The Medical or Remedial Expense Deduction Made Easy

Presented by live webcast January 21, 2026 and available on demand afterward at https://www.elderlawwis.com/pro-toolkit/medical-remedial-expense/

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Objective: Explain the medical or remedial expense deduction, which Wisconsin elder law attorneys can use to help their clients enrolled in Medicaid pay overdue nursing home bills, hospital bills, and other out-of-pocket expenses not covered by the Medicaid program. Discuss sources of law and policy, relevant examples from Medicaid fair hearing decisions, and the practical actions needed to use this deduction, including a recommended process and forms.

Agenda:

12:00 p.m. Webinar start, brief introductory remarks
12:05 p.m. Begin explanation of medical or remedial expense deduction
12:55 p.m. Time for Q&A
1:00 p.m. End of webinar

Submitted to the Wisconsin BBE for 1.0 CLE, pending approval.

Contents

When working with a client on a Medicaid plan, the focus is often on eligibility—spending down to the asset limit—and preserving as many resources as possible. But there comes a time when you must explain how the finances work after the Medicaid application is finally approved. The institutionalized client will have less than $2,000 and still have to pay nearly all his income to the facility, in many cases. At this point, the client naturally asks: *But then, how am I going to pay X?*

X might be prescriptions, an old medical bill, a long-overdue nursing home bill, over-the-counter medical supplies, an ambulance bill, dental care, or something else related to the client's medical condition. If so, the medical or remedial expense deduction is the answer. (If the concern is paying a phone bill, real estate expenses, a life insurance premium, etc.—also common—the options are more limited and not the subject of this guide.)

The medical/remedial expense deduction is intended to ensure Medicaid enrollees can pay for any remaining out-of-pocket expenses related to their health. It is often an imperfect solution, but a useful one.

References

Medicaid Eligibility Handbook, Release 25-04 (Wis. DHS Dec. 10, 2025)

- § 15.7.3, Medical/Remedial Expenses
- § 20.3.6, Mandatory Verification Items: Medical or Remedial Expenses
- § 27.7.7, Intitutional Long-Term Care: Cost of Care Calculation: Medical or Remedial Expenses
- § 28.6.3.5, Home and Community-Based Waivers LTC: Groups and Cost Sharing: Medical/Remedial Expenses

Wis. Admin. Code § DHS 103.07(1)(d) (Jan. 2026), Special Situations of Institutionalized Persons: Computing Income Available Towards Cost of Care

Wis. Stat. § 49.455 (2023-24)

- § 49.455(4)(a) [Order of deductions from income]
- § 49.455(8)(d)3. [Mentions medical/remedial expenses in requiring IS to give all available income to CS before using a fair hearing to increase CSRA]

IRIS Policy Manual §§ 2.1A.1.1 & 2.1A.2.1, Medical/Remedial Expenses (Wis. DHS Oct. 2025)

42 C.F.R. §§ 435.726, 435.832 (2026), Post-eligibility treatment of income of individuals: Application of patient income to cost of care

42 U.S.C. § 1396a(r) (2026), Disregarding payments for certain medical expenses by institutionalized individuals

Forms referenced

These forms are appended to the materials. They can also be downloaded at https://www.elderlawwis.com/pro-toolkit/medical-remedial-expense/.

Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist

ELW Checklist: Medical or Remedial Expense Deduction

ELW Form Letter: To Client re Verification of Medical or Remedial Expense

ELW Form Letter: To Consortium Requesting Medical or Remedial Expense

ELW Form Letter: To Client re Paying Medical or Remedial Expense

ELW Form: Repayment Agreement for Medical or Remedial Expense

Fair hearing decisions referenced

These fair hearing decisions are appended to the materials. They can also be read or downloaded at https://www.elderlawwis.com/fair-hearing-decisions/.

