant changes in Statewide method or standards for setting payment rates

R455-1-66a

4 19(k) Payments to Physicians for Clinical Laboratory Services

For services performed by an outside laboratory for a physician who bills for the service, payment does not exceed the amount that would be authorized under Medicare in accordance with 42 CFR 405 515 (b), (c) and (d)

X Not applicable The Medicaid agency does not allow payment under the plan to physicians for outside laboratory services

R455-1-67

4 20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

X Not applicable No direct payments are made to recipients

R455-1-68

4 21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447 10

R455-1-69

4 22 Third Party Liability

(a) The Medicaid agency meets all requirements of 42 CFR 433 138 and 433 139

Attachment 4 22A specifies the threshold amount or other guideline used in determining whether to seek reimbursement from a liable third party, or describes the process by which the agency determines that seeking reimbursement would not be cost effective It also specifies the dollar amount or time period the State uses to accumulate billings from a particular liable third party for this purpose

R455-1-70

(c) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following (Check as appropriate)

X State title IV-D agency The requirements of 42 CFR 433 152 (b) are met

(d) The Medicaid agency meets the requirements of 42 CFR 433-153 and 433 154 for making incentive payments and for distributing third party collections

R455-1-71

4 23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434 All contracts meet the requirements of 42 CFR Part 434

R455-1-72

4 24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services

With respect to skilled nursing and intermediate care facilities, all applicable requirements of 42 CFR Part 442, Subparts B and C are met

R455-1-73

4 25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators

R455-1-75

4 27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431 115

R455-1-76

4 28 Appeals Process for Skilled Nursing Facilities and Intermediate Care Facilities

The Medicaid agency has established appeals procedures for skilled nursing facilities and intermediate care facilities as specified in 42 CFR 431 153 and 431 154

R455-1-77

4 29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902 (a) (4) (C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by Section 207 or 208 of title 18, United States Code

R455-1-78

4 30 Exclusion of Providers and Suspension of Practitioners and other Individuals

All requirements of 42 CFR Part 455, Subpart C are met

R455-1-79

4 31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455 104 through 455 106

4 32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance

stitution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

R455-1-56

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

X Not applicable. No such charges are imposed.

R455-1-56a

(iii) Attachment 4.18A specifies the:

(A) Services(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

X Not applicable. There is no maximum.

R455-1-56b

(c) Individuals are covered as medically needy under the plan.

X Yes. With respect to them:

(1) An enrollment fee, premium or similar charge is imposed.

X Not applicable. No such charge is imposed.

R455-1-56c

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

R455-1-56d

(iii) All services furnished to pregnant women.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

R455-1-56e

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

X Not applicable. No such charges are imposed.

R455-1-56f

(iii) Attachment 4.18C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service.

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a family during a specified time period.

X Not applicable. There is no maximum.

R455-1-57

4.19 Payment for Services

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payment for inpatient hospital services. Attachment 4.19A describes the methods and standards used to determine rates for payment for inpatient hospital services

R455-1-58

4.19(b) In addition to the services specified in paragraphs 4.19(a) and (d), the Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payment for all other types of services provided under the plan.

Attachment 4.19B describes the methods and standards used for the payment of each of these services except for inpatient hospital, skilled nursing facility and intermediate care facility services that are described in other attachments.

R455-1-59

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

X yes. The State's policy is described in Attachment 4.19C.

R455-1-60

4.19(d) X 1. The Medicaid agency meets the requirements of 42 CFR Part 447 Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

Attachment 4.19D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services

X 2. The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital at the average rate per patient day for routine SNF services furnished during the previous calendar year.

X 3. The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital at the average rate per patient day for ICF services other that ICF's for the mentally retarded furnished during the previous calendar year.

R455-1-61

4.19(e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients This agency is UTAH STATE DEPARTMENT OF HEALTH

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are) UTAH STATE DEPARTMENT OF HEALTH

(c) Attachment 4 11A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request

R455-1-43

4 11(d) The UTAH STATE DEPARTMENT OF HEALTH (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program The requirements in 42 CFR 431 610(e), (f) and (g) are met

R455-1-44

4 12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities home health agencies, clinics and laboratories in accordance with 42 CFR 431 105(b)

X Not applicable Similar services are not provided to other types of medical facilities

R455-1-45

4 13 Required Provider Agreement

All requirements of 42 CFR 431 107 are met with respect to agreements between the Medicaid agency and each provider furnishing services under the plan

R455-1-46

4 14 Utilization Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments and that assesses the quality of services The requirements of 42 CFR Part 456 are met

X Directly

R455-1-47

4 14(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services

X Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for

X All hospitals (other than mental hospitals)

R455-1-48

4 14(c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals

X No waivers have been granted

R455-1-49

4 14(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services

X Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for

X All skilled nursing facilities

R455-1-50

4 14 X (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services Utilization review in facilities is provided through

X Direct review by personnel of the medical assistance unit of the State agency

R455-1-51

4 15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services

R455-1-52

4 16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with Title V grantees, that meet the requirements of 42 CFR 431 615

Attachment 4 16A describes the cooperative arrangements with the health and vocational rehabilitation agencies

R455-1-53

4 17 Liens and Recoveries

Liens are imposed against an individual's property

X Yes

(a) Liens are imposed against an individual's property before his or her death because of Medicaid claims paid or to be paid on behalf of that individual following a court judgment which determined that benefits were incorrectly paid for that individual

X Item (a) applies only to an individual's real property,

(b) Liens are placed against the real property of an individual before his or her death because of Medicaid claims paid or to be paid for that individual in accordance with 42 CFR 433 36(g) (2)

X Item (b) is not applicable No such lien is imposed

(c) Adjustments or recoveries for Medicaid claims correctly paid are imposed only in accordance with section 433 36(h)

(d) No money payments under another program are reduced as a means of recovering Medicaid claims incorrectly paid

(e) Attachment 4 17A

R455-1-54

(a) Specifies the process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home The description of the process meets the requirements of 42 CFR 433 36(d)

(b) Defines the terms specified in 42 CFR 433 36(e)

(c) Specifies the criteria by which a son or daughter can establish that he or she has been providing care, as specified under 42 CFR 433 36(f)

R455-1-55

(iii) All services furnished to pregnant women

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the in-

services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

X Not applicable. The conditions in the first sentence do not apply.

R455-1-28

3.1(g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

R455-1-29

3.2 Coordination of Medicaid with Medicare Part B

X The Medicaid agency makes the entire range of benefits under Part B of title XVIII available as part of the plan to certain eligible individuals under a buy-in agreement, through payment of the premium charges on behalf of such individuals, or by meeting all or part of the cost of the deductible, cost sharing or similar charges under Part B.

Attachment 3.2A describes the method by which such benefits are made available. The agency makes the same services available to recipients not covered by Medicare.

X No.

R455-1-30

3.3 Medicaid for Individuals Age 65 or Over in institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

X Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

R455-1-31

3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.

R455-1-32. Section 4: General Program Administration.

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health, Education and Welfare to be necessary for the proper and efficient operation of the plan.

R455-1-33

4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

R455-1-34

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

All other requirements of 42 CFR Part 431, Subpart F are met.

R455-1-35

4.4 Medicaid Quality Control

(a) A system of eligibility quality control is implemented that meets the requirements of 42 CFR 431,800(d), (f), (h), (i) and (k).

(b) The agency operates a claims processing assessment system that meets the requirements of Section 431.800 (e), (g), (h), (j), and (k).

X Not applicable. The agency has a Medicaid Management Information System (MMIS) approved under 42 CFR Part 433, Subpart C.

R455-1-36

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13-455.21 for prevention and control of program fraud and abuse.

R455-1-37

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

R455-1-38

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provisions of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met

R455-1-39

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

R455-1-40

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

R455-1-41

4.10 Free Choice of Providers

Unless an exception under 42 CFR 431.55 applies, the Medicaid agency assures that any individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

R455-1-42

4.11 Relations with Standard-Setting and Survey Agencies

that nurse-midwives are authorized to practice under State law or regulation

Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider

(iii) For any women who, while pregnant, were eligible for, applied for, and received medical assistance under the approved State Plan, all pregnancy-related and postpartum services will continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy

X (iv) For pregnant women, services for any other medical condition that may complicate the pregnancy

(v) Home health services are provided to categorically needy recipients entitled to skilled nursing facility services as indicated in item 3 1(b) of this plan

Attachment 3 1A identifies the medical and remedial services provided to the categorically needy and specifies all limitations on the amount, duration and scope of those services

R455-1-20

3 1(a)(2) This State Plan covers the medically needy

X Yes The services described below and in Attachment 3 1B are provided

Services for the medically needy include

(i) Prenatal care and delivery services for pregnant women

(ii) For women who, while pregnant, were eligible for applied for, and received medical assistance under the approved State Plan, all pregnancy-related and postpartum services will continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last day of pregnancy

X (iii) For pregnant women, services for any other medical condition that may complicate the pregnancy

(iv) Ambulatory services, as defined in Attachment 3 1B for recipients under age 18 and recipients entitled to institutional services

(v) Home health services to recipients entitled to nursing facility services as indicated in item 3 1(b) of this plan

X (vi) Services in an institution for mental diseases

X Services in an intermediate care facility for the mentally retarded

Each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (18) The services are provided as defined in 42 CFR Part 440, Subpart A and in section 1905(o) of the Act

Attachment 3 1B identifies the services provided to each covered group of the medically needy, specifies all limitations on the amount, duration, and scope of those items, and specifies the ambulatory services provided under this plan and any limitations on them

R455-1-21

3 1(a)(3) Except for those items or services for which section 1902(a)(10) of the Act and 42 CFR 440 250 permit exceptions

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy

X Yes

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group

X Yes

R455-1-22

3 1(a)(5) The Medicaid agency meets the requirements of 42 CFR 441 56 — 441 62 with respect to early and periodic screening, diagnosis and treatment (EPSDT) services

X The Medicaid agency has in effect agreements with continuing care providers Described below are the methods employed to assure the providers' compliance with their agreements

Methods employed to assure provider's compliance are identified in the respective contracts(s) with each continuing care provider (e g , sample recipient audits, and SURS Reports)

R455-1-23

3 1(b) Home health services are provided in accordance with the requirements of 42 CFR 441 15

(1) Home health services are provided to all categorically needy individuals 21 years of age or over

(2) Home health services are provided to all categorically need individuals under 21 years of age

X Yes

(3) Home health services are provided to the medically needy

X Yes, to all

X Yes, to individuals age 21 or over, SNF services are provided

X Yes, to individuals under age 21, SNF services are provided

R455-1-24

3 1(c) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers Methods used to assure such transportation are described in Attachment 3 1D Methods of Providing Transportation

R455-1-25

3 1(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in Attachment 3 1C

R455-1-26

3 1(e) Family Planning Services

The requirements of 42 CFR 441 20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning

R455-1-27

3 1(f) Optometric Services

Optometric services (other than those provided under Sections 435 531 and 436 531) are not now but were previously provided under the plan Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians'

X Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in Attachment 2.2A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

R455-1-6

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

R455-1-7

1.2 Organization for Administration

(a) Attachment 1.2A contains a description of the organization and functions of the Medicaid agency and organization chart of the agency.

(b) Within the State agency, the DIVISION OF HEALTH CARE FINANCING AND STANDARDS has been designated as the medical assistance unit. Attachment 1.2B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) Attachment 1.2C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2D contains a description of the staff designated to make such determination and the functions they will perform.

R455-1-8

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

X The plan is state administered.

R455-1-9

1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

R455-1-10. Section 2: Coverage and Eligibility.

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility and furnishing Medicaid.

R455-1-11

2.1(b) Individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6A.

2.1(c) The Medicaid agency elects to enter into a risk contract with an HMO that is

X Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in Attachment 2.1A.

R455-1-12

2.2 Coverage and Conditions of Eligibility

Medicaid is available to groups specified in Attachment 2.2A.

X Both categorically needy and medically needy

The conditions of eligibility that must be met are specified in Attachment 2.6A.

All applicable requirements of 42 CFR Part 435 are met.

R455-1-13

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403.

R455-1-14

2.4 Blindness

(a) The definition of blindness in terms of ophthalmic measurement used in this plan is specified in Attachment 2.6A.

(b) All other requirements of 42 CFR 435.530 and 42 CFR 435.531 are met.

R455-1-15

2.5 Disability

(a) The definition of disability that is used in this plan is specified in Attachment 2.6A.

(b) All other requirements of 42 CFR 435.540 and 435.541 are met.

R455-1-16

2.6 Financial Eligibility

(a) Categorically needy

(1) With respect to AFDC-related families and individuals under age 21 (not otherwise eligible under this plan), the financial eligibility conditions of the State's approved AFDC plan apply.

(2) With respect to aged, blind and disabled individuals, the financial eligibility conditions described in Attachment 2.6A apply.

(3) All requirements of 42 CFR Part 435; Subparts G and H are met with respect to the families and individuals to whom the requirements apply.

R455-1-17

2.6(b) Medically needy

All requirements of 42 CFR Part 435, Subparts G and I are met with respect to the families and individuals to whom the requirements apply. The level of income and resources, expressed in total dollar amounts, that are used as a basis for establishing eligibility under the plan are as described in Attachment 2.6A.

R455-1-18

2.7 Medicaid Furnished out of State

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another state, to the same extent that Medicaid is furnished to residents in the State.

R455-1-19

3.1 Amount, Duration and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B.

(1)(i) Each item of service listed in section 1905 (a)(1) through (5) of the Act, as defined in 42 CFR Part 440, Subpart A is provided for the categorically needy.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided for the categorically needy to the extent

26-18-3. Administration of Medicaid program by department — Disciplinary measures and sanctions — Funds collected.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

(3) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws to the extent permitted by law and quality control services.

(4) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(5) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as nonlapsing dedicated credits to be used by the division in accordance with the requirements of that section.

History: C. 1953, 26-18-3, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 5; 1989, ch. 165, § 1; 1990, ch. 183, § 9.

Amendment Notes. — The 1989 amendment, effective April 24, 1989, added the (a) and (b) designations in Subsection (4); substituted "shall provide, by rule" for "may provide by rule for" and "may not extend" for "shall not extend" in the introductory language of Subsection (4); deleted "or" from the end of Subsection (4)(a); added "and" to the end of Subsection (4)(b); added Subsection (4)(c); made punctuation changes throughout Subsection (4); and added Subsection (5).

The 1990 amendment, effective April 23, 1990, substituted "Human" for "Social" in Subsection (3).

Federal Law. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq. Section 1919 of Title XIX is 42 U.S.C. § 1396r.

