FH [redacted]

# STATE OF WISCONSIN
# Division of Hearings and Appeals

In the Matter of

[redacted]

**DECISION**
Case #: MGE - 207353

## PRELIMINARY RECITALS

Pursuant to a petition filed on January 11, 2023, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Dodge County Human Services regarding Medical Assistance (MA), a hearing was held on March 1, 2023, by telephone.

The issue for determination is whether the agency correctly required verification of a medical expense in order to apply it to reduce to the monthly patient liability.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
Dodge County Human Services
199 Cty Rd DF
Juneau, WI 53039

ADMINISTRATIVE LAW JUDGE:
Beth Whitaker
Division of Hearings and Appeals

## FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of [redacted], a skilled nursing facility in [redacted].
2. Until some date in November 2022, petitioner received Medicare benefits.
3. On December 14, 2022 the agency issued to petitioner a notice informing him that effective December 1, 2022 he was eligible for Medicaid Institutional Long Term Care program benefits.
4. Petitioner's monthly Medicaid patient liability was determined to be $982 for December 2022 and $1089 beginning in January 2023.
5. On December 20, 2022, [redacted] issued a statement of accounting stating that $7,252 was due by November 1, 2022 for room and board from November 8, 2022 to November 30, 2022 for petitioner, in the amount of $7,252, of an initial balance of $8,234, after a payment of $982.
6. On January 2, 2023, petitioner's representative requested that the Capital Consortium apply an ongoing credit of $1,089 per month toward petitioner's monthly Medicaid patient liability of $1,089, beginning in January 2023 based on the December 20, 2022 statement.
7. On January 9, 2023, the agency issued to petitioner a Notice of Proof Needed, informing him that to get or keep Nursing Home Long-Term Care benefits, he must provide proof of items listed by January 18, 2023,
8. On January 11, 2023, the Division received petitioner's request for hearing by fax.

## DISCUSSION

Medical Assistance (MA) rules require that after an institutionalized person is determined eligible for MA, an agency must calculate the amount of income the institutionalized person must contribute to defray the cost of care incurred by MA on his or her behalf on a monthly basis. 42 CFR §435.725. Wisconsin law specifically allows only $45.00 to be retained by institutionalized persons as a personal needs allowance. Wis. Stat. §49.45(7)(a) further provides that " . . . the recipient shall apply income in excess of $45.00, less any amount deducted under rules promulgated by the department, toward the cost of care in the facility." (Emphasis added). Based on what was provided at hearing, the personal allowance and the medical bill are the only available deductions to petitioner. Also see…..The rules referred to in the above statute are found in the Wisconsin Administrative Code. Wis. Admin. Code §DHS 103.07(1)(d) and MEH 27.7.1. for what expenses may be considered in determining patient liability toward cost of care.

The Medicaid Eligibility Handbook (MEH) Section 27.7.1 states:

> After an institutionalized person has been determined eligible for Medicaid, his or her cost of care must be calculated. Cost of care is the amount the person will pay each 3 month to partially offset the cost of his or her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution, including those enrolled in Family Care, Family Care Partnership, or PACE who are in or likely to be in a medical institution for 30 or more days. Institutionalized people are expected to pay their patient liability to the institution they are residing in, or to their MCO if they are enrolled in Family Care, Family Care Partnership, or PACE, as of the first day of the month.

Petitioner does not dispute patient liability calculation. Petitioner asks that he be allowed to pay for past due nursing home bill from his patient liability under authority of MEH 27.7.7.1, by receiving a credit in the amount of $1,089 per month. Medicaid members in nursing homes are allowed to pay for some medically necessary noncovered services out of their patient liability. They are not required to use their personal needs allowance for these services. The agency does not dispute that this type of payment may qualify as a credit toward the patient liability. It takes the position that the petitioner has not provided

information sufficient to verify the claimed monthly payments will actually be paid. The agency's January 9, 2023 Notice of Proof Needed explained: "Please provide a signed repayment agreement or other verification from [redacted] showing your payment of your existing balance of $7,252 with the nursing home for November 2022 room & board. This repayment agreement should indicate the amount you are paying each month, as well as the month the payments will both begin and end. This is required per Medicaid Handbook 27.7.7.1 as prior to allowing the deduction we must verify that the expense is being actually paid, not just owed.'

Medical or remedial expenses that an institutionalized applicant or member has incurred, is actually paying, and is legally obligated to pay are allowable expenses and are used as a need item when determining his or her eligibility for Medicaid. These actual payments are also allowed as an income deduction to reduce the cost share or patient liability amount. This includes payments for medical or remedial expenses that the institutionalized applicant or member is currently incurring as well as payments for certain previously incurred medical or remedial expenses.