The Repayment Agreement Saga:

- DHA Case No. MGE 207353 (Wis. Div. of Hearings and Appeals March 28, 2023) (DHS), Repayment agreement required for medical/remedial expense
- DHA Case No. MGE 207353 (Wis. Div. of Hearings and Appeals June 21, 2023) (Decision on Remand) (DHS), Decision on remand: Repayment agreement required for medical/remedial expense
- DHA Case No. MGE 208326 (Wis. Div. of Hearings and Appeals July 18, 2023) (DHS), Repayment agreement must promise periodic payments in particular amounts

DHA Case No. MGE 217939 (Wis. Div. Hearings and Appeals Jul. 3, 2025) (DHS), Unpaid patient liability is not a medical/remedial expense

DHA Case No. MGE 216220 (Wis. Div. Hearings and Appeals May 27, 2025) (DHS), Petitioner failed to use medical/remedial expense deduction to actually pay SNF bill

DHA Case No. MGE 211474 (Wis. Div. of Hearings and Appeals May 20, 2024) (DHS), IRIS Consultant Agencies must maintain eligibility, monitor and report medical/remedial expenses

DHA Case No. MGE 211383 (Wis. Div. of Hearings and Appeals March 28, 2024) (DHS), [In which the ALJ opines that new shoes might count as a medical/remedial expense with sufficient evidence]

DHA Case No. MGE 162960 (Wis. Div. of Hearings and Appeals March 6, 2015) (DHS), Retroactive designation of burial funds denied, spouse-paid health insurance not deducted

DHA Case No. MGE 210319 (Wis. Div. of Hearings and Appeals October 20, 2023) (DHS), [In which the ALJ notes that an overpayment might not qualify as a medical/remedial expense]

DHA Case No. MGE 207580 (Wis. Div. of Hearings and Appeals April 14, 2023) (DHS), [Primarily on other issues, but the ALJ ordered the agency to consider medical/remedial expenses for a $100/mo repayment plan submitted shortly before hearing]

DHA Case No. FCP 155113 (Wis. Div. of Hearings and Appeals May 14, 2014) (DHS), Overnight supervision allowed as a remedial expense in calculating cost share

Explanation

The medical or remedial expense deduction is used when calculating patient liability or cost share—the amount of monthly income an enrollee must pay towards her cost of care—for persons enrolled in Institutional MA or Community Waivers long-term care programs (Family Care and IRIS, mainly). (It can also factor into MAPP eligibility and premium calculations and meeting a Medicaid deductible, but those issues are not commonly addressed by Wisconsin elder law attorneys.) Essentially, if your client has a patient liability or cost share and also has an out-of-pocket medical bill, the State will reduce her patient liability or cost share so she can pay it.

What is a medical expense? A medical expense is nearly any item or service provided or prescribed by a licensed medical practitioner "for the diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body." Medicaid Eligibility Handbook (MEH) § 15.7.3. Common examples are doctor's bills, hospital bills, prescriptions, and over-the-counter medical supplies. Also note that medical expenses include the services of any licensed "medical practitioner," which could arguably include services such as chiropractors, massage therapists, and acupuncturists.

Health insurance premiums are technically medical expenses, but Wisconsin generally treats them separately.

What is a remedial expense? A remedial expense is nearly any out-of-pocket expense "for services or goods provided for the purpose of relieving, remedying, or reducing a medical or health condition." MEH § 15.7.3. Common examples include day care, home modifications for accessibility, respite care, and medical transportation. This can also include "program costs" charged by a CBRF, AFH, or RCAC *other than* room and board.

- DHA Case No. 211383 is an example of how difficult it is to pay even minimal expenses on the personal needs allowance (then $45/month). The ALJ in that case noted, by way of trying to help, that new shoes could perhaps qualify as a remedial expense if prescribed or needed to relieve a health condition.

- In DHA Case No. FCP 155113, the cost of overnight supervision—which was not a covered benefit under Family Care—was counted as a remedial expense. The main issue in this case was an important DHS policy: any item or service that *could* be covered by Family Care but is not included in the individual's care plan is not an allowable remedial expense, even if the individual chooses to buy it out-of-pocket.

Any medical or remedial expense must be:

- Out-of-pocket, not reimbursable by any other source;

- Owed by the member, not anyone else; and

- For the member, not for anyone else (even if the member is legally responsible for it).

See MEH § 27.7.7. For example, in DHA Case No. MGE 162960, health insurance provided through the community spouse's employer and paid by the community spouse was not a deductible expense. It was out-of-pocket and for the member, but it was owed by the member's spouse only.

Additionally, the medical or remedial expense **must be an expense that the member "has incurred, is actually paying, and is legally obligated to pay."** MEH § 27.7.7. In some cases, the State has used this language to insist that a member not only have a bill for the expense but also a signed repayment agreement for a specific monthly amount and a specific repayment period. (See below for further discussion of repayment agreements.)