The 1987 amendment, effective July 1, 1987, in Subsection (1), substituted "Medicare under Title XVIII of that act" for "Medicare under Title XVII of said act," deleted former Subsection (6), which provided for relief of the obligation of counties to provide medical care to the indigent, and made minor changes in phraseology and punctuation throughout the section

The 1988 amendment, effective July 1, 1988, substituted "division" for "department" in Subsections (1) and (4) and in Subsection (1) inserted "which shall be known as the Utah Medical Assistance Program"

Social Security Act. — Title XIX of the federal Social Security Act, cited in Subsection (1), appears as 42 U.S.C §§ 1396 to 1396s Title XVIII of the act appears as 42 U.S.C §§ 1395 to 1395ccc

COLLATERAL REFERENCES

Journal of Contemporary Law. — Utah's Medicaid Program A Senior's Eligibility Guide for Private Practitioners, 14 J Contemp L 1 (1988)

26-18-11. Rural hospitals.

(1) For purposes of this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.

(2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing shall not discriminate among rural hospitals on the basis of size.

History: C. 1953, 26-18-11, enacted by L. 1988, ch. 12, § 1.

Effective Dates. — Laws 1988, ch 12, § 2 makes the act effective on July 1, 1988

CHAPTER 19

MEDICAL BENEFITS RECOVERY ACT

Section	
26-19-1	Short title
26-19-2	Definitions
26-19-3	Program established by department — Promulgation of rules
26-19-4	Repealed
26-19-5	Recovery of medical assistance from third party liable for payment — Notice — Action — Compromise or waiver — Recipient's right to action protected — Limit on payment for liability
26-19-6	Action by department — Notice to recipient
26-19-7.	Action or claim by recipient — Consent of department required — Department's right to intervene — Department's interests protected — Attorney's fees and costs
26-19-8	Statute of limitations — Survival of right of action — Insurance policy not to limit time allowed for recovery
26-19-9 to 26-19-12	Repealed
26-19-13	Recovery of medical assistance payments from recipient — Lien against estate — Recovery of incorrectly paid amounts
26-19-14	Insurance policies not to deny or reduce benefits of persons eligible for state medical assistance — Exemptions
26-19-15	Attorney general or county attorney to represent department
26-19-16	Department's right to attorney's fees and costs
26-19-17.	Application of provisions contrary to federal law prohibited
26-19-18	Release of medical billing information by provider restricted — Liability for violation

26-18-9. Prohibited acts of state or local employees of Medicaid program — Violation a misdemeanor.

Each state or local employee responsible for the expenditure of funds under the state Medicaid program, each individual who formerly was such an officer or employee, and each partner of such an officer or employee is prohibited for a period of one year after termination of such responsibility from committing any act, the commission of which by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by Section 207 or Section 208 of Title 18, United States Code. Violation of this section is a class A misdemeanor.

History: C. 1953, 26-18-9, enacted by L. 1981, ch. 126, § 17.

Compiler's Notes. — 18 U.S.C. §§ 207 and 208 deal respectively with participation by former federal officers or employees in matters involving the government and with involvement by federal officers or employees in their official capacity in matters in which they have a personal financial interest.

Cross-References. — Penalty for misdemeanors, §§ 76-3-204, 76-3-301.

26-18-10. Utah Medical Assistance Program — Policies and standards.

(1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.

(2) Persons in the custody of prisons, jails, halfway houses, and other nonmedical government institutions are not eligible for services provided under this section.

(3) The department shall develop standards and administer policies relating to eligibility requirements for participation in the program, and for payment of medical claims for eligible persons.

(4) The program shall be a payor of last resort. Before assistance is rendered the division shall investigate the availability of the resources of the spouse, father, mother, and adult children of the person making application.

(5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.

(6) The department shall not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(7) The department may establish rules to carry out the provisions of this section.

History: C. 1953, 26-18-10, enacted by L. 1982, ch. 26, § 1; 1985, ch. 165, § 38; 1987, ch. 181, § 3; 1988, ch. 21, § 9.

Repeals and Reenactments. — Laws 1982, ch 26, § 1 repealed former § 26-18-10 (C. 1953, 26-18-10, enacted by L. 1981, ch. 126, § 17), relating to duties of the department, and enacted present § 26-18-10.

Amendment Notes. — The 1985 amendment substituted "equivalent of .00005" for "equivalent of 1/4 mill" in two places in Subsection (6).

26-18-6. Federal aid — Authority of executive director.

The executive director, with the approval of the governor, may bind the state to any executive or legislative provisions promulgated or enacted by the federal government which invite the state to participate in the distribution, disbursement or administration of any fund or service advanced, offered or contributed in whole or in part by the federal government for purposes consistent with the powers and duties of the department. Such funds shall be used as provided in this chapter and be administered by the department for purposes related to medical assistance programs.

History: C. 1953, 26-18-6, enacted by L. 1981, ch. 126, § 17.

26-18-7. Medical vendor rates.

Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division. As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

History: C. 1953, 26-18-7, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 7.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in the first sentence twice substituted "division" for "department."

26-18-8. Enforcement of public assistance statutes — Contract with Office of Recovery Services.

(1) The department shall enforce or contract for the enforcement of the provisions of Sections 62A-9-121, 62A-9-129, 62A-9-131 through 62A-9-133, and 62A-9-135 insofar as these sections pertain to benefits conferred or administered by the division under this chapter.

(2) The department may contract for services covered in Part 1, Chapter 11, Title 62A insofar as that chapter pertains to benefits conferred or administered by the division under this chapter.

History: C. 1953, 26-18-8, enacted by L. 1981, ch. 126, § 17; 1988, ch. 1, § 2; 1988, ch. 21, § 8.

Amendment Notes. — The 1988 amendment by Chapter 1, effective January 19, 1988, substituted the present statutory references for "Sections 55-15a-24, and 55-15a-29 through 55-15a-33" in Subsection (1) and "Chapter 15c of Title 55" in Subsection (2).

The 1988 amendment by Chapter 21, effective July 1, 1988, substituted "division" for "department" throughout the section.

This section has been reconciled by the Office of Legislative Research and General Counsel.

(3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.

(4) Any person or organization that, under the guise of other medical treatment, provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

History: C. 1953, 26-18-4, enacted by L. 1981, ch. 126, § 17; 1987, ch. 181, § 2.

Amendment Notes. — The 1987 amendment deleted former Subsection (1), relating to the responsibility of counties, redesignated the subsequent subsections accordingly and made minor changes in phraseology throughout the section.

Cross-References. — Penalties for misdemeanors, §§ 76-3-204, 76-3-301.

Sentencing for felonies, §§ 76-3-201, 76-3-203, 76-3-301.

26-18-5. Contracts for provision of medical services — Federal provisions modifying department rules — Compliance with Social Security Act.

(1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other state agencies, contracts shall provide that other state agencies transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.

(2) All contracts for the provision or purchase of medical services shall be established on the basis of the state's fiscal year and shall remain uniform during the fiscal year insofar as possible. Contract terms shall include provisions for maintenance, administration, and service costs.

(3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation; providing, the provisions of this section shall not apply to department rules governing abortion.

(4) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

History: C. 1953, 26-18-5, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 6.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in the first sentence of Subsection (1) substituted "division" for "department" and in Subsection (3) substituted "its rules as necessary" for "department rules necessary."

Social Security Act. — The federal Social Security Act is codified as 42 U.S.C. § 301 et seq.

(3) The department may, in its discretion, contract with the Department of Social Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws to the extent permitted by law and quality control services.

(4) The department may provide by rule for disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively shall not extend beyond termination from the program or recovery of claim reimbursements incorrectly paid.

History: C. 1953, 26-18-3, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 5.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in Subsection (2) substituted "this chapter, the requirements of Title XIX, and applicable federal regulations" for "the requirements of Title XIX and with regulations adopted pursuant thereto by the federal agency" and made various minor phraseology and stylistic changes.

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

COLLATERAL REFERENCES

C.J.S. — 81 C.J.S. Social Security and Public Welfare § 126.

Key Numbers. — Social Security ⇐ 241.

26-18-3.5. Copayments by health service recipients, spouses, and parents.

The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

History: C. 1953, 26-18-3.5, enacted by L. 1983, ch. 135, § 1.

COLLATERAL REFERENCES

Utah Law Review. — Utah Legislative Survey — 1983, 1984 Utah L. Rev. 115, 169.

26-18-4. Department standards for eligibility under Medicaid — Funds for abortions.

(1) The department may develop standards and administer policies relating to eligibility under the Medicaid program. An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.

(2) The department shall not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.

History: C. 1953, 26-18-2.2, enacted by L. 1988, ch. 21, § 3.

Effective Dates. — Laws 1988, ch 21, § 10 makes the act effective on July 1, 1988.

26-18-2.3. Division responsibilities — Emphasis — Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay. The division shall deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity appropriateness. The division shall place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

(2) The division shall implement and utilize cost-containment methods, where possible, which may include, but are not limited to:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) coordination of benefits; and

(g) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

History: C. 1953, 26-18-2.3, enacted by L. 1988, ch. 21, § 4.

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective July 1, 1988.

26-18-3. Administration of Medicaid program by department.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

by § 17 of the act. For present provisions relating to confidential information, see Chapter 25 of this title.

26-18-2. Definitions.

As used in this chapter:

(1) "Applicant" means any person who requests assistance under the medical programs of the state.

(2) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.

(3) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

(4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.

(5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.

(6) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

History: C. 1953, 26-18-2, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 1.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, added present Subsections (2) and (3), designated former Subsections (2) and (3) as Subsections (5) and (6), and, in Subsection (6), substituted "has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10" for "the department has determined to be eligible for medical or hospital assistance under the medical programs of the state"

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

26-18-2.1. Division — Creation.

There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

History: C. 1953, 26-18-2.1, enacted by L. 1988, ch. 21, § 2.

Effective Dates. — Laws 1988, ch 21, § 10 makes the act effective on July 1, 1988

26-18-2.2. Director — Appointment — Responsibilities.

The director of the division shall be appointed by the executive director of the department. The director of the division may employ other employees as necessary to implement the provisions of this chapter, and shall:

(1) administer the responsibilities of the division as set forth in this chapter;

(2) prepare and administer the division's budget; and

(3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

ARTICLE 3

TESTS OF NEWBORN INFANTS

26-17-21. PKU tests of newborn infants — Board of Health to establish rules and regulations.

The Board of Health shall establish rules and regulations requiring each newborn infant to be tested for the presence of phenylketonuria (PKU) and other metabolic diseases which may result in mental retardation or brain damage and for which a preventive measure or treatment is available and for which a laboratory diagnostic test method has been found reliable.

History: L. 1965, ch. 49, § 1; 1967, ch. 174, § 36

Cross-References. — Fees for and restriction on testing, § 26-10-6

26-17-22. Repealed.

Repeals — Section 26-17-22 (L 1965, ch 49, § 2), relating to the penalty for violations of regulations relating to PKU tests, was repealed by Laws 1967, ch 174, § 162

CHAPTER 18

MEDICAL ASSISTANCE ACT

Sunset Act. — See Section 63-55-7 for the termination date of the Medical Assistance Act

Section	
26-18-1	Short title
26-18-2	Definitions
26-18-2 1	Division — Creation
26-18-2 2	Director — Appointment — Responsibilities
26-18-2 3	Division responsibilities — Emphasis — Periodic assessment
26-18-3	Administration of Medicaid program by department
26-18-3 5	Copayments by health service recipients, spouses, and parents
26-18-4	Department standards for eligibility under Medicaid — Funds for abortions
26-18-5	Contracts for provision of medical services — Federal provisions modifying department rules — Compliance with Social Security Act
26-18-6	Federal aid — Authority of executive director
26-18-7	Medical vendor rates
26-18-8	Enforcement of public assistance statutes — Contract with Office of Recovery Services
26-18-9	Prohibited acts of state or local employees of Medicaid program — Violation a misdemeanor
26-18-10	Utah Medical Assistance Program — Policies and standards
26-18-11	Rural hospitals

26-18-1. Short title.

This chapter shall be known and may be cited as the "Medical Assistance Act."

History: C. 1953, 26-18-1, enacted by L. 1981, ch. 126, § 17.

Repeals and Reenactments. — Laws 1981, ch 126, § 1 repealed former §§ 26-18-1 to 26-18-4 (L 1963, ch 38, §§ 1 to 4, 1969, ch 197, §§ 64, 65, 1971, ch 53, § 1), relating to use of confidential information in research Present §§ 26-18-1 to 26-18-10 were enacted

§ 435.852 Treatment of income and resources: State plan requirements.

(a) The State's plan must specify the methodology used to treat the income and resources for each covered medically needy group.

(b) If the agency uses a methodology that is not presumed to be reasonable under § 435.851, the State plan must describe that methodology.

[46 FR 47989, Sept. 30, 1981]

Subpart J—Eligibility in the States and District of Columbia

SOURCE: 44 FR 17937, Mar. 23, 1979, unless otherwise noted.

§ 435.900 Scope.

This subpart sets forth requirements for processing applications, determining eligibility, and furnishing Medicaid.

GENERAL METHODS OF ADMINISTRATION

§ 435.902 Consistency with objectives and statutes.

The Medicaid agency's standards and methods for determining eligibility must be consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and all other relevant provisions of Federal and State laws.

§ 435.903 Simplicity of administration.

The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient.

§ 435.904 Adherence of local agencies to State plan requirements.

The agency must—

(a) Have methods to keep itself currently informed of the adherence of local agencies to the State plan provisions and the agency's procedures for determining eligibility; and

(b) Take corrective action to ensure their adherence.

APPLICATIONS

§ 435.905 Availability of program information.

(a) The agency must furnish the following information in written form, and orally as appropriate, to all applicants and to all other individuals who request it:

(1) The eligibility requirements.

(2) Available Medicaid services.

(3) The rights and responsibilities of applicants and recipients.

(b) The agency must publish in quantity and make available bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms.

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980]

§ 435.906 Opportunity to apply.

The agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

§ 435.907 Written application.

The agency must require a written application from the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The application must be on a form prescribed by the agency and signed under a penalty of perjury.

§ 435.908 Assistance with application.

The agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency must not require a separate application for Medicaid from an individual, if—

(a) The individual receives AFDC; or

(b) The agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

(1) The individual receives SSI;

(2) The individual receives a mandatory State supplement under either a

(d) If the agency uses a medically needy resource standard not specified in paragraphs (b) and (c) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

[46 FR 47988, Sept. 30, 1981; 46 FR 54743, Nov. 11, 1981]

§ 435.843 Medically needy resource standards: State plan requirements.