In order to use the medical or remedial expense as an income deduction in the cost share calculation, the institutionalized person must be legally liable for payment of the incurred medical or remedial expense. Any amount to be paid by a legally liable third party, like private health insurance, Medicare, or Medicaid, cannot be used as a deduction. Also, the institutionalized person must provide verification of the allowable expense. MEH Sec. 27.7.7.2.

For all Medicaid programs, verification is a part of determining eligibility. See MEH Sec. 20.1. Verification is the act of establishing the accuracy of verbal or written statements made about a group's circumstances." There are general rules for MA verification in MEH Sec. 20.1.4. For the Institutional Long Term Care Program, the criteria in MEH 27.7.7.2 provide examples that guide the agency in applying those rules to petitioner's case.

The dispute in this case is limited to whether the agency may require additional documentation in the form of a payment agreement between petitioner and the creditor, or similar documentation. Petitioner argued that he has met these two criteria and specifically that by submitting a statement from the nursing home showing the entire amount owed, that it is verified the expense. Petitioner maintains in his request for hearing that the agency has no authority to request a signed payment agreement or any other form of additional verification, because merely receiving a medical service or being admitted for care is a "contract for payment" because "payment is a condition of receiving the provided services."

Petitioner proved that he owes $7,252 to the nursing home. Petitioner failed to show that receipt of services or admission amounts to proof that in any particular month, payment is actually being made. Under petitioner's reasoning, he would have paid $8,234 no later than December 2022, when he got the bill for November services.

This case is similar to Example 2 in MEH 27.7.7.2:

> In April, Edna applied for institutional Medicaid and requested a one month backdate. Her request for eligibility in March was denied because her assets exceeded program limits, but was approved effective April 1. Edna used her excess assets to make a partial payment to the nursing home for March costs, but still has an outstanding balance of $1,800. Edna agrees to make payments to the nursing home of $500 per month until the expense is paid in full. The $500 payment to the nursing home should be used as an income deduction when calculating her cost share for the months of April through June. In July, she will only owe $300 to the nursing home so the deduction for July should be decreased to $300 prior to adverse action in June. Edna will no longer be making

> payments in August, so the expense should be decreased to zero prior to adverse action in July.

It is reasonable and permissible for the agency to require evidence that an enforceable payment agreement actually exists between petitioner and the creditor to find that he has "agreed to make payments."

Similarly, see MEH, Sec. 27.7.7.2, Example 6:

> Joe has been determined eligible for MI S. He has an outstanding nursing home bill for $35,000 (for the months he was over assets for Medicaid). He has provided a copy of his repayment plan with the nursing home. Per the agreement, Joe is paying $1500 per month to the nursing home. The worker enters the $1500 payment on the Medical Expenses page and documents in case comments when the final payment is due and the amount of that final payment

Petitioner asserts that the Capital Consortium as an "arbitrary and irregular process" imposing the signed agreement requirement at will. The agency is under no obligation to require identical verification for each criteria requiring verification in each Long Term Medicaid Institutional Long Term Care case. In this case the agency representative has a reasonable question about whether $1,089 will actually be paid each month.

this case there is no documentation of any kind of an obligation to pay that monthly amount or any other amount, other than the total owed, which petitioner has not paid four months after the expense was incurred. It is not clear why, if he intends to pay that amount, he would be unable or unwilling to enter into an enforceable agreement with the nursing home and provide some proof of that agreement to the agency. It might be that such an agreement could be proven by some evidence other than a written, signed agreement, however, in this case there is no evidence at all of such an agreement or other obligation to pay on the schedule petitioner represents.

The agency acted reasonably and within its authority to require additional documentation to verify actual payment of petitioner's claimed monthly medical expense to allow it as a deduction from his monthly payment liability. I find that the agency correctly requested additional documentation and correctly refused to allow the requested deduction from patient liability when petitioner failed to provide that documentation.

## CONCLUSIONS OF LAW

In order to use petitioner's medical expense as an income deduction in the cost share calculation, the agency must verify that petitioner is legally liable for payment and that the payment is actually being made. Petitioner proved that he owes the money in question, but failed to present any proof that he is actually paying it or will pay it in the monthly amount asserted. The agency correctly required additional documentation of monthly payment obligation and declined to apply the requested monthly income deduction without that verification.

## THEREFORE, it is ORDERED

That the petition for review is dismissed.

## REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 4822 Madison Yards Way, 5th Floor North, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

## APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Madison,
Wisconsin, this 28th day of March, 2023

\s_____
Beth Whitaker
Administrative Law Judge
Division of Hearings and Appeals

**State of Wisconsin\DIVISION OF HEARINGS AND APPEALS**

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The preceding decision was sent to the following parties on March 28, 2023.

Dodge County Human Services
Division of Health Care Access and Accountability
[redacted]