The following expenses are specifically **not allowed** as medical/remedial expenses:

- Unpaid patient liability or cost share. MEH § 27.7.7.2. For example, in DHA Case No. MGE 217939 the petitioner owed a whopping $22,504 to a nursing home in unpaid patient liability, due entirely to his brother/POA's mismanagement (charitably) or perhaps theft. Despite the sympathetic circumstances, the ALJ could not make an exception to allow the petitioner to pay this outstanding bill from his income. The nursing home presumably went unpaid.

- Any expense incurred *as a result of a divestment penalty period*. See Example 6 in MEH § 27.7.7.2, in which a nursing home bill incurred during a divestment penalty period could not be used as a medical/remedial expense.

- Any expense that has previously been deducted as a medical/remedial expense. MEH § 27.7.7.2. In other words, you get one shot to actually pay the expense with

your reduced patient liability or cost share. This means it is essential that the client follows through on actually paying the expense. For an example of how this can go wrong, see DHA Case No. MGE 216220, where the petitioner failed to actually pay an $11,000 bill owed to a nursing home that was used to reduce her patient liability.

- Life insurance premiums (except premiums for a long-term care rider). *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist.
- Vehicle-related costs such as loan payments; insurance; gasoline; maintenance and repair; registration, license, and title fees; etc. (except a disability-related vehicle modification may count as a remedial expense). *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist.
- Housing and food costs (except for accessibility home modifications and exceptional energy or food costs incurred due to the member's medical condition). *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist.
- Expenses for items or services that only promote general health or wellbeing, or that were incurred for non-medical or non-remedial reasons. *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist.
- Expenses for which there is "neither evidence nor a reasonable basis for concluding the remedial effect will occur." *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist.
- Donations, including when dining with a group. *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist.
- Medicaid overpayments (currently, DHS has stopped pursuing overpayments altogether, so this is not likely to be an issue; but see DHA Case No. MGE 210319 for an example of how tricky it can be to actually pay an overpayment while maintaining Medicaid eligibility). MEH § 15.7.3.

Medical or remedial expenses **must be verified** to get the deduction, though the agency may not deny or terminate eligibility for a failure to verify them. MEH § 20.3.6. To verify a medical or remedial expense, you must document:

1. The amount of the expense,
2. The amount of any third party's liability, and
3. The date of the service.

MEH § 20.3.6. For Community Waivers programs, the care manager, ADRC staff, or IRIS consultant agency (ICA) may verify and calculate the expense instead of Income Maintenance (IM). *Id.* These programs use DHS Form F-00295, Medical and Remedial

Expenses Checklist, which is a useful reference for a detailed list of allowable and unallowable expenses. It is also worth noting that IRIS Consultant Agencies (ICAs) now have an ongoing responsibility to monitor and report a member's medical and remedial expenses. See DHA Case No. MGE 211474 for an example of this responsibility and how it can affect IRIS members.

In some cases, **the agency may also require a signed repayment agreement** to verify that the applicant or member "has incurred, is actually paying, and is legally obligated to pay" the expense. MEH § 27.7.7. The agency is most likely to insist on a repayment agreement if the expense is a large overdue bill from a facility. The agreement should be signed by the facility and the member, state the total amount owed, list the dates of service, state that the member owes it, provide a monthly payment amount, and provide a definite term for repayment.

- To learn vicariously about the need for a repayment agreement, see a series of fair hearing decisions I like to call The Repayment Agreement Saga:
    - In DHA Case No. MGE 207353 (March 28, 2023), the petitioner verified an outstanding balance of $7,252 with the nursing home, but the agency refused to allow a medical expense deduction without a signed repayment agreement showing a monthly payment amount and a starting and ending month for payments. Despite the argument that the consortium enforced this requirement irregularly and arbitrarily, the ALJ concluded it was reasonable for the agency to question whether a payment would actually be made and require evidence that an enforceable payment agreement actually exists.
    - The petitioner's attorney then asked for a rehearing and argued that requiring a repayment agreement violated federal law. In DHA Case No. MGE 207353 (June 21, 2023), the ALJ rejected these arguments and again found it reasonable for the agency to require verification "that the expense is being actually paid, not just owed."
    - Then, in DHA Case No. MGE 208326 (Jul. 18, 2023), the petitioner got a repayment agreement wherein the facility agreed to "accept a Medicaid Liability Diversion" but provided for no specific payments or payment period. Importantly, the agreement included no commitment by the petitioner to make any payment, in any amount or at any time. "The written agreement contains no reference to any action to be taken by the petitioner." Unsurprisingly, this didn't fly.
    - Why was this such an issue? I think it was a chicken-and-egg problem: How can you promise actual payment to a nursing home before the agency grants the deduction you need to actually pay it? As an attorney, I

understand the hesitancy to sign the client up for liability. And some facilities can get pretty unpleasant about collections.