(a) The State plan must specify the resource standard for each covered medically needy group.

(b) If the agency uses a resource standard that is not presumed to be reasonable under § 435.841, the State plan must describe that standard.

[46 FR 47989, Sept. 30, 1981]

DETERMINING ELIGIBILITY ON THE BASIS OF RESOURCES

§ 435.845 Medically needy resource eligibility.

To determine eligibility on the basis of resources for medically needy individuals, the agency must—

(a) Consider only the individual's resources and those that are considered available to him under the financial responsibility requirements for relatives in § 435.821, § 435.822, or § 435.823;

(b) Consider only resources available during the period for which income is computed under § 435.831(a);

(c) For individuals under age 21 and caretaker relatives, deduct the value of resources that would be deducted in determining eligibility under the State's AFDC plan;

(d) For aged, blind, or disabled individuals in States covering all SSI recipients, deduct the value of resources that would be deducted in determining eligibility under SSI;

(e)(1) For aged, blind, or disabled individuals in States using requirements more restrictive than SSI, deduct the value of resources in an amount no more restrictive than those deducted under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI.

(2) However, the amounts specified in paragraph (e)(1) of this section must be the same as those that would be deducted in determining, under § 435.121, the eligibility of the categorically needy; and

(f) Apply the resource standards established under § 435.843.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24886, Apr. 11, 1980; 46 FR 47989, Sept. 30, 1981]

TREATMENT OF INCOME AND RESOURCES

§ 435.850 Treatment of income and resources: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a methodology for the treatment of income and resources that is—

(a) Uniform for all individuals in a covered group; and

(b) Reasonable (see § 435.851).

[46 FR 47989, Sept. 30, 1981]

§ 435.851 Treatment of income and resources: Reasonableness.

(a) The agency must use a methodology for the treatment of income and resources, to determine eligibility of the medically needy, that is reasonable.

(b) The methodology used to determine eligibility of individuals in the cash assistance program related to the covered medically needy group is presumed to be reasonable.

(c) If the agency provides Medicaid for the aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI, the methodology for the treatment of income and resources of those aged, blind, or disabled individuals under the State's plan on January 1, 1972, is presumed to be reasonable.

(d) If the agency uses a methodology not described in paragraphs (b) and (c) of this section—

(1) The methodology is not presumed to be reasonable; and

(2) HCFA must approve that methodology.

[46 FR 47989, Sept. 30, 1981]

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24886, Apr. 11, 1980, as amended at 46 FR 47988, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983, 53 FR 3596, Feb. 8, 1988; 53 FR 5344, Feb. 23, 1988, 56 FR 8850, 8854, Mar. 1, 1991]

Medically Needy Resource Standards

§ 435.840 Medically needy resource standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a resource standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a group; and

(c) Reasonable. (See § 435.841)

[46 FR 47988, Sept. 30, 1981, 46 FR 54734, Nov. 11, 1981]

§ 435.841 Medically needy resource standards: Reasonableness.

(a) The agency must use a medically needy resource standard that is reasonable, according to the provisions of this section.

(b) The following medically needy resource standards are presumed to be reasonable:

(1) The agency provides one medically needy resource standard for all covered medically needy groups. Except as provided in paragraph (c) of this section, the standard must at least equal the highest resource standard used to determine eligibility in the cash assistance programs related to the covered medically needy groups.

(2) The agency provides a different medically needy resource standard for each covered medically needy group. Except as provided in paragraph (c) of this section, the standard for each covered group must at least equal the highest resource standard used to determine eligibility in the cash assistance program related to that covered medically needy group.

(c) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use a resource standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy resource standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(d) *Eligibility based on incurred medical expenses.* Once deduction of incurred medical expenses reduces income to the income standard, the individual is eligible for Medicaid.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24886, Apr. 11, 1980; 46 FR 42067, Aug. 19, 1981; 46 FR 47988, Sept. 30, 1981]

§ 435.832 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to medically needy individuals in medical institutions and intermediate care facilities.

(c) *Required deductions.* The agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

(1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—

(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or diability.

(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the highest medically needy income standards for one person established under § 435.814.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's approved AFDC plan.

(B) The standards used to determine eligibility under the State's Medicaid plan, as provided for in § 435.814.

(4) Expenses not subject to third party payment. 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 permiums, deductibles, or coinsurance charges; and

(ii) 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.

[46 FR 47988, Sept. 30, 1981; 46 FR 54743, Nov. 4, 1981]

§ 435.823 Financial responsibility of relatives of aged, blind, or disabled individuals in States using more restrictive requirements than SSI.

(a) The agency must meet the requirements of this section in determining eligibility under § 435.330 of medically needy aged, blind, and disabled individuals.

(b) For aged, blind, or disabled individuals with spouses, the agency—

(1) Must consider income and resources as available if they are actually contributed by one spouse to the other; and

(2) May consider income and resources of spouses as available to each other even if they are not actually contributed.

(c) For blind or disabled individuals under age 21, the agency—

(1) Must consider the parent's or spouse's income and resources as available if they are actually contributed to the individual; and

(2) May consider the parent's or spouse's income and resources as available even if they are not actually contributed.

[46 FR 47988, Sept. 30, 1981]

MEDICALLY NEEDY INCOME ELIGIBILITY

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) *Determining countable income.* The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determining eligibility, under § 435.121, of the categorically needy.

(b) *Eligibility based on countable income.* If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under § 435.814, the individual or family is eligible for Medicaid.

(c) *Deduction of incurred medical expenses.* (1) If countable income exceeds the income standard, the agency must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges, incurred by the individual or family or financially responsible relatives, including enrollment fees, copayments, or deductibles imposed under § 447.51 or § 447.53 of this subchapter.

(ii) 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.

(iii) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c)(1) (i) and (ii) of this section.

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§ 416.1212 Exclusion of the home.

(a) *Defined.* A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

(b) *Home not counted.* We do not count a home regardless of its value. However, see §§ 416.1220 through 416.1224 when there is an income-producing property located on the home property that does not qualify under the home exclusion.

(c) *If an individual changes principal place of residence.* If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

(d) *Proceeds from the sale of an excluded home.* The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within 3 months of the date of receipt of the proceeds.

[50 FR 42686, Oct. 22, 1985, as amended at 51 FR 7437, Mar. 4, 1986]

§ 416.1216 Exclusion of household goods and personal effects.

(a) *Household goods and personal effects; defined.* Household goods are defined as including household furniture, furnishings and equipment which are commonly found in or about a house and are used in connection with the operation, maintenance and occupancy of the home. Household goods would also include the furniture, furnishings and equipment which are used in the functions and activities of home and family life as well as those items which are for comfort and accommodation. Personal effects are defined as including clothing, jewelry, items of personal care, individual education and

(b) *Limitation on household goods and personal effects.* In determining the resources of an individual (and spouse, if any), household goods and personal effects are excluded if their total equity value is $2,000 or less. If the total equity value of household goods and personal effects is in excess of $2,000, the excess is counted against the resource limitation.

(c) *Additional exclusions of household goods and personal effects.* In determining the resources of an individual (and spouse, if any) and in determining the value of the household goods and personal effects of such individual (and spouse), there shall be excluded a wedding ring and an engagement ring and household goods and personal effects such as prosthetic devices, dialysis machines, hospital beds, wheel chairs and similar equipment required because of a person's physical condition. The exclusion of items required because of a person's physical condition is not applicable to items which are used extensively and primarily by members of the household in addition to the person whose physical condition requires the item.

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979]

§ 416.1218 Exclusion of the automobile.

(a) *Automobile; defined.* As used in this section, the term *automobile* includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

(b) *Limitation on automobiles.* In determining the resources of an individual (and spouse, if any), automobiles are excluded or counted as follows:

(1) *Total exclusion.* One automobile is totally excluded regardless of its value if, for the individual or a

of the month. A resource determination is based on what assets an individual has, what their values are, and whether or not they are excluded as of the first moment of the month.

(b) *Increase in value of resources.* If, during a month, a resource increases in value or an individual acquires an additional resource or replaces an excluded resource with one that is not excluded, the increase in the value of the resources is counted as of the first moment of the next month

(c) *Decrease in value of resources.* If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decrease in the value of the resources is counted as of the first moment of the next month.

(d) *Treatment of items under income and resource counting rules.* Items received in cash or in kind during a month are evaluated first under the income counting rules and, if retained until the first moment of the following month, are subject to the rules for counting resources at that time.

(e) *Receipts from the sale, exchange, or replacement of a resource.* If an individual sells, exchanges or replaces a resource, the receipts are not income. They are still considered to be a resource. This rule includes resources that have never been counted as such because they were sold, exchanged or replaced in the month in which they were received. See § 416.1246 for the rule on resources disposed of for less than fair market value (including those disposed of during the month of receipt).

Example: Miss L., a disabled individual, receives a $350 unemployment insurance benefit on January 10, 1986. The benefit is unearned income to Miss L. when she receives it. On January 14, Miss L. uses the $350 payment to purchase shares of stock. Miss L. has exchanged one item (cash) for another item (stock). The $350 payment is never counted as a resource to Miss L. because she exchanged it in the same month she received it. The stock is not income; it is a different form of a resource exchanged for the cash. Since a resource is not countable until the first moment of the month following its receipt, the stock is not a countable resource to Miss L. until February 1.

[52 FR 4283, Feb. 11, 1987]

§ 416.1210 Exclusions from resources; general.

In determining the resources of an individual (and spouse, if any) the following items shall be excluded:

(a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in § 416.1212;

(b) Household goods and personal effects to the extent that their total value does not exceed the amount provided in § 416.1216;

(c) An automobile to the extent that its value does not exceed the amount provided in § 416.1218;

(d) Property of a trade or business which is essential to the means of self-support as provided in § 416.1222;

(e) Nonbusiness property which is essential to the means of self-support as provided in § 416.1224;

(f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in § 416.1226;

(g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see § 416.1228);

(h) Life insurance owned by an individual (and spouse, if any) to the extent provided in § 416.1230; and

(i) Restricted allotted land owned by an enrolled member of an Indian tribe as provided in § 416.1234;

(j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute;

(k) Disaster relief assistance as provided in § 416.1237;

(l) Burial spaces and certain funds up to $1,500 for burial expenses as provided in § 416.1231.

(m) Title XVI or title II retroactive payments as provided in § 416.1233.

(n) Housing assistance as provided in § 416.1238.

[40 FR 48915, Oct. 20, 1975, as amended at 41 FR 13338, Mar. 30, 1976; 44 FR 15664, Mar. 15, 1979; 48 FR 57127, Dec. 28, 1983; 51 FR 34464, Sept. 29, 1986; 55 FR 28378, July 11, 1990]

applicable exclusions from resources are explained in §§ 416.1210 (paragraphs (a) through (i) and (k)) through 416.1237. For resources excluded by Federal statutes other than the Social Security Act, as applicable to the resources of sponsors deemed to aliens, see the appendix to subpart K, Income. We next allocate for the sponsor or for the sponsor and spouse (if living together). (The amount of the allocation is the applicable resource limit described in § 416.1205 for an eligible individual and an individual and spouse.)

(b) *An alien sponsored by more than one sponsor.* The resources of an alien who has been sponsored by more than one person are deemed to include the resources of each sponsor.

(c) *More than one alien sponsored by one individual.* If more than one alien is sponsored by one individual the deemed resources are deemed to each alien as if he or she were the only one sponsored by the individual.

(d) *Alien has a sponsor and a parent or a spouse with deemable resources.* Resources may be deemed to an alien from both a sponsor and a spouse or parent (if the alien is a child) provided that the sponsor and the spouse or parent are not the same person and the conditions for each rule are met.

(e) *Alien's sponsor is also the alien's ineligible spouse or parent.* If the sponsor is also the alien's ineligible spouse or parent who lives in the same household, the spouse-to-spouse or parent-to-child deeming rules apply instead of the sponsor-to-alien deeming rules. If the spouse or parent deeming rules cease to apply, the sponsor deeming rules will begin to apply. The spouse or parent rules may cease to apply if an alien child reaches age 18 or if either the sponsor who is the ineligible spouse or parent, or the alien moves to a separate household.

(f) *Alien's sponsor also is the ineligible spouse or parent of another SSI beneficiary.* If the sponsor is also the ineligible spouse or ineligible parent of an SSI beneficiary other than the alien, the sponsor's resources are deemed to the alien under the rules in paragraph (a), and to the eligible spouse or child under the rules in §§ 416.1202, 1205, 1234, 1236, and 1237.

[52 FR 8888, Mar. 20, 1987]

§ 416.1204a Deeming of resources where Medicaid eligibility is affected.

Section 416.1161a of this part describes certain circumstances affecting Medicaid eligibility in which the Department will not deem family income to an individual. The Department will follow the same standards, procedures, and limitations set forth in that section with respect to deeming of resources.

[49 FR 5747, Feb. 15, 1984]

§ 416.1205 Limitation on resources.

(a) *Individual with no eligible spouse.* An aged, blind, or disabled individual with no spouse is eligible for benefits under title XVI of the Act if his or her nonexcludable resources do not exceed $1,500 prior to January 1, 1985, and all other eligibility requirements are met. An individual who is living with an ineligible spouse is eligible for benefits under title XVI of the Act if his or her nonexcludable resources, including the resources of the spouse, do not exceed $2,250 prior to January 1, 1985, and all other eligibility requirements are met.

(b) *Individual with an eligible spouse.* An aged, blind, or disabled individual who has an eligible spouse is eligible for benefits under title XVI of the Act if their nonexcludable resources do not exceed $2,250 prior to January 1, 1985, and all other eligibility requirements are met.

(c) *Effective January 1, 1985 and later.* The resources limits and effective dates for January 1, 1985 and later are as follows:

Effective date	Individual	Individual and spouse
Jan 1, 1985	$1,600	$2 400
Jan 1, 1986	1,700	$2 550
Jan 1, 1987	1,800	$2 700
Jan 1, 1988	1,900	$2 850
Jan 1, 1989	2,000	$3 000

[50 FR 38982, Sept. 26, 1985]

§ 416.1207 Resources determinations.

(a) *General.* Resources determinations are made as of the first moment

such individual's resources shall be deemed to include any resources, not otherwise excluded under this subpart, of such spouse whether or not such resources are available to such individual. In addition to the exclusions listed in § 416.1210, pension funds which the ineligible spouse may have are also excluded. *Pension funds* are defined as funds held in individual retirement accounts (IRA), as described by the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed individuals, sometimes referred to as Keogh plans).

