FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 208326

PRELIMINARY RECITALS

Pursuant to a petition filed on April 17, 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 May 31, 2023, by telephone.

The issue for determination is whether the agency correctly required verification that a medical expense would be paid in order to apply it to reduce petitioner's monthly patient liability.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Brenda Haskins
Haskins, Short & Brindley LLC
5113 Monona Dr
Monona, WI 53716

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Nathaniel Wissell
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 Dodge County.
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. Petitioner incurred expense at [redacted] in the amount of $8,234 for the period from November 8, 2022 to November 30, 2022 and on December 31, 2022 made a payment of $982, leaving a balance due of $7,252.
6. On January 2, 2023, petitioner's representative requested that the agency 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, petitioner filed a request for hearing with the Division to appeal the agency's action.
9. On March 28, following an administrative hearing, the Division's Administrative Law Judge issued a decision dismissing the appeal (Case No. 207353).
10. On June 21, 2023, following a rehearing, the Division's Administrative Law Judge issued a decision dismissing the appeal.
11. On April 3, 2023, petitioner entered into a written agreement with [redacted] in which the creditor facility agreed that it "will accept a Medicaid Liability Diversion as arranged by his Medicaid authorized representative to allow for private payment of any amount owed said facility prior to [redacted] Medicaid approval as of December 1, 2022.
12. On April 4, 2023, petitioner's representative wrote to the agency to request "an ongoing $1,089 credit off [redacted] monthly Medicaid patient liability of $1,089 starting in April 2023 for $7,252 in past due medical expenses owed to [redacted] prior to December 1, 2022 MA approval for [redacted]."
13. On April 12, 2023, the petitioner requested a rehearing in case 207353, asserting that the Administrative Law Judge failed to consider its argument that the agency's verification requirement was contrary to federal Medicaid law.
14. On April 13, 2023 [redacted], business office manager for [redacted] communicated to petitioner's representative that the agency requested a signed agreement between the parties including an agreement to pay the monthly liability.
15. On April 13, 2023 petitioner's representative contacted the agency by telephone and demanded that the agency assist the applicant in obtaining verification.
16. On April 25, 2023, petitioner filed a request for hearing with the Division.

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.

Following the issuance of the decision following hearing in case 207353, petitioner's representative entered into a written agreement in which the facility to whom petitioner owes money for past incurred medical expense, [redacted], agreed to accept payment in any amount from petitioner with no reference to payment dates. Petitioner did not, in this agreement, or in any other way, commit to or even express an intention to make any such payment, in any amount or at any time. The written agreement contains no reference to any action to be taken by the petitioner.

Petitioner submitted this April 3, 2023 agreement as evidence at hearing arguing that it meets the verification requirement imposed by the agency. It does not. The agency has not requested verification that the creditor will accept payment. No reference to petitioner's intentions or obligation to pay is included in the April 3, 2023 agreement.

The Medicaid Eligibility Handbook offers a relevant example of what constitutes evidence that payment of medical expense will occur in this situation.

> 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.

MEH 27.7.7.2, Example 2.

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

The examples refer to agreements to make periodic payments in particular amounts. Petitioner has not offered anything of that nature. The written agreement submitted in this case does not obligate the petitioner to pay any particular amount on any particular schedule or to do anything whatsoever. It does not in any way document payments that support the request for deduction. It is not relevant to the requirement to verify that petitioner will pay the medical expense owed. Under authority of the Medicaid Eligibility Handbook (MEH) Sec. 27.7.7.2, the agency has requested verification that the liability incurred will actually be paid. The agency reasonably found that the written agreement submitted was insufficient to meet the verification requirement under MEH 27.7.7.2.

When petitioner's representative learned that the agency's verification requirement was not met by the written commitment of the facility to accept payment, petitioner's response was to assert that petitioner does not understand what the agency requires and to demand that the agency assist the applicant in obtaining verification "if they request help or have difficulty in obtaining it" citing MEH Sec. 20.1.4.

After being presented with the April 3, 2023 agreement of the facility to accept petitioner's payment in any amount at any time, the agency representative did apparently contact the nursing home by telephone in an attempt to get assurance that petitioner agreed to make payments. No such assurance was provided. The agency has provided clear instructions that it seeks some evidence that, if the requested medical expense deduction is granted for the requested monthly amount and schedule, that petitioner will make corresponding payments toward the past medical expense debt. There is no evidence or assertion in this case that petitioner has made a promise, oral or written, to make any payment on any particular. The lack of verification cannot be corrected by any further assistance from the agency. The agency has fully met its duty under MEH 20.1.4.

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. It correctly found that an agreement by the facility [redacted] to accept payment, with no corresponding agreement by petitioner to make payments, was inadequate to verify that payments would be made. I find that the agency correctly refused to allow the requested deduction from patient liability when petitioner failed to provide documentation of an agreement of some kind to make payments. Further, I find that the agency offered all assistance required in obtaining the needed verification.

CONCLUSIONS OF LAW

In order to use petitioner's medical expense as an income deduction in cost share calculations, the agency must verify that petitioner is legally liable for payment and that the payment is actually being made or will be made upon the agency's granting of the medical expense deduction. 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 a monthly amount equivalent to the deduction requested, or in any amount at any time. The agency correctly required additional documentation of 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 18th day of July, 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 July 18, 2023.

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