    - The solution, I think, is a repayment agreement that promises payment only if and when the medical/remedial expense is granted. This should satisfy all requirements without risking more than the client actually gets.

- Hospitals will routinely allow individuals to establish repayment plans. See DHA Case No. MGE 207580 for a minor example of a $100/month repayment plan with a hospital being used to reduce patient liability.

Finally, note that **medical or remedial expenses are the lowest-priority income deduction**, after the personal needs allowance, any income allocation to the community spouse, court-ordered guardianship costs, and any of the other, less common deductions. See MEH §§ 27.7.1 (institutionalized) & 28.6.3 (Community Waivers) for the full order of deductions. See also Wis. Stat. § 49.455(4)(a), which gives any spousal income allocation priority over medical/remedial expenses. In practical terms, this means the medical/remedial expense deduction is only useful if the Medicaid member still owes a patient liability or cost share after all other available deductions. In some cases, the member will be able to allocate all of his or her income to the community spouse; in others, the member may not have a patient liability or cost share due to other deductions or qualifying for Group A. The medical or remedial expense deduction is not useful for those members.

How to use the medical/remedial expense deduction

The medical/remedial expense deduction is generally useful if:

A. Your client owes—or you expect your client to owe—a patient liability or cost share after all other income deductions and any income allocation for the community spouse; and

B. Your client has an allowable medical or remedial expense. Some of the most common expenses are: overdue facility bills (*not* incurred during a divestment penalty); bills for doctors, hospital stays, and ambulance rides; dentist and optometrist bills; prescriptions not covered by Medicaid or other insurance; incontinence supplies; and other medical supplies.

If the above conditions are met, I recommend following this checklist:

Preliminary check for eligibility

☐ The Medicaid member owes, or is expected to owe, a patient liability or cost share.

If there is no patient liability or cost share, a medical/remedial expense deduction will not help. This deduction is the lowest priority, after the personal needs allowance, health insurance premiums, any community spouse income allocation, and any other income deductions.

☐ The Medicaid member has an allowable medical or remedial expense.

See reverse for what is an allowable expense. An expense incurred as a result of a divestment penalty period is not allowed.

Checklist for verifying a medical/remedial expense

☐ Get basic information about the expense from the client:

Amount of the expense: _____

Who the expense was for: _____

When the expense was incurred: _____

☐ Document the expense.

This will usually be a copy of a bill or invoice, but it could also be a letter or other official document.

☐ Document shows exact amount of the expense
☐ Document shows the date of service or purchased item
☐ Document shows the amount any third party (insurance, usually) is liable for
☐ Document shows who the expense was incurred for

☐ If needed, get a repayment agreement.

The agency may or may not insist on a repayment agreement; you will need to learn the practice in your area. This is most likely to be needed if the expense is a large balance due from a nursing home, assisted living facility, or hospital.

☐ The agreement is signed by the institution and the client
☐ The agreement states the total amount to be repaid and a monthly payment amount
☐ The agreement states the anticipated repayment period

☐ Submit verification of the expense and any repayment agreement to the consortium with a cover letter requesting the medical/remedial expense deduction.

☐ Follow up with the consortium as needed to ensure the request is processed timely.

☐ After the deduction is approved, review the official notice for accuracy. Note when the reduction in patient liability or cost share will be effective (it should be the month following the mandatory 10-day minimum notice period).

☐ Instruct the client to use the reduced patient liability or cost share to actually pay the expense, starting the month the reduction is effective.

What is an allowable medical or remedial expense

Any medical or remedial expense must be (a) out-of-pocket, not reimbursable by insurance or any other source; (b) owed by the member, not anyone else; and (c) for the member, not for anyone else.

In general, a **medical expense** is any item or service provided or prescribed by a licensed medical practitioner for the diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body.

In general, a **remedial expense** is any item or service provided for the purpose of relieving, remedying, or reducing a medical or health condition.