(b) *Child.* In the case of a child (as defined in § 416.1856) who is under age 18, such child's resources shall be deemed to include any resources, not otherwise excluded under this subpart, of an ineligible parent of such child (or the ineligible spouse of a parent) who is living in the same household (as defined in § 416.1851) as such child, whether or not available to such child, to the extent that the resources of such parent (or such spouse of a parent) exceed the resource limits described in § 416.1205. (If the child is living with only one parent, the resource limit for an individual applies. If the child is living with both parents (or one parent and his or her spouse), the resource limit for an individual and spouse applies.) In addition to the exclusions listed in § 416.1210, pension funds which the ineligible parent or spouse of a parent may have are also excluded. *Pension funds* are defined in paragraph (a) of this section. As used in this section, the term *parent* means the natural or adoptive parent of a child and *spouse of a parent* means the spouse (as defined in § 416.1806) of such natural or adoptive parent.

(c) *Applicability.* When used in this subpart L, the term *individual* refers to an eligible aged, blind, or disabled person, and also includes a person whose resources are deemed to be the resources of such individual (as provided in paragraphs (a) and (b) of this section).

[40 FR 48915, Oct. 20, 1975, as amended at 50 FR 38982, Sept. 26, 1985; 52 FR 8888, Mar. 20, 1987; 52 FR 29841, Aug. 12, 1987; 52 FR 32240, Aug. 26, 1987]

§ 416.1203 Deeming of resources of an essential person.

In the case of a qualified individual (as defined in § 416.221) whose payment standard has been increased because of the presence of an essential person (as defined in § 416.222), the resources of such qualified individual shall be deemed to include all the resources of such essential person. If such qualified individual would not meet the resource criteria for eligibility (as defined in §§ 416.1205 and 416.1260) because of the deemed resources, then the payment standard increase because of the essential person will be nullified and the provision of this section will not apply; essential person status is lost permanently. However, if such essential person is an ineligible spouse of a qualified individual or a parent (or spouse of a parent) of a qualified individual who is a child under age 21, then the resources of such person will be deemed to such qualified individual in accordance with the provision in § 416.1202.

[39 FR 33797, Sept. 20, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§ 416.1204 Deeming of resources of the sponsor of an alien.

The resources of an alien who first applies for SSI benefits after September 30, 1980, are deemed to include the resources of the alien's sponsor for 3 years after the alien's date of admission into the United States. The *date of admission* is the date established by the Immigration and Naturalization Service as the date of admission for permanent residence. The resources of the sponsor's spouse are included if the sponsor and spouse live in the same household. Deeming of these resources applies regardless of whether the alien and sponsor live in the same household and regardless of whether the resources are actually available to the alien. For rules that apply in specific situations, see § 416.1166a(d).

(a) *Exclusions from the sponsor's resources.* Before we deem a sponsor's resources to an alien we exclude the same kinds of resources that are excluded from the resources of an individual eligible for SSI benefits. The

similar programs, unless determined by the Director of the Action Agency to constitute the minimum wage, under sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973 (87 Stat. 409, 413), as amended by Pub. L. No. 96-143; (93 Stat. 1077); 42 U.S.C. 5044(g) and 5058).

NOTE—This exclusion does not apply to the income of sponsors of aliens.

(b) Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a).

[45 FR 65547, Oct. 3, 1980, as amended at 52 FR 8888, Mar. 20, 1987]

Subpart L—Resources and Exclusions

AUTHORITY: Secs. 1102, 1602, 1611, 1612, 1613, 1614(f), 1621, and 1631 of the Social Security Act; 42 U.S.C. 1302, 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, and 1383; sec. 211 of Pub. L. 93-66; 87 Stat. 154.

SOURCE: 40 FR 48915, Oct. 20, 1975, unless otherwise noted.

§ 416.1201 Resources; general.

(a) *Resources; defined.* For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

(2) Support and maintenance assistance not counted as income under § 416.1157(c) will not be considered a resource.

(3) Except for cash reimbursement of medical or social services expenses already paid for by the individual, cash received for medical or social services that is not income under § 416.1103 (a) or (b) is not a resource for the calendar month following the month of its receipt. However, cash retained until the first moment of the second calendar month following its receipt is a resource at that time.

(4) Death benefits, including gifts and inheritances, received by an individual, to the extent that they are not income in accordance with paragraphs (e) and (g) of § 416.1121 because they are to be spent on costs resulting from the last illness and burial of the deceased, are not resources for the calendar month following the month of receipt. However, such death benefits retained until the first moment of the second calendar month following their receipt are resources at that time.

(b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in § 416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, bank accounts (savings and checking), certificates of deposit and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources.

(c) *Nonliquid resources.* (1) Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days excluding certain nonwork days as explained in § 416.120(d). Examples of resources that are ordinarily nonliquid are loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Nonliquid resources are evaluated according to their equity value except as otherwise provided. (See § 416.1218 for treatment of automobiles.)

(2) For purposes of this subpart L, the *equity value* of an item is defined as:

(i) The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus

(ii) Any encumbrances.

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979; 48 FR 33259, July 21, 1983; 52 FR 4283, Feb. 11, 1987; 52 FR 16845, May 6, 1987; 53 FR 23231, June 21, 1988; 56 FR 36001, July 30, 1991]

§ 416.1202 Deeming of resources.

(a) *Married individual.* In the case of an individual who is living with a person not eligible under this part and who is considered to be the husband or wife of such individual under the criteria in §§ 416.1806 and 416.1811,

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a-3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request

payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and ar-

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(E) for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1395*l*(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 1395*l*(a)(3) of this title; and

(F) for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards,

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396*o* of this title,

(15) Repealed. Pub.L. 100–360, Title III, § 301(e)(2)(C), as added by Pub.L. 100–485, Title VI, § 608(d)(14)(I)(iii), Oct. 13, 1988, 102 Stat. 2416.

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (*l*)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money

(V) who are qualified family members as defined in section 1396d(m)(1) of this title;[1]

(VI) who are described in subparagraph (C) of subsection (*l*)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of subsection (*l*)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(C) of this section for such a family;

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;[1]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan de-

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(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (13) and (14) [1] of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37), 606(h), or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title),

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (*l*)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (*l*)(2)(A) of this section for such a family;[1]

of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

3. Eligibility

Although persons eligible for Aid to Families with Dependent Children are automatically eligible for medicaid, persons who do not qualify for welfare assistance may nevertheless still qualify for medicaid. Perez v. Lavine, D.C.N.Y. 1976, 412 F.Supp. 1340, supplemented 422 F.Supp. 1259.

If alien was permanently residing in United States under color of law within meaning of federal regulation, she was eligible to receive Medicaid benefits, even though she was not eligible pursuant to state regulation. Cruz v. Commissioner of Public Welfare, 1985, 478 N.E.2d 1262, 395 Mass. 107.

In order for person to qualify for medicaid, that person must be eligible and to be eligible a person must qualify under a state plan which agrees with all the statutes and regulations promulgated under this chapter. Flathead Health Center v. Flathead County, 1979, 598 P.2d 1111, 183 Mont. 211.

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment

tion and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, c. 531, Title XIX, § 1901, as added July 30, 1965, Pub.L. 89–97, Title I, § 121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub.L. 93–233, § 13(a)(1), 87 Stat. 960; July 18, 1984, Pub.L. 98–369, Div. B, Title VI, § 2663(j)(3)(C), 98 Stat. 1171.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1965 Act. Senate Report No. 404 and Conference Report No. 682, see 1965 U.S.Code Cong. and Adm.News, p. 1943.

1973 Act. House Report No. 93–627, see 1973 U.S.Code Cong. and Adm.News, p. 3177.

1984 Act. House Report No. 98–432 Part II and House Conference Report No. 98–861, see 1984 U.S.Code Cong. and Adm.News, p. 697.

Amendments

1984 Amendment. Pub.L. 98–369 struck out "of Health and Human Services" following "Secretary". See Change of Name note set out under this section.

1973 Amendment. Pub.L. 93–233 substituted in item (1) "disabled individuals" for "permanently and totally disabled individuals".

Effective Dates

1984 Act. Amendment by Pub.L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status or interpretation which existed (under the provisions of law involved) before that date, see section 2664(b) of Pub.L. 98–369, set out as a note under section 401 of this title.

1973 Act. Amendment by Pub.L. 93–233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see 13(d) of Pub.L. 93–233, set out as a note under section 1396a of this title.

Change of Name

"Secretary of Health and Human Services" was substituted for "Secretary of Health, Education, and Welfare" in text pursuant to section 509(b) of Pub.L. 96–88 which is classified to section 3508(b) of Title 20, Education.

LIBRARY REFERENCES

Administrative Law

Federal financial participation, see 45 C.F.R. § 304.10 et seq.
Medicare and Medicaid, see West's Federal Practice Manual § 5811 et seq.
State fiscal administration, see 42 C.F.R. § 433.1 et seq.

American Digest System

Appropriations and disbursement of federal funds, see United States ⇐82 et seq.
Medical assistance programs, see Social Security and Public Welfare ⇐241 et seq.

Encyclopedias

Appropriations and disbursement of federal funds, see C.J.S. United States § 122 et seq.
Medical assistance programs, see C.J.S. Social Security and Public Welfare § 126 et seq.

Law Reviews

Barriers to hospital diversification: The regulatory environment. Reed Hamilton, 24 Duquesne L.Rev. 425 (1985).
Behind closed doors: The confidentiality of psychotherapeutic records in medicaid fraud investigations. 6 Pace L.Rev. 441 (1986).

Laboratories excluded from participation under this subchapter, see 42 USCA § 263a.
Maximum amount available to Saint Elizabeths Hospital from Federal sources, see 24 USCA § 170a.
Medical care for military spouses and children, see 10 USCA § 1079.
Modification of mortgage insurance of hospital receiving revenue from program under this subchapter, see 12 USCA § 1715z-7.
National Health Services Corps Programs, see 42 USCA § 254d et seq.
Notice by Secretary describing limited benefits for long-term care services, see 42 USCA § 1395b-2.
Office of Rural Health Policy; determination of effects of policies under this subchapter, see 42 USCA § 912.
Payment for services in general—
Health care costs incurred by military dependents, see 10 USCA § 1095.
Health maintenance organizations, see 42 USCA §§ 1395mm, 1395vv.
Physicians' services, see 42 USCA §§ 1395w-1, 1395w-4.
Reasonable charges, factors considered, see 42 USCA § 1395u.
State imposed higher requirements as condition to purchase of services; like requirements as condition of payment, see 42 USCA § 1395z.
Veterans' Administration, department of medicine and surgery; acceptance of payments, see 38 USCA § 4108.
Payment for services to hospitals—
Average reasonable cost per patient-day, see 42 USCA § 1395tt.
Determination of reasonable costs; development of model systems, see 42 USCA §§ 1320b-3, 1320b-4.
State hospital reimbursement control system, see 42 USCA § 1395ww.
Payments under National Vaccine Injury Compensation Program, see 42 USCA § 300aa-15.
Peer review; general provisions, see 42 USCA § 1301 et seq.
Period within which State must file claim for expenditures under program, see 42 USCA § 1320b-2.
Pooling of funds for transportation services with State or area agencies on aging, see 42 USCA § 3026.
Program under this subchapter not health-plan contract for purposes of recovery of costs of certain veterans' care services, see 38 USCA § 629.
State plan for child and spousal support; determination of paternity of child born out of wedlock, support from parents for child in foster care, see 42 USCA § 654.
State plan requirements—
Federal-State pilot program to provide medical and social services for certain handicapped individuals, see 42 USCA § 1382i.
Income and eligibility verification system, see 42 USCA § 1320b-7.
Waiver; disallowance of items, see 42 USCA §§ 1315, 1316.
State planning councils for persons with developmental disabilities; representative of State agency administering program included, see 42 USCA § 6024.
Student loans with respect to services in certain health care facilities in underserved areas; requirements with respect to facilities, see 42 USCA § 297n.
Utilization and quality control peer review organization, see 42 USCA § 1320c et seq.

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§ 1396. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilita-

ADDENDUM D

SOCIAL SECURITY AMENDMENTS OF 1965

For text of Act see p. 305

House Report (Ways and Means Committee) No. 213, Mar. 29, 1965
[To accompany H.R. 6675]
Senate Report (Finance Committee) No. 404, June 30, 1965
[To accompany H.R. 6675]
Conference Report No. 682, July 26, 1965 [To accompany H.R. 6675]
Cong. Record Vol. 111 (1965)

DATES OF CONSIDERATION AND PASSAGE
House Apr. 8, July 27, 1965
Senate July 9, July 28, 1965
The Senate Report and the Conference Report are set out.

SENATE REPORT NO. 404

THE Committee on Finance, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

PART I

I. BRIEF SUMMARY

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.

Second, to expand the services for maternal and child health, crippled children, child welfare, and the mentally retarded, and to establish a 5-year program of "special project grants" to provide comprehensive health care and services for needy children (including those who are emotionally disturbed) of school age or preschool age.

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and over 246,000 aged were aided in March 1965. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs."

Under the House bill, after an interim period ending June 30, 1967, all States would have to adopt the new program or lose Federal matching as to vendor medical payments since the current provisions of law would expire at that time. Under the committee bill the States will have the option of participating under the new program or continuing to operate under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program). Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(b) State plan requirements

(1) Standard provisions

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, the committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that, effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, the committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

The committee's bill would add a requirement that the State plan include a description of the standards, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance. This amendment would give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods. In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new title XIX, requiring States to have an authority or authorities responsible for establish-

ing and maintaining standards for private or public institutions in which recipients may receive care or services.

The committee also added an amendment to require that, after June 30, 1967, private and public medical institutions must meet standards (which may be in addition to the standards prescribed by the State) relating to protection against fire and other hazards to the health and safety of individuals, which are established by the Secretary of Health, Education, and Welfare. The committee assumes that the standards prescribed by many States at the present time will meet or exceed those prescribed by the Secretary.

The House bill provided that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State supervised, the same State agency shall supervise the administration of title XIX.

The committee believes that the States should be given the opportunity to select the agency they wish to administer the program. A number of witnesses appearing before the committee have expressed the belief that the State health agency should be given the primary responsibility under this program. The committee bill leaves this decision wholly to the States with the sole requirement that the determination of eligibility for medical assistance be made by the State or local agency administering State plans approved under title I or XVI. The committee agrees with the statement in the House report that the welfare agencies have "long experience and skill in determination of eligibility."

The committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the new program, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individuals. This would include the eligibility determining function. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is hoped that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of the committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of ad-

ministration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. The committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

The committee hopes that there will be continuing evaluation of all State plan requirements in relation to the basic objectives of the legislation.

(c) Eligibility for medical assistance

Under the committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. It is only if this group is provided for that States may include medical assistance to the less needy.

Under the committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various categories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

The committee has amended the House bill, however, so that this provision as to comparability does not apply in the case of services in institutions for tuberculosis or mental diseases. Federal financial participa-

tion is authorized only with respect to recipients aged 65 and over in mental and tuberculosis institutions so it would not be appropriate to include them within the scope of this provision.

(d) Determination of need for medical assistance

The committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled, and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him Income and resources taken into account furthermore, must be reasonably evaluated by the States These provisions are designed so that the States will not assume the availability of income which may not, in fact be available or overevaluate income and resources which are available Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.

The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted pro-

grams which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, the committee bill requires that the State's standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

This determination must be made by the agency administering the old-age assistance or combined adult program; i.e., the welfare agency.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similar charge, or of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect to require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this

provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits The committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles or cost sharing shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need For this reason, the committee's bill provides that the States make provisions, for individuals 65 years or older who are included in the new plan, of the cost of any deductible or cost sharing imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibit adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under the committee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) Scope and definition of medical services

"Medical assistance" is defined under the bill to mean payment of all or part of the cost of care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for

ADDENDA E

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(Cite as: 1986 WL 20891 (N.D.Ill.))

Bessie FOLEY, et al., Plaintiffs,
v.
Gregory COLER, Defendant.
No. 83-C-4736.
United States District Court, N.D. Illinois, E.D.
Oct. 1, 1986.

Joseph Bomba, Cook County Legal Assistance Foundation, River Forest, Ill., for plaintiffs.
Barbara L. Greenspan, Attorney General's Office, Chicago, Ill., for defendant.

REPORT AND RECOMMENDATION

ELAINE E. BUCKLO, United States Magistrate.

*1 Plaintiffs, a class of aged, blind and disabled Medicaid applicants and recipients, seek to enjoin defendant, the Director of the Illinois Department of Public Aid, from denying Medicaid benefits to class members solely because their resources exceed the Medicaid eligibility standard, when the class members' medical expenses exceed the excess of their resources over the eligibility standard. Both parties have moved for summary judgment. I recommend that plaintiffs' motion be granted and defendant's motion denied.

I.

Title XIX, 42 U.S.C. ss 1396 et seq. (1985) (the Medicaid Program) authorizes the federal government to pay part of the cost of medical services provided through the states to eligible elderly, blind and disabled individuals. States choosing to participate in this program must provide services to all individuals who are eligible for supplemental security income (SSI), except that a state may provide services only to those individuals who would have been eligible under the state's plan that was in effect on January 1, 1972. 42 U.S.C. s 1396a(f) (the s 209(b) option). Illinois participates in the Medicaid Program under the s 209(b) option. Schweiker v. Gray Panthers, 453 U.S. 34, 39 n. 6 (1981).

In addition to providing assistance to those eligible for SSI (the categorically needy), the states may provide Medicaid benefits to those individuals whose income and resources exceed the SSI eligibility standards, but who would be eligible if their medical expenses were deducted from their income (the medically needy). 42 U.S.C. ss 1396a(a)(10), a(17)(D), a(f). Illinois provides such assistance.

In Illinois, the Medicaid Program is administered by the Illinois Department of Public Aid. It is given broad rulemaking power to

determine, within limits, the resource eligibility standards or cut-offs and the amount of resources to be disregarded in determining whether an applicant's resources exceed that standard. Ill.Rev.Stat. Ch. 23, ss 5-2, 5-4 (1986). Prior to February 1, 1982, its regulations ("old regulations") provided that if an applicant's assets and income exceeded the standards for eligibility, the excess assets and income would be applied to reduce reimbursement of the applicant's medical expenses, but the applicant would still be eligible for Medicaid. These regulations thus provided for both income and resource spend-down.

On February 1, 1982, this regulation was amended so that only spend-down of excess income was allowed. If the applicant's resources exceeded the eligibility standard, the applicant would be ineligible for Medicaid, even if his medical expenses were greater than his excess resources. 82 Ill.Admin.Reg. 2150 (1982). Plaintiffs challenge this regulation on several grounds.

II.

Initially, defendant argues that in Action Transmittal 80-58 sent by the Secretary of the U.S. Department of Health and Human Services (HHS) to all participating states in August, 1980, the Secretary interpreted the statute and regulations to prohibit resource spend-down and that the court should grant deference to that interpretation. Generally, an administrative agency's interpretations of its own regulations and the statute it administers are entitled to substantial deference and should not be disturbed unless they are clearly inconsistent with the statute or regulation. Udall v. Tallman, 380 U.S. 1, 16-17 (1965); FEC Democratic Senatorial Campaign Comm., 454 U.S. 27, 39 (1981). If the agency's interpretation is reasonable, the court should sustain it, even though the court might have interpreted the statute or regulation differently. Udall, supra, 380 U.S. at 16; Psychiatric Institute v. Schweiker, 669 F.2d 812, 814 (D.C.Cir.1981); see State of Wisconsin Dept. of Health v. Bowen, 797 F.2d 391, 398 (7th Cir.1986). But where the agency's interpretation contradicts its earlier position, the interpretation is entitled to little deference. United Housing Foundation, Inc. v. Forman, 421 U.S. 837, 858 n. 25 (1975); General Electric Co. v. Gilbert, 429 U.S. 125, 140-5 (1976).

Under these standards, Action Transmittal 80-58 should not be given much weight. Its interpretation of the statute and regulations is directly contrary to the Secretary's prior interpretation, and there had been no concurrent changes in the statute or regulations. The Action Transmittal's justification for the change in interpretation is that *2 Although Section 1902(a)(17)(D) of the Social Security Act provides this option [spend-down] with respect to income ... neither the Act nor Federal regulations allow for such flexibility with regard to resources. Id. This argument fails to explain why SSI interpreted the Act and Regulations otherwise prior to this time. The court will, therefore, examine the statutory scheme and regulations adopted by the Secretary. Accord, Haley v. Com'r. of Public Welfare, 394 Mass. 466, 476 N.E.2d 572, 577-8 (1985).

III.

42 U.S.C. s 1396a(4)(A) requires state Medicaid plans to "provide

such methods of administration ... as are found by the Secretary to be necessary for the proper and efficient operation of the plan." Id. Pursuant to this provision, the Secretary has promulgated regulations requiring that the state plan provide for the establishment of a Medical Care Advisory Committee (MCAC) "to advise the Medicaid agency director about health and medical care services." 42 C.F.R. s 431.12(b). The MCAC "must have opportunity for participation in policy development and program administration...." 42 C.F.R. s 431.12(e). The new Illinois regulation was never submitted to the MCAC for advice. (Defendant's Response to Interrogatory 15.) Plaintiffs contend that the regulation is, therefore, invalid.

The language of the federal regulations states that the MCAC "must" be able to participate "in policy development and program administration." Id. The MCAC must be consulted before policy changes are made, Morabito v. Blum, 528 F.Supp. 252, 264 (S.D.N.Y.1981), and 'policy' is to be broadly interpreted, covering "the entire field of state decision-making with respect to the Medicaid Program...." Id. Policy changes affecting eligibility for Medicaid, as well as policy changes affecting the sort of services provided, must be submitted to the MCAC for advice. Id. at 263. The discontinuance of the use of resource spend-down in determining the eligibility of the medically needy is a policy change, and consultation with the MCAC would seem to be required before the new regulation was promulgated.

The defendant promulgated the rule, however, because it believed the amendment was required by federal law. Although the amendment affected Medicaid policy, it was not, in defendant's view, discretionary. Whatever advice the MCAC might give, it could not affect or alter defendant's decision. Prior review of the amendment by the MCAC would have been fruitless, and arguably the regulation should not be invalidated merely because defendant failed to solicit advice which in its view it was bound by law to ignore.

The plaintiffs, however, argue that the MCAC could have given advice on how defendant might mitigate the impact of the amended rule, for example by recommending that defendant advise applicants of the importance of promptly applying excess resources to medical bills. The MCAC must be given the opportunity to participate in policy decision-making and program administration; decisions about how to implement the new regulation eliminating spend-down of resources involve policy or program administration on which the MCAC must be consulted.

*3 There remains the question of what relief would be appropriate. The plaintiffs argue that since the regulation was promulgated improperly, the court should strike down the regulation. However, this remedy is not always appropriate. Thus, where there was not total failure to consult the MCAC, the district court did not abuse its discretion in refusing to enjoin the policy changes. Burgess v. Affleck, 683 F.2d 596, 600 (1st Cir.1982). Here, the MCAC was not consulted, but its advice would have been irrelevant to defendant's decision on whether to adopt the amended rule. Where the courts have invalidated or enjoined the new policy, the policy was usually implemented at the discretion of the

state agency, and presumably that agency, if it had had the benefit of the MCAC's advice, might not have implemented the new policy or might have made changes in it. See, e.g., Morabito, supra, 528 F.Supp. at 256-8 (decision by state to switch from giving benefits to all applicants eligible under SSI to giving benefits to those eligible under the state's 1972 plan); Becker v. Toia, 439 F.Supp. 324, 332 (S.D.N.Y.1977) (state statute requiring applicants to make payments on prescription drugs and medical appliances; statute gave agency discretion in setting amount of payments). Robinson v. Maher, CCH Medicare & Medicaid Guide P 27,707 (D.Conn. Jan. 19, 1976) (budgetary shortfall required agency to reduce Medicaid expenditures; "It may well be that such a consultation ... might suggest to the commissioner alternative ways to reduce expenditures ... avoiding unnecessary hardship.") Since defendant would have promulgated the amended regulation regardless of any advice the MCAC would have given it, striking down the regulation on this ground would be an excessive remedy. If this were the only ground on which plaintiffs would prevail, they would at most be entitled to an order that defendants obtain the MCAC's advice on what measures should be taken to soften the impact of the amended rule.

IV.

Plaintiffs argue that because their resources were insufficient to meet their medical expenses, the resources were not "available" within the meaning of 42 U.S.C. s 1396a(a)(17)(B) and (C) and 42 C.F.R. s 435.845. Plaintiffs misconstrue the meaning of "available." The statutory and regulatory provisions in question require that the applicant actually be able to use his resources and that the value of those resources be evaluated reasonably. Resources are unavailable when although the applicant has some right in the resource, he cannot use the resource to increase his purchasing power. Jackson v. Schweiker, 683 F.2d 1076, 1086 (7th Cir.1982) (difference between subsidized rent paid by applicant and market rent of his apartment not a resource available to applicant). These provisions do not, however, deal with the sufficiency of the applicant's resources to meet his medical and other needs. Here, the plaintiffs do not contend that their resources cannot increase their purchasing power or that the value of their resources has been incorrectly determined. Their resources are, therefore, available.

V.

*4 Plaintiffs argue that the new Illinois regulations are invalid because they require the medically needy to reduce their resources below the eligibility standard for the categorically needy. If a state elects to provide Medicaid to the medically needy, 42 U.S.C. s 1396a(a)(10)(C)(i)(III) requires the state to use a single standard and methodology in determining resource eligibility. In addition, 42 U.S.C. s 1396a(a)(17)(B) requires the state, in determining eligibility of the medically needy, to take into account only such resources as would not be disregarded in determining eligibility of the categorically needy. These provisions limit the freedom of the states to treat the medically needy differently from the categorically needy. Thus, the state must use the same income disregards, Calkins v. Blum, 675 F.2d 44,

45 (2d Cir.1982), and transfer of assets rules, Beltran v. Myers, 701 F.2d 91, 94 (9th Cir.), cert. den. 462 U.S. 1134 (1983), for both groups.

In the present case, the new Illinois regulation does not treat the medically needy differently from the categorically needy. The same resource eligibility level applies to both groups, and neither group is permitted to spend down their resources in order to qualify.

The plaintiffs argue, however, that the statute was intended to prevent states from requiring the medically needy to spend their resources below the level of eligibility of the categorically needy. They cite S.Rep. 404, reprinted in 1965, U.S. Code Cong. & Ad. News 1943, 2019. That report, however, is directed at the income spend-down provision. Once an applicant has been found eligible through income spend-down, The State may require the use of all the excess income of the individual toward his medical expenses.... In no event, however, with respect to either this provision or that described below with reference to the use of deductibles ... may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Id. The income spend-down provisions were aimed at preventing the applicant from being determined ineligible when his income was less than his medical expenses and the categorical assistance level. However, there was no similar resource spend-down provision. The report does refer to "resources," but only insofar as spending them would reduce the applicant's income. The statute does not require the states to use resource spend-down, even when not doing so results in the applicants' having to expend their resources below the resource eligibility level of the categorically needy.

VI.

Plaintiffs argue that since Illinois is a s 209(b) state, its Medicaid eligibility criteria may be no more restrictive than those in place in its 1972 plan and that since under its 1972 plan, Illinois permitted resource spend-down, it may not now prohibit it, even if the regulations and statute do not allow non-s 209(b) states (SSI states) to use resource spend-down in determining the eligibility of the medically needy.

In 1972, Congress replaced three assistance programs with Supplemental Security Income for the Aged, Blind and Disabled (SSI). 42 U.S.C. ss 1381 et seq. In some states more people were eligible for SSI than had been eligible for the assistance programs SSI replaced, and since all individuals eligible for SSI were eligible for Medicaid, the financial burden of Medicaid on the states increased. To lessen that increased burden and dissuade states from withdrawing from Medicaid, Congress enacted 42 U.S.C. s 1396a(f, s 209(b)). Schweiker v. Gray Panthers, 453 U.S. 34, 38 (1981). That statute provides that *5 Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under Title XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of Subchapter XVI of this chapter [SSI]) for any month unless such State would be (or would

have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month.... Id.

s 209(b) thus did not authorize states to create an alternative basis for eligibility but only to further restrict the eligibility of persons who would otherwise qualify for Medicaid under the SSI standards. Savage v. Toan, 795 F.2d 643, 645-6 (8th Cir.1986); Morris by Simpson v. Morrow, 783 F.2d 454, 459-60 (4th Cir.1986). If Illinois' new regulation is more restrictive than its 1972 plan, the regulation is nonetheless valid if the 1972 plan provided eligibility on a broader basis than authorized for SSI states and the new regulation is required by the Medicaid statute or regulations. s 209(b) does "not confer authority upon states to create broader eligibility standards than exist nationally for SSI." Id. at 459. Before concluding that the new Illinois regulation is invalid because it is more restrictive than Illinois' 1972 plan, it is necessary to determine whether the 1972 plan violated the social security statute or regulations.