Specific examples:

Health insurance, including premiums, deductibles, copayments, coinsurance, and long-term care riders on life insurance
Dental care, except for services only intended to approve appearance
Vision care, including eye exams, prescription glasses/sunglasses, contact lenses, and contact lens cleaning supplies
Prescription drugs, including prescribed over-the-counter drugs and supplements, not covered by Medicaid, other health insurance, or any other third party
Over-the-counter medical supplies, disposable or reusable, including incontinence supplies, skin care products, rubbing alcohol, antiseptics, bandages, enema apparatus and kits, hydrogen peroxide, lemon or glycerin swabs, lubricating jellies, tinctures of benzoin, cotton balls and applicators, gloves, catheters, syringes and needles, irrigation solutions, stoma care products, tracheotomy care components, tube feeding components, tongue depressors, bedpans, thermometers, rubber pants, etc.
Program costs charged by a CBRF, AFH, or RCAC, other than room and board
Case management services
Day care and respite care services
Supportive home care services needed to meet daily living needs, ensure adequate functioning in the home, and safely access the community, including assistance with ADLs, attendant care and supervision, reporting changes in the member's condition, assistance with medication and self-administered medical procedures, extension of therapy services, ambulation and exercise, and essential household chores (lawn care, snow removal, cleaning, changing storm or screen windows, etc.)
Home modifications for accessibility needed because of a medical condition or disability, but only to the extent the cost exceeds any increase in the home's value
Vehicle modifications needed because of a medical condition or disability
Medical and community transportation, except transportation that is purely for recreational or diversional purposes
Nutritional products needed because of a medical condition or functional limitation
Exceptional food costs incurred because of a medical condition, but only to the extent they exceed the cost of a normal diet
Exceptional energy costs incurred because of a medical condition, but only to the extent they exceed typical energy costs and only to the extent the member's calculated maintenance needs allowance exceeds the maximum permitted
Phone and electronics, including equipment and service, needed for the operation of a personal emergency response system, medication monitoring device, or other remote monitoring technologies, but only to the extent not in prior use or for personal use
Housing and board costs of a live-in attendant paid out-of-pocket, but housing costs only to the extent the member's calculated maintenance needs allowance exceeds the maximum permitted

Specific exclusions:

Any expense **incurred as a result of a divestment penalty period**
Any **unpaid patient liability or cost share**

Any expense that has **previously been deducted as a medical/remedial expense** (you get only one shot)
Any **unverified** expense
Any expense that was **previously used to meet a Medicaid deductible**
Medicaid **overpayments**

Also note

- The federal law that requires states to deduct medical or remedial expenses allows them to impose "reasonable limits … on amounts of these expenses." 42 U.S.C. § 1396a(r) (2026), 42 C.F.R. §§ 435.726, 435.832 (2026). Wisconsin has no official policy imposing any limits to date. Whether the State could impose limits on a case-by-case basis is, to my knowledge, an open question.
- If enrolled in a Community Waivers program (Family Care, IRIS, Partnership, or PACE) and the service or item is potentially coverable by the program, you must first receive a denial of coverage from the program before using it as a medical/remedial expense. *See* Wis. DHS Form F-00295, Medical and Remedial Expenses Checklist; DHA Case No. FCP 155113 (Wis. Div. of Hearings and Appeals May 14, 2014) (DHS).
- For IRIS participants, the IRIS Policy Manual notes a difference in what is an allowable medical/remedial expense for Group B and Group B Plus.
    - Group B: "When determining the person's monthly total amount of medical/remedial expenses for Group B financial eligibility, only those allowable expenses that are both incurred and paid by the applicant can be counted. Items or services that were bought for someone else (a spouse, child, etc.) or paid for by another person, or by the IRIS program, the Medicaid card, a private health plan or any other program are not counted. This differs from expenses allowed for Group B+ financial eligibility calculations … ."
    - Group B+: "Allowable medical/remedial expenses for Group B+ include out-of-pocket medical/remedial expenses, as defined in Group B above, and may also include the costs of any planned services that would otherwise be funded by the IRIS program."
    - I believe this means Group B+ members can use the medical/remedial expense deduction for future, planned services while Group B members cannot. But the exact difference is not clear to me from the language in the policy manual. *See* IRIS Policy Manual §§ 2.1A.1.1 & 2.1A.2.1, Medical/Remedial Expenses (Wis. DHS Oct. 2025).
- When seeking to increase the community spouse resource allowance through a fair hearing under Wis. Stat. § 49.455(8)(d) (to compensate for the community

spouse's income being below the minimum monthly maintenance needs allowance), Wis. Stat § 49.455(8)(d)3. imposes a condition: the institutionalized spouse must first allocate as much as possible of his or her income to the community spouse, *except* for amounts equal to the personal needs allowance, any family allowances, and any medical or remedial expenses.

Appendix: Forms and Fair Hearing Decisions

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00295 (01/2018)

ME

MEDICAL AND REMEDIAL EXPENSES CHECKLIST FOR MEDICAID LONG-TERM CARE WAIVER PROGRAMS

Name – Member/Participant

PURPOSE: This form is used to determine any medical and remedial expenses that can be used to reduce a cost share. A cost share is the monthly amount you must pay to get long-term care services through Medicaid. This includes the following Medicaid long-term care programs: Family Care, Family Care Partnership, PACE (Program of All-Inclusive Care for the Elderly), and IRIS (Include, Respect, I Self-Direct).

INSTRUCTIONS: Using the criteria below, the aging and disability resource center counselor, care manager, or IRIS consultant working with you (the program applicant or participant) determine if you have any expenses that can be counted as a medical or remedial expense. Then the agency staff person enters the amount of the expense in the correct category below to determine all expenses. Once completed, both you and the agency staff person sign the form and the staff person submits it to the income maintenance agency.

STEP 1: Determine if your expense can be counted as a medical or remedial expense. A list of what cannot be counted is listed on the last page of this form.

To be counted as a medical or remedial expense a service or item must meet the following criteria**:**

1. The service or item must meet the definition of a medical or remedial expense.
   - A **medical expense** means a licensed medical practitioner provided or prescribed an item or service for you to:
     - Prevent, diagnose, treat, or cure a disease or injury.
     - Treat an affected part of your body.
   - A **remedial expense** means it helps you relieve, remedy, or reduce a medical or health condition.
2. You must be legally liable for the expense and paying for it out-of-pocket during the time you are getting benefits. You must verify that you are making payments.
3. Another source will not pay or pay back the expense. Examples of other sources include: Medicaid (Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party.
4. If the service or item is coverable by the program you must have received a denial from the program (Family Care, Partnership, PACE, or IRIS) for the out-of-pocket purchase.

STEP 2: If the service or item meets the requirements listed above, fill in the dollar amounts below for each expense.

$	**Health Insurance** Include any expenses for deductibles, copayments, coinsurance, including services covered by Medicaid, Medicare, or any other public or private health insurance. Do not count any cost share required for this program.
$	**Unpaid Medical/Remedial Bills** Payments for unpaid bills for medical or countable remedial services/items received by you that you are liable for and that are not paid for by any other source.
$	**Dental Care** For services not covered for you by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party payer. Services which are only intended to improve your appearance may not be counted.
$	**Vision Care** Products and services for you including eye exams, prescription eyeglasses, prescription sunglasses, contact lenses, and contact lens cleaning supplies. Count only to the extent the expense is not paid for by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party.
$	**Prescription Drugs** For drugs not covered for you by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party.
$	**Over-the-Counter (OTC) Disposable or Reusable Medical Supplies** For supplies not covered for you by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party. Examples: Skin care products; rubbing alcohol, antiseptics and antiseptic swabs; bandages; enema apparatus and kits; hydrogen peroxide; lemon or glycerin swabs; lubricating jellies; tincture of