Defendant argues that the Medicaid statute forbids resource spend-down and that, therefore, the new regulation is valid regardless of whether it is more restrictive than the 1972 plan.

It might appear that 42 U.S.C. s 1396a(a)(10)(C)(i)(III) (hereinafter "CIII") would prohibit resource spend-down. That provision requires a state providing Medicaid to the medically needy to employ a single standard ... in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility ... shall be the same methodology which would be employed under the supplemental security income program.... Id. In determining eligibility for SSI, resource spend-down is not provided for, [FN1] and so it could not be used in determining eligibility for Medicaid.

The history of CIII, however, suggests that it may not be applicable here. Prior to 1981, the Medicaid statute required that states providing Medicaid to the medically needy determine resource and income eligibility of the medically needy "in accordance with comparable standards" to those used in determining eligibility for the categorically needy under SSI. 42 U.S.C. s 1396a(a)(10)(C)(i) (1976); Atkins v. Rivera, --- U.S. ----, 106 S.Ct. 2456, 2462 (1986). In 1981, the "comparability" requirement was deleted in order to give states more flexibility in setting eligibility criteria and scope of services for the medically needy. Omnibus Budget Reconciliation Act of 1981, s 2171(a)(3)(C)(i) (OBRA), 95 Stat. 357, 807; Atkins, supra, 106 S.Ct. at 2462; H.R.Rep. No. 208, 97th Cong., 1st Sess. 971, reprinted in 1981 U.S. Code Cong. & Ad. News 396, 1333.

*6 In response to this amendment, in 1981 the Secretary revised the Medicaid regulations to provide that state plans could use income and resource methodologies for determining eligibility of the medically needy that were different from those used in determining the eligibility of the categorically needy: Section 2171 of the 1981 Amendments revised the Medicaid statute so that the direct linkage between cash assistance programs and the medically needy is no longer explicit. Therefore, we have

concluded that the State need not adopt the methodology of a related cash assistance program in treating income and resources of the medically needy. Rather, the State may develop its own. However, Section 1902(a)(17) of the Act has not been amended. Consequently, these final regulations require that the State must use a methodology for the treatment of income and resources that is reasonable. 46 Fed.Reg. 47,980 (1981). The Secretary implemented the amendment by promulgating 42 C.F.R. ss 435.850-52. The "same methodology" provision, 42 U.S.C. s 1396a(a)(10)(C)(i)(III), was enacted in response to the Secretary's new regulations. Atkins, supra, 106 S.Ct. at 2463. The provision reflected Congress' belief that the 1981 amendments, upon which the regulations were based, gave states certain flexibility in structuring their medically needy programs. They were allowed to limit coverage to certain categories of medically needy individuals, and to vary the services they offered to the different groups they covered. No change was made or intended to be made with regard to financial eligibility policy. H.R.Rep. No. 861, 98th Cong., 2nd Sess. 1366, reprinted in 1984 U.S. Code Cong. & Ad. News 697, 2054. The "same methodology" provision was intended to restore the status quo before the Secretary's 1981 regulations, and "not ... to change policies governing the income and resource standards and methodologies for determining eligibility of the medically needy from those in effect before OBRA." Id. at 1367, 2055. Congress' sole intent in enacting CIII was to invalidate the Secretary's post-OBRA regulations. Atkins, supra, 106 S.Ct. at 2463 n. 10. Those regulations "had nothing to do with the treatment of excess income for the medically needy or with the calculation of spend-downs." DeJesus v. Perales, 770 F.2d 316, 325 (2d Cir.1985) (Friendly, J.). The post-OBRA regulations were intended to give the states freedom to develop methodologies for determining the financial eligibility of the medically needy that differed from those used for the categorically needy; the purpose of CIII was to invalidate those regulations and require that the methodologies be the same.

The requirement of uniformity is reasonable in such matters as calculation of income and resources in which comparable procedures must be applied to both groups. Since spend-down of income, however, *7 has no counterpart in the eligibility methodologies, it would have been tautologous for Congress to direct that the states calculate spend-downs using 'the same methodology' as they use in determining eligibility for those programs. DeJesus, supra, 770 F.2d at 327. Accordingly, CIII has no effect on treatment of excess income and calculation of spend-downs. Atkins, supra, 106 S.Ct. at 2463.

Similarly, CIII does not prohibit the use of resource spend-downs. Arguably, since resource spend-down, unlike income spend-down, is not separately authorized, it could be applied only as part of the evaluation of resources.

The SSI regulations require the deduction of incumbrances from the value of assets, 20 C.F.R. s 1201, and presumably could also require the deduction of unsecured debt, including medical expenses, from the applicant's resources; since they do not, the same methodology requirement would prevent the use of similar deductions in determining the eligibility of the medically needy

for Medicaid. But resource spend-down, like income spend-down, is really not part of the methodology for evaluating the applicant's resources. The resource methodology is the process whereby the value of the applicant's resources is calculated. See DeJesus, supra, 770 F.2d at 324. In determining the eligibility of both the categorically needy and the medically needy, the applicant's resources are evaluated and measured against the SSI standard. A resource spend-down would be applicable only after the applicant's resources had been evaluated, the resource standard applied, and the applicant found ineligible; it would be applicable only to the medically needy. It would have no counterpart in the eligibility methodology of the categorically needy. Consequently, the "same methodology" provision would not prevent the use of resource spend-down. No other statutory provisions forbid the use of resource spend-down in determining the eligibility of the medically needy. 42 U.S.C. s 1396a(a)(17)(D) requires states to use income spend-down but is silent regarding resource spend-down. Defendant argues from this silence, and the fact that elsewhere in s 1396a(a)(17) Congress speaks of both income and resources, that the statute implicitly forbids the use of resource spend-down. s 1396a(a)(17)(D), however, does not merely permit but requires income spend-down. It was included in the Medicaid statute to prevent states from choosing not to use income spend-down. See S.Rep. 404, 89th Cong., 1st Sess. 78 (1965), reprinted in 1965 U.S. Code Cong. & Ad. News 1943, 2018-9. The provision was not needed to permit states to use income spend-down. See id. It cannot be held to implicitly forbid states to use resource spend-down.

*8 Resource spend-down is consistent with the goals of the statute. The Medicaid program was enacted "(f)or the purpose of enabling each State ... to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services...." 42 U.S.C. s 1396. The income spend-down provision, 42 U.S.C. s 1396a(a)(17)(D), was incorporated in the Medicaid statute to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed.

... [Under the spend-down provision] before an individual is found ineligible ..., the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires. S.Rep. 404, supra, 1965 U.S. Code Cong. & Ad. News at 2018-9. Resource spend-down serves a similar goal. An individual may have resources above the eligibility level, but his medical expenses may exceed the excess. Resource spend-down measures the

applicant's resources in terms of his medical expenses, so that the applicant is not found ineligible in this situation. A resource spend-down provision in a state plan would thus further the general purpose of the Medicaid program of providing medical assistance to those "whose income and resources are insufficient to meet the costs of necessary medical care." 42 U.S.C. s 1396. See Haley, supra, 394 Mass. 466, 476 N.E.2d at 578.

The regulations similarly do not forbid resource spend-down. 42 C.F.R. s 435.845 (1985) provides that in determining resource eligibility of the medically needy, the agency must--

* * *

(d) For aged, blind or disabled individuals in States covering all SSI recipients, deduct the value of resources that would be deducted in determining eligibility under SSI;

(e)(1) For aged, blind or disabled individuals in States using requirements more restrictive than SSI, deduct the value of resources in an amount no more restrictive than those deducted under the Medicaid plan on January 1, 1972, and no more liberal than those deducted in determining eligibility under SSI.

*9 (2) However, the amounts specified in paragraph (e)(1) of this section must be the same as those that would be deducted in determining, under s 435.121, the eligibility of the categorically needy; and (f) apply the resource standards established under s 435.843. Id. [FN2] These regulations require that resources be evaluated in the same way in determining eligibility of the medically needy as in determining eligibility of the categorically needy. However, they do not forbid the states to apply the resource standard flexibly after the applicant's resources have been evaluated, by applying a resource spend-down.

Resource spend-down is thus permitted, but not required, by the Medicaid statute and regulations. Because Illinois is a s 209(b) state, its Medicaid eligibility requirements may be no more restrictive than those it used in its 1972 plan. That plan required the use of resource spend-down. A s 209(b) state generally has the option of picking and choosing among the SSI eligibility criteria or the state's 1972 eligibility criteria. However, if the 1972 criteria are not invalid, the state may not impose more restrictive criteria, even if those criteria are also permitted under SSI. See Brogan v. Miller, 537 F.Supp. 139, 144 n. 12 (N.D.Ill.1982). Accordingly, since Illinois' 1972 plan was not invalid and the new regulation, by eliminating resource spend-down, imposes more restrictive eligibility criteria than the 1972 plan, the new regulations are invalid.

For the reasons stated above, plaintiffs' motion for summary judgment should be granted.

FN1. There is a limited exception. Where the applicant's non-liquid resources are not more than one-fourth of the statutory maximum resource standard, the applicant is eligible. He must liquidate his non-liquid resources within six months, and the excess of that amount over the standard is applied against his SSI benefits. 20 C.F.R. ss 416.1240-4.

FN2. The pre-OBRA regulations provided that the amounts

deducted "must be at least the same as those that would be deducted ... under 435.121...." 42 C.F.R. s 435.845(e) (1979).

N.D.Ill.,1986.
Foley v. Coler
1986 WL 20891 (N.D.Ill.)
END OF DOCUMENT

ADDENDUM F

not have prepared in presenting her evidence and of which she could not have had notice. The Tenth Circuit has pointed out that a proposed rule does not serve as notice of the final rule:

> At the point of publication of the proposed rule the agency is, of course, not bound to the issuance of the rule in any exact form. . . . [U]ntil publication is made of the rule actually adopted, the public of course does not know which course the agency will take or how to prepare for the regulation. *Rowell v. Andrus*, 631 F.2d 699, 702, n.2 (10th Cir. 1980).

Therefore, the ALJ was not restricted to the list of mitigating factors in the proposed regulation.[9]

The I.G.'s position seems to be that once a conviction has been demonstrated, untrustworthiness is sufficiently proved to require a five-year exclusion and that any reduction in that period reflects a "sympathy" standard not derived from the law. I.G. Br. at 6, 9-12. In arguing that remorse and personal circumstances are not valid grounds to reduce an exclusion period, the I.G. cited *Frank J. Haney*, DAB Civ. Rem. C-156 (1990). In that case, the ALJ reduced an exclusion period from five years to three, also over the I.G.'s objection, despite Petitioner's conviction for a felony. While rejecting the stress of Petitioner's involvement in a lawsuit as mitigation, because it might recur, the ALJ considered other factors including character evidence, Petitioner's mother's illness and death, and Petitioner's otherwise good record.

In *Haney*, as here, the ALJ determined that a conviction alone does not end the discussion, since a "criminal conviction in 1988 does not necessarily evidence that [Haney] . . . is, at this time, an untrustworthy individual." *Id.* at 8. If anything, the *Haney* decision suggests that the ALJ in each case viewed the evidence of mitigation individually and carefully weighed it against the factors favoring exclusion. The ALJ reasonably determined that Petitioner, who completed a one-year probation for a misdemeanor theft, should not undergo a longer exclusion than Mr. Haney, who was convicted of two felonies in a tax fraud scheme spreading over several years for which he was still serving five years probation.

This does not mean that we would have reduced the exclusion here as substantially as the ALJ did if we were making the decision in the first instance. Our review of the record indicates that there are factors which the ALJ may not have fully considered (but which the I.G. did not raise) which lead us to question the reduction of the period of exclusion to one year. For example, Petitioner testified that she turned the patient account books for the Bellmead Nursing Home over to her sister. Transcript (Tr.) at 72. It is not clear whether the ALJ considered the fact that this may have contributed to further thefts and that Petitioner could have instead set up a system for accounting for the patient funds such as the system she testified she later used in other nursing homes. Tr. at 90.

We view our role as a limited one, however. Our guidelines state that our standard of review on disputed issues of fact is "whether the ALJ's decision is supported by substantial evidence" and on disputed legal issues is whether "the ALJ's decision was erroneous." DAB Guidelines, Appendix B at 28.29 (1989). The I.G. did not challenge the ALJ's findings of fact, and we have concluded that the I.G.'s arguments concerning the legal standard applied are without merit. Thus, given the limited scope of our review, we must affirm the ALJ's decision.

Conclusion

Based on the foregoing analysis, we affirm the ALJ decision.

[¶ 39,089] Christine Harriman v. Commissioner, Maine Department of Human Services.

U.S. District Court, District of Maine, Civil No. 90-0046-B, Nov. 9, 1990.

Medicaid: Financial Eligibility

Maine—Resource spenddown.—An individual who (together with her spouse) had over $10,000 in assets and was in hospital intensive care for about a month in January and February of

[9] We also note that the I.G presented nothing which convincingly shows that application of the factors in the proposed regulation would have made a difference here The I G argued that these regulations would have barred evidence of Petitioner's later remorse and of the circumstances motivating the crime if not appearing in the criminal record The I.G did not, however, assert that the criminal record contained no evidence of Petitioner's remorse or the circumstances considered relevant by the ALJ. As the ALJ found, Petitioner was sentenced to one-year probation, not incarceration. Finally, we note that limiting the ALJ's consideration to *only* those factors listed in the proposed regulations would appear to be unwise, based on our experience in deciding cases It is extremely difficult to anticipate what all relevant circumstances might be. The approach in the existing regulations allows for consideration of "[a]ny other factors bearing on the nature and seriousness of the program violations."

1989 following a pancreatic attack was not entitled to spend down to Maine's Medicaid resource-eligibility level of $3,000 by incurring medical expenses, even though her hospital bill was $42,000. She received the hospital bill in February, began paying it in March, and applied for Medicaid in April. As a result, she could not qualify under the state's rules that allow a resource spenddown only if an individual applies for Medicaid and spends down to the state's eligibility level in the month in which the expenses were incurred. Although federal law requires states (such as Maine) that cover medically needy individuals to allow applicants to spend down their income to the state's income-eligibility level for Medicaid by incurring medical expenses, it allows but does not require a resource spenddown. Finding that "the plaintiff appears to have all the logic and policy on her side of the argument, but the Commissioner appears to have the law on his side," the court invited the parties to consider whether to certify to the Maine Law Court questions of whether a comprehensive resource spenddown must be allowed and whether refusal to allow it violates the Equal Protection Clause.

See ¶ 14,311.74, 15,594.

Memorandum

HORNBY, District Judge:

I.

The question in this class action is whether a state must consider the amount of accrued medical bills in evaluating whether an applicant's personal resources disqualify her for Medicaid—in other words, whether the state must apply a "resource spend-down" rule as it does in evaluating income. The plaintiff appears to have all the logic and policy on her side of the argument, but the State Commissioner of Human Services appears to have the law on his side, and I conclude that federal law does not require the state to use a resource spend-down rule. Before ruling on the question whether state law requires it, however, I invite the parties to consider whether that question should be certified to the Maine Law Court pursuant to Maine Rule of Civil Procedure 76B. The Clerk's office shall schedule a conference of counsel to discuss that issue.

The plaintiff suffered a pancreatic attack in early January of 1989, and spent nearly one month in intensive care. Upon her release from the hospital in early February she received a bill in excess of $42,000. At the time she went into the hospital, she, together with her husband, had over $10,000 in liquid assets. According to her uncontested affidavit, she has spent all but $500 on the outstanding medical bills, leaving her with only the home she owns jointly with her husband. On April 4, 1989, she sought Medicaid coverage to pay the remaining medical bills The Commissioner found her ineligible for coverage from January through March because, on the first day of each of those months, her assets exceeded the $3,000 eligibility limitation contained in the Maine Department of Human Services regulations. The Commissioner did find her eligible for coverage beginning April 1, 1989, but that coverage would not apply to these medical bills. In an administrative appeal, a fair hearing officer upheld the decision.

The plaintiff brought this class action against the Commissioner of Human Services seeking to have herself declared eligible and an injunction enjoining the Commissioner to adopt a resource spend-down policy. The Commissioner impleaded the United States Secretary of Health and Human Services. The plaintiff has now moved for summary judgment against the Commissioner on all her state and federal claims except her claim that the program violates the equal protection clause of the Fourteenth Amendment. The defendant Commissioner has not contested any of the facts asserted by the plaintiff, but has disputed her legal conclusions. The third-party Secretary of the United States Department of Health and Human Services has not participated in the arguments on the motion.

II.

The Medicaid program is a joint federal/state venture created by Title 19 of the Social Security Act, 42 U.S.C. § § 1396 *et seq.* It is designed to furnish financial assistance to those whose "income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396(1).

Applicants who are ineligible for AFDC (Aid to Families with Dependent Children) or SSI (Supplemental Security Income) assistance may qualify for Medicaid if they meet the definition of "medically needy" and are disabled like the plaintiff. 42 U.S.C. § 1396a(a)(10)(C); 22 M.R.S.A. § 3173. So far as resources are concerned, Maine has provided by regulation that a married spouse is eligible as "medically needy" only if the couple's available assets are $3,000 or less. Maine Medical Assistance Eligibility Manual, § 3340.

There is, likewise, an income limit. In the case of income, however, eligibility is determined by setting off any excess income against the medical bills and then providing Medicaid for the remainder of the bills. This procedure is known as the "spend-down" rule. Manual § 5000. The Department regulations contain no comparable provision for considering resources.

The plaintiff argues that the federal statute requires the Commissioner to include in the

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state program a resource spend-down rule. She relies upon the stated purpose of the federal statute—that it is designed to furnish assistance to persons whose "income *and resources* are insufficient to meet the costs of necessary medical services" (emphasis supplied). 42 U.S.C. § 1396(1). The federal statute specifically requires the state to have an *income* spend-down rule. 42 U.S.C. § 1396a(a)(17)(D). But there is no similar requirement in the federal statute for a resource spend-down rule. There is confusing language in the Senate Report to the bill that produced the income spend-down requirement. Specifically,

> [t]he state may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a state require the use of income *or resources* which would bring the individual's *income* below the amount established as the test of eligibility under the state plan. Such action would reduce the individual below the level determined by the state as necessary for his maintenance.

S. Rep. No. 404, 89th Cong., 1st Sess., 78 (1965), *reprinted in* 1965 U.S. Code Cong. & Admin. News, 1943, 2019 (emphasis supplied). But whatever the reference to resources might mean in the Senate Report, the federal statute clearly deals only with *income* spend-down. I am satisfied, therefore, that the federal statute does not *require* a state to have a resource spend-down rule.[1]

Federal law does, however, *permit* a state to adopt a resource spend-down rule. See *Westmiller By Hubbard v. Sullivan*, 729 F.Supp. 260, 263 (W.D.N.Y. 1990) ("Although the Medicaid Act does not expressly mention a resource spend-down, it is clear from other sections of the Act and from the legislative history that the states have discretion in utilizing such a [resource] spend-down in determining eligibility."); *Foley v. Suter*, No. 83 C 4736, slip. op. at 9 (N.D. Ill. 1986) (unpublished 1986 WL 20891) ("Resource spend-down is thus permitted, but not required by the Medicaid statute and regulations."); *Hession v. Illinois Department of Public Aid*, 129 Ill.2d 535, 544 N.E.2d 751, 757 (Ill. 1989) ("[W]e perceive nothing in section 1396a(A)(17) which precludes a State that participates in the Medicaid program from using the resource spend down methodology if it chooses to do so."); *Haley v. Commissioner of Public Welfare*, 394 Mass. 466, 476 N.E.2d 572, 578 (Mass. 1985) ("We conclude that, although Congress did not require use of a resource spend down, such use is a reasonable method of evaluating resources.") (footnote omitted); *Contra*, *Ramsey v. Department of Human Services*, 301 Ark. 285, 783 S.W.2d 361, 364 (1990) ("The pertinent federal statutes and regulations and their application through the Arkansas state Medicaid Plan establish no authority in any category for a 'spend-down' of excess resources that is similar or identical to the expressly authorized 'spend-down' of excess income.")

Clearly, if the goal of Medicaid is to assist individuals who are medically needy—defined as having insufficient income or resources to meet the cost of necessary medical services—the sensible solution is the spend-down rule, a rule that has been applied in assessing income by both the federal and state governments. It makes no sense to find that someone with $10,000 in assets, but $42,000 in medical bills is not needy, while finding that someone with $2,999 in assets and $3,001 in medical bills is needy. The Commissioner has advanced absolutely no reason for treating assets differently from income in considering a spend-down; I have been unable to conceive of such a reason; and the only reason I have found in the case law is this cryptic statement in *Ramsey v. Department of Human Services*, 301 Ark. 285, 783 S.W.2d 361, 364 (Ark. 1990):

> The rationale behind treating resources and income differently is that income merely restores resources to their previous levels. It is accrued day by day in return for labor. On the other hand, resources in place, or acquired, are viewed as wealth in hand that increases the recipient's well-being. A rational basis, therefore, can be said to exist for this distinction in treating resources and income differently.

Somehow that rational basis still eludes my understanding.

The remaining question in this case, therefore, is whether Maine statutes and regulations require the use of a resource spend-down and, if not, whether the failure to provide such a rule violates the Equal Protection Clause. The question of state law may be determinative of the cause. There are no precedents on this issue in

[1] The fact that 42 U.S.C. § 1396p permits individuals to give away their resources in order to establish Medicaid eligibility does not translate into congressional legislation requiring a resource spend-down rule; nor does the fact that 42 U.S.C § 1396(b)(u)(D)(ii) (TEFRA) treats as an erroneous excess payment only the difference between the allowable resource level under the plan and the actual amount of the family's assets (here, approximately $7,000, the amount of the resource spend-down if such a rule applied). The fact that Congress, in providing for federal recovery of erroneous excess state payments, contemplated that a state *might* use a resource spend-down rule and calculated the recovery of federal funds accordingly does not establish that Congress mandated the use of such a rule

the decisions of the Maine Supreme Judicial Court. It is for this reason that I will meet with the lawyers to discuss whether this question of Maine statutory construction should be certified to the Law Court under Me. R. Civ. P. 76B.[2]

The plaintiff's motion for summary judgment is therefore *DENIED.*

[¶ 39,090] In the Matter of New York State Medical Transporters Association, Inc. v. Cesar A. Perales.

New York Court of Appeals, 77 NY2d. 126, Dec. 20, 1990.

Before: WACHTLER, Chief Judge, and TITONE, HANCOCK, JR., BELLACOSA, KAYE, ALEXANDER, and SIMMONS, Judges.

Medicaid: Transportation Services

New York—Prior authorization for transportation services.—The New York Medicaid agency was entitled to enforce a state law provision requiring prior authorization as a condition of payment for nonemergency transportation services, even though its fiscal agent sometimes responded to an overwhelming number of prior authorization requests by granting "retroactive prior approval" after the services were provided. The agency had informed providers that prior authorization would be deferred only when providers experienced extreme difficulty in obtaining it by telephone and that retroactive prior approval requests may never be made more than 30 days after transportation of a patient. The providers sought to have their claims considered despite their failure to secure prior authorization or to obtain timely retroactive prior approval. They claimed that (1) the agency had compromised the provision and should, therefore, be estopped from enforcing it; and (2) the provision was unenforceable because the agency had, in effect, ratified the fiscal agent's failure to abide by it. Estoppel and ratification may not be used, however, to keep an agency from discharging its statutory duties. Since the law is clear that prior authorization is required and that providers are expected to abide by it, providers could not establish that they had suffered "manifest injustice" as a result of the agency's refusal to consider all of their claims.

See ¶ 14,605.89, 14,729.62, 15,620.

Opinion of the Court

KAYE, J.: Petitioners, providers of nonemergency transportation services to Medicaid recipients, by this proceeding seek to compel respondent, Commissioner of the Department of Social Services (DSS), to process their claims for transportation services rendered to Medicaid recipients without the agency's prior approval. Petitioners acknowledge that prior agency approval is a statutory prerequisite but contend they are nonetheless entitled to have their claims processed because of an informal practice permitting them to obtain "retroactive prior approval" after the services were rendered, which respondent should either be estopped from contesting, or found to have ratified. In that there is no basis here for the application of estoppel or ratification, we affirm the order of the Appellate Division dismissing the petition.

By statute, DSS must provide Medicaid recipients with "transportation when essential to obtain care and services" (Social Services Law § 365-a [2] [j]) The statute requires that such transportation be "upon prior approval, except in cases of emergency," and the implementing regulation states that "[p]rior authorization by the local social services official shall be required for * * * transportation when essential to obtain medical care and services, except emergency care" (18 NYCRR 505.10[b]).

Petitioner New York State Medical Transporters Association, Inc. is an association of companies that provide nonemergency invalid

[2] Maine does, apparently, permit a spend-down of assets within the month of application Thus, if an applicant has $5,000 in the bank on January 1 and applies for Medicaid assistance on January 5, she may become eligible retroactively, for the entire month, if she spends or gives away $2,001 before the end of January Manual § 3340

In this case, Mrs Harriman incurred her medical obligations in January, did not receive the bill until February and apparently did not begin spending the $10,000 to pay the bill until March Thus, she is considered ineligible during January and February Since the bill was received in February, her spend-down in March also does not count Manual § 1530, example 2 She now cannot obtain Medicaid assistance to pay this bill and may, instead, have to sell her home (jointly owned with her husband), otherwise an exempt asset under the Manual, § 3310.01. The Maine Law Court may conclude, as did the courts in Massachusetts and Illinois, that the state goal of preserving certain assets, such as a home, from being consumed by medical bills, along with the statutory requirement that assistance be available to those who do "not have sufficient income *or resources* to provide a reasonable subsistence compatible with decency and health," 22 M.R.S.A § 3174 (emphasis supplied), requires the use of a retroactive resource spend-down rule But that is solely a question of state law

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ADDENDUM G

deficient because it does not provide a sufficient basis to determine that the appropriate legal standards have been followed by the hearing officer in reaching her decision. We reverse and remand for further proceedings because the appealed order fails to set forth in sufficient detail the five-step analysis required by 20 C.F.R. § 416.920 and the analysis required by 20 C.F.R. § 404, Appendix 2, Subpart P, Rule 202.03 (1991), as a predicate to the hearing officer's decision approving the denial of the claimed benefits. *Walker v. Department of Health and Rehabilitative Services*, 533 So.2d 836 (Fla. 1st DCA 1988) (*Walker* I); cf. *McDaniel v. Bowen*, 800 F.2d 1026 (11th Cir.1986). In the absence of the hearing officer's detailed evaluation of the criteria and questions under the cited regulations, we are unable to provide adequate appellate review of that decision. Cf. *Walker v. Department of Health and Rehabilitative Services*, 554 So.2d 1202 (Fla. 1st DCA 1989) (*Walker* II).

REVERSED AND REMANDED FOR FURTHER PROCEEDINGS.

2 MMLR ¶ 90

Giuseppina MATARAZZO,

v.

Lorraine ARONSON, Commissioner of Income Maintenance,

No. CV91-0388251

Connecticut Superior Court, Judicial District of Hartford-New Britain

June 30, 1992

The plaintiff appealed from an administrative decision upholding the denial of retroactive Medicaid coverage for medical expenses incurred before the assets possessed by her and her spouse were reduced below the $2,400 limit on such assets as specified by state law. The plaintiff maintained that the denial of retroactive benefits by refusing to apply a resource spend down provision was unlawful in that Connecticut, as a § 209(b) state, was required to maintain the same eligibility requirements in effect as of January 1, 1972, including that of a resource spend down provision. Further, the plaintiff asserted that a resource spend down provision was necessary for compliance with the disregard of assets provision of state law. Otherwise, potential beneficiaries would have to be stripped of all assets before establishing eligibility, argued the plaintiff.

HELD for the state agency.

The court ruled that the state agency was not compelled to employ an asset spend down provision. First, § 209(b) states were required only to maintain eligibility requirements specified in the approved state plan in effect as of January 1, 1972. The court noted that the record was totally silent as to whether or not that state plan contained a resource spend down provision. Second, while the court disregarded, due to its inconsistency with prior policy, a 1980 transmittal from the Health Care Financing Administration prohibiting states from employing resource spend down, the court noted that state law effectively prohibited resource spend down by specifically excluding married couples with more than $2,400 in assets from Medicaid coverage. Third, since both state and federal law protected an applicant's resources up to $2,400, the plaintiff realized the same financial loss with or without resource spend down. On the basis of the foregoing, the plaintiff's appeal was dismissed.

HOLZBERG, J.

Memorandum of Decision

In this administrative appeal the plaintiff contests the defendant's denial of her application for Title XIX benefits. At the time of her initial application the plaintiff and her husband had joint assets, consisting principally of a bank account, of nine thousand dollars. Because the Medicaid resource limit for a married couple is twenty-four hundred dollars, plaintiff's application was denied even though during the three-month period prior to the application being denied plaintiff had incurred in excess of $150,000 in medical bills. The principal issue raised in this appeal is whether the refusal of the defendant to set off plaintiff's accrued medical expenses against her excess resources is a violation of state and federal laws governing Title XIX. Resolution of this issue requires an odyssey through the labyrinths of the Social Security Act, a statute aptly described by one court as "an aggravated assault on the English language, resistant to attempts to understand it." *Friedman v. Berger*, 409 Fed. Supp. 1225, 1226 (S.D.N.Y.1976).

The relevant facts are as follows. In February, 1990, the plaintiff, at the age of sixty-two, became seriously ill and was hospitalized for emergency treatment. Because she had no medical insurance she filed an application for medicaid benefits with the Department of Income Maintenance. As part of the application Mrs. Matarazzo, who was being assisted by her daughter, disclosed that she and her husband had a joint savings account of nine thousand dollars, which represented their life savings. Title XIX regulations require that a married applicant have less than twenty-four hundred dollars in assets. Based on information provided to them by the intake worker, Mrs. Matarazzo and her daughter reasonably believed that once the savings account was reduced to less than twenty-four hundred dollars, plaintiff's application would be approved retroactive to the date of application such that Title XIX would cover the approximately $150,000 in medical bills incurred by plaintiff. However, when plaintiff's application was approved on June 27, 1990, she was informed that it was granted retroactive to June 1. Consequently, the plaintiff remains responsible for the substantial medical bills that she incurred in the preceding three

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ble for the state supplement program whose assets as defined by the commissioner exceed sixteen hundred dollars, or it living with a spouse, exceed twenty-four hundred dollars." The plain language of the statute itself prohibits the defendant from granting Title XIX benefits to any married person, such as plaintiff, whose assets exceed twenty-four hundred dollars. Additionally, the use of a resource spend down appears, by implication, to be barred by General Statutes Sec. 17-134b. That provision directs the Commissioner to grant assistance to individuals whose income is applied to the cost of authorized medical care: "Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance *shall be granted* for the balance of the cost of authorized medical assistance." (Emphasis supplied). Because the enumeration of a power in a statute impliedly forbids things not enumerated, State ex. rel. *Barlow v. Kaminsky*, 144 Conn. 612 (1957), Connecticut law prohibits the use of a resource spend down.

Thus, while federal law may permit use of a resource spend down, Connecticut law does not. Plaintiff's reliance on Hessian and Foley is unavailing since both Illinois and Massachusetts statutes, unlike Connecticut's, specifically authorize a resource spend down. In Hessian, the court noted that the Illinois code, "requires that, in the case of single individuals residing alone, the Department must disregard at least $1500 in assets when determining Medicaid eligibility." 544 N.E.2d at 757. The Illinois court further observed that the lower appellate court, "agreed with Hessian that the Illinois Public Aid Code requires the Department to utilize a resource spend down methodology in determining an applicant's eligibility." Id. at 753.

Finally, petitioner asserts that Connecticut's asset disregard statute requires the use of a resource spend down. General Statutes §§ 17-82, 17-134b and 17-134c makes ineligible any married person whose assets exceed $2400. Put differently, DIM must disregard $2400 of a married person's assets when considering eligibility for Title XIX. Petitioner argues that without a resource spend down she will have to deplete all of her resources to become eligible. Because state and federal law explicitly allow an applicant to retain up to $2400 in resources, it appears that with or without a resource spend down petitioner cannot be required to divest herself of the statutorily protected $2400 as a condition of eligibility. In the absence of any proof that petitioner was not permitted to retain the $2400 of protected assets plaintiff cannot prevail in this claim.

While this is a case in which the plaintiff appears to "have all the logic and policy on her side of the argument, but the state appears to have the law," *Harriman v. Commissioner of Maine Department of Human Resources*, # 900046, F.Supp. (D.Me. Nov. 9, 1990), our Supreme Court has again reminded us that policy flaws in the Medicaid statute are a matter for legislative correction, not judicial modification. *Mercado v. Commissioner of Department of Income Maintenance, supra.* Because this court is not free to substitute its judgment for the state and federal legislatures, and because it concludes that neither state nor federal law require the use of a resource spend down, it declines to reverse the decision of the hearing officer. The plaintiff's appeal is therefore dismissed.

In summary, this court concludes that the plaintiff has not sustained her burden of proving that the state plan in effect as of January 1, 1972, authorizes the use of a resource spend down. Even if plaintiff had provided proof of that fact she cannot prevail because, even assuming the HCFA prohibition should be ignored, state law does not require the use of a resource spend down. In the absence of any claim that use of a resource spend down is required by federal law, the defendant did not act illegally, arbitrarily or capriciously in denying plaintiff's application. Plaintiff's appeal is therefore dismissed.

---

[1] A resource spend down allows an applicant who is ineligible because of excess resources to obtain retroactive coverage once she spends down her excess resources. For example, an individual may have resources above the eligibility level, but her medical expenses may exceed the excess. Resource spend down measures the applicant's resources in terms of her medical expenses, so that the applicant is not found ineligible in this situation.

[2] Section 209(b) provides in pertinent part:

> Notwithstanding any other provision of this subchapter, ... no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan it (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972.

42 U.S.C. § 1396a(t) (1982).

[3] ACTION TRANSMITTAL 80-58 states:

> The current page 6 of ATTACHMENT 2.6-C allows States to require a "spend-down" of an individual's resources, by indicating that excess liquid resources can be applied to the cost of medical care. Although section 1962(a)(17)(D) of the Social Security Act provides this option with respect to income (by taking into account incurred medical expenses), neither the Act nor Federal regulations allow for such flexibility with regard to resources. We have, therefore, eliminated this option on page 6 of ATTACHMENT 2.6-C to correct this error and reflect Federal law and regulations.

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ADDENDUM H

DECISIONS

Volume 1, Issue 24

1 MMLR ¶ 318

Christine HARRIMAN, et al.,

v.

COMMISSIONER, MAINE DEPARTMENT OF HUMAN SERVICES, et al.,

No. 90-0046-B-H

U.S. District Court, Maine

March 4, 1992

The appellant represented a class of individuals whose level of assets rendered them ineligible for Medicaid benefits. In an underlying decision, Maine's Supreme Court ruled that state law did not require an asset spend down. The appellant filed another motion, contending that the Commissioner's policy of allowing for income spend down, but not asset spend down, violated the Equal Protection Clause.

HELD: for the Commissioner.

The court, while finding that the policy made "little economic or logical sense," concluded that it met the rational basis standard, and thus did not violate the Equal Protection Clause. In considering the class of individuals whose assets exceeded the threshold level, the court opined that this group was likely, on the whole, to "have greater flexibility in making alternative arrangements for their medical needs." In addition, the court noted that the state had a legitimate interest in avoiding the costly asset evaluation process that would accompany an asset spend down provision. Accordingly, the appellant's motion for summary judgment was denied.

HORNBY, J.

This class action challenges the Commissioner of Human Services' ("Commissioner") refusal to consider accrued medical bills in evaluating whether an applicant's personal resources disqualify her for Medicaid.[1] I have previously ruled in this case that the federal statute, 42 U.S.C. §§ 1396 *et seq.*, does not require a state to adopt a so-called resource "spend down" rule. On December 18, 1990, I certified to the Maine Supreme Judicial Court (sitting as the Law Court) the question whether 22 M.R.S.A. § 3174 required the Commissioner to apply a resource spend down. In a Mandate dated August 12, 1991, the Law Court held that the Maine statute does not compel an asset spend down. The parties have now filed cross-motions for summary judgment on the sole remaining question: whether the Commissioner's policy providing for an income spend down but not a resource spend down is inherently irrational and thus violates the Equal Protection Clause (Plaintiffs' Complaint, Counts IV and V). Because I conclude that a rational basis does exist for the Commissioner's policy, the plaintiff's motion for summary judgment is DENIED and the Commissioner's motion is GRANTED.

An applicant may qualify for Medicaid assistance if she meets the definition of "medically needy" and is disabled. 42 U.S.C. § 1396a(a)(10)(C); 22 M.R.S.A. §§ 3173, 3174. In determining whether she is medically needy the State evaluates the applicant's income and resources. Income eligibility is determined by calculating her gross income and applying certain deductions to arrive at her "countable income." *See* 42 C.F.R. § 435.831(a); Maine Medical Assistance Eligibility Manual ("*Manual*") §§ 3530-3554. She is eligible if her countable income falls below the State's income limit. Medically needy applicants may subtract from their income any incurred but unpaid medical expenses, thus reducing their net countable income to the eligibility standard. 42 U.S.C. § 1396a(a)(17); 42 C.F.R. § 435.831(c); *Manual* § 5000. This is referred to as the income spend down rule and it essentially permits a "special deduction" for an applicant's incurred medical expenses. *Hogan v. Heckler*, 769 F.2d 886, 889 (1st Cir. 1985). With respect to resources, a person is eligible as "medically needy" only if her assets do not exceed the State's asset eligibility limit ($3,000 or less in the case of a married couple). *Manual* § 3340. Unlike the case of income eligibility, however, no deductions are permitted and no comparable "spend down" provision exists for incurred medical expenses unless the resources are actually spent for such a purpose during the month in question.[2]

Harriman contends that the Commissioner's refusal to consider her (or class members' like her) incurred but unpaid medical expenses when evaluating her assets, while considering such expenses when evaluating another applicant's income, creates inequities and irrationally discriminates against those with resources. Harriman points out that she is in substantially the same financial position as those medically needy persons

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who have income exceeding the Medicaid limits but are found eligible only by application of the spend down rule; if the State were to include her incurred medical expenses in its evaluation of her assets she would fall below the $3,000 eligibility limit.[3]

The Equal Protection Clause dictates that "all persons similarly circumstanced shall be treated alike." *Plyler v. Doe*, 457 U.S. 202, 216 (1982), *quoting F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920). In the area of economics and social welfare, however, it is clear that a state's separate treatment is not unconstitutional merely because the classification is inequitable or unwise. *Schweiker v. Hogan*, 457 U.S. 569, 589 (1982). If there is a rational basis for the classification related to a legitimate state interest, then the classification does not violate the Equal Protection Clause. *Dandridge v. Williams*, 397 U.S. 471, 485 (1970) ("[T]he Equal Protection Clause does not require that a State must choose between attacking every aspect of a problem or not attacking the problem at all. It is enough that the State's action be rationally based and free from invidious discrimination." *Id.* at 486-87 (citation omitted).)

Although the State's decision to provide for a spend down when measuring income but not when measuring resources makes little economic or logical sense and although it is a very close question, I have concluded that the policy does barely meet the rational basis standard. *Hogan* instructs us that the validity of a broad classification "is not properly judged by focusing solely on the portion of the disfavored class that is affected most harshly by its terms," 457 U.S. at 589—here, people like the Harrimans who have minimal income but have saved some money and now find it offset by a hospital debt. Instead, a court is to look at the broad category—in this case, people with accumulated resources. Considering such people as a class, I conclude that the State could rationally believe that they "generally are better able to provide for their medical needs," 457 U.S. at 590, than people who have been unable to accumulate resources. In other words, people with accumulated resources, as a group, are likely to have greater flexibility in making alternative arrangements for their medical needs, whether it be by previous purchase of insurance, arranging for loans, family assistance, etc. Thus, it is rational to define need on the basis of these resources—even though some persons with resources, like the Harrimans, may actually be in greater need of assistance because of an accrued medical bill, than persons who receive assistance because they had no resources to start with. This conclusion is fortified by the administrative convenience arguments the State has made. So long as the State is evaluating assets only of those applicants who claim to have less than $3,000 (per couple) the administrative task is comparatively light. If, however, persons with substantial assets are able to claim benefits because a large medical bill offsets those assets, the State will be confronted with evaluating many more assets and the task will not always be simple—for example, collectibles, stock that does not trade on a public exchange, etc.[4] Use of the spend down to reduce income presents no comparable difficulties, because in most instances it is simple to measure the amount of the income stream to an applicant (except perhaps in instances of some self-employed individuals). Moreover, once that particular item of excess income has passed, the Commissioner need no longer be concerned with it. In the case of a spent down resource, on the other hand, once used it would presumably be disqualified from a similar use in the future and it would, therefore, have to be tracked as, for example, if a particular item were sold and the proceeds used to purchase a different item. All of these administrative problems support as rational the decision to draw the line between income and resources for purposes of applying the spend down rule. The State should not be compelled to use its limited budget to hire more people to apply a difficult rule where the alternative is to direct the funds to people in need even though not all people in need can be reached.

Accordingly, the plaintiffs' motion for summary judgment on Counts IV and V is DENIED and the defendants' motion for summary judgment is GRANTED. SO ORDERED.

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[1] The Medicaid program is a cooperative federal and state venture providing financial assistance to those whose "income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396(1). The applicable federal and state statutory provisions regarding eligibility are found at 42 U.S.C. § 1396a and 22 M.R.S.A. § 3174 respectively.

[2] Certain assets are excluded from the asset evaluation, including the applicant's primary residence, vehicle and household goods. *Manual* § 3310. Moreover, in the case of assets encumbered by debt, the Commissioner only considers the applicant's equity in the property (i.e., the amount by which the fair market value of the asset exceeds the debt owed on it). *Manual* § 3300.

[3] During a period of hospitalization from January 1989 to February 1989, Harriman incurred over $42,000 in medical bills. At the time she was hospitalized she and her husband had over $10,000 in liquid assets. By April 1989, Harriman had spent all but $500 of these assets on her outstanding medical bills and applied for Medicaid to cover the remaining bills. The Commissioner denied Medicaid coverage for the period January through March, however, because on the first day of each of those months her available assets exceeded the State's $3,000 eligibility limitation. According to Harriman, the Commissioner should have determined eligibility by spending down her assets by the amount of her incurred expenses (whether she paid them or not), as the Commissioner does when determining eligibility on the basis of income.

[4] Although the applicant must in the first instance total up her resources and present their value, the State must review the evaluation to avoid fraud or erroneous overpayments.

1 MMLR ¶ 319

JEWISH HOSPITAL, INC.,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,

No. C 90-0791-L(A)

U.S. District Court, Western District of Kentucky

March 16, 1992

The hospital contested the Secretary's interpretation of 42 U.S.C. § 1395ww(d)(5)(F)(5)(vi) as it pertained to his calculation of its "dispropor-

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