	benzoin; cotton balls and applicators; gloves; incontinence supplies, adult diapers, and underpads; catheters, catheter sets, and components; syringes and needles; irrigation solutions; stoma care products; tracheotomy care components; tube feeding components; tongue depressors; reusable supplies (e.g., bedpans, thermometers, rubber pants, etc.).
$	**Prescribed OTC Drugs** For those not covered for you by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party. Examples: Internal and external painkillers (such as aspirin, acetaminophen, ibuprofen, naproxen); cold, cough and allergy products; gastrointestinal products; topical skin products; eye care products; other prescribed OTC drugs. OTC drugs have a National Drug Code (NDC).
$	**Prescribed OTC Supplements** If the supplement is not covered by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party. Examples: Vitamins and minerals; herbs and other botanicals; enzymes; amino acids; other dietary substances. Products are labeled as supplements, not drugs.
$	Expenses to acquire or maintain a **trained service animal** needed by you due to a medical condition or disability and not covered by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party. Allowable expenses include the cost of the animal, food, equipment needed for the animal to perform its function, veterinary services, and prescribed medications.
$	**Home modifications** due to a medical condition or disability that make the home more accessible or usable, not covered by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party, but only to the extent the cost exceeds any increase in the value of the home.
$	**Vehicle modifications** due to a medical condition or disability necessary to make the vehicle usable for you, when not paid for by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party.
$	**Exceptional food costs** paid by you while living in a private residence which are incurred due to a medical condition, but only to the extent costs exceed the cost of a normal diet.
$	**Exceptional energy costs** paid by you while living in a private residence which are incurred due to a medical condition, but only to the extent the costs exceed typical energy costs. Exceptional energy costs are countable only to the extent your calculated maintenance needs allowance exceeds the maximum permitted.
$	**Board costs of a live-in attendant** paid by you. In addition, the housing costs of a live-in attendant paid by you, but only to the extent your calculated maintenance needs allowance exceeds the maximum permitted.
$	**Nutritional products** such as Ensure, Boost, etc. to provide extra calories and nutrients when the need is related to a medical condition or functional limitation, if the expenses are not otherwise included in exceptional food costs above. The cost must be paid by you and not by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party.
$	**Phone and Electronics** The cost of landline or cellular telephone equipment and/or service, or other electronic devices and service costs when not in prior use which are necessary for the operation of a personal emergency response system (PERS), medication monitoring device, or other remote monitoring technologies. If such devices will also be for personal use, only a reasonable share of the cost is countable. The costs must be paid by you and not by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party.
$	The cost of **medical and community transportation** for yourself, with the exception of transportation that is purely for recreational or diversional purposes, and which is paid by you and not by Medicaid (including Family Care, Partnership, PACE, or IRIS), Medicare, private health insurance, another public program, or any other third party. The service must be denied by the program for your purchase to be countable.
$	**Subtotal**

The cost of any other item or service coverable by Medicaid (including by Family Care, Partnership, PACE or IRIS), but you were denied by the program for, or purchased because the item or service is covered in an amount, duration, or scope less than requested, when paid by yourself and not by Medicare, private health insurance, another public program, or any other third party.

$	Description:
$	Description:
$	Description:
$	Description:
$	Description:

OTHER MEDICAL OR REMEDIAL EXPENSES NOT COVERED ABOVE

$	Description:
$	Description:
$	Description:
$	Description:
$	**TOTAL MONTHLY MEDICAL AND REMEDIAL EXPENSES**

STEP 3: Sign and date the form. The ADRC counselor, care manager, or IRIS consultant who helped you fill out this form must also provide his or her signature and date. That staff person will share the information with your local agency that determines your cost share.

I hereby certify that the information given is accurate to the best of my knowledge. I understand that I may be required to present records and documents to support the figures given.

SIGNATURE – Member/Participant	Date Signed
SIGNATURE – Staff	Date Signed

MEDICAL AND REMEDIAL EXPENSES THAT CANNOT BE COUNTED

The following items or services are not countable as medical and remedial expense deductions for reducing a cost share:

1. Unpaid bills previously used to meet a deductible for getting Medicaid.
2. Bills for the cost of institutional care received during a Medicaid divestment penalty period.
3. Bills representing a patient liability amount or a cost share incurred, but not paid, for a prior period of Medicaid-covered institutional care or enrollment in Family Care, IRIS, or a legacy waiver program.
4. Medical bills that will be paid by a legally liable third party, such Medicare, Medicaid, or private health insurance.
5. Bills that were previously allowed as a medical and remedial expense and used to reduce a Family Care, IRIS, or legacy waiver program cost share or nursing home patient liability amount.
6. Expenses that are not verified.
7. Expenses for medical and remedial services received by another person, even if the applicant or member is legally responsible for the expense.
8. Premiums for a life insurance policy, except that premiums for a long-term care rider to the policy may be counted as a health insurance premium expense.
9. Vehicle-related costs, except for a countable vehicle modification. Not countable are: vehicle loan payments; insurance costs; operating, maintenance and repair expenses; fees for registration, license, title, etc.
10. Housing or room and board expenses, unless one of the specific exceptions for member-paid home modifications or exceptional energy or food costs apply.
11. Donations the person makes, including at group dining sites.
12. Expenses for items or services that promote general health or well-being or would have been incurred for non-remedial or non-medical reasons.
13. Expenses for which there is neither evidence nor a reasonable basis for concluding the remedial effect will occur.
14. Health insurance premiums, including for Medicare or other public or private health insurance. (NOTE: Health insurance premiums are separately deducted from income in calculating cost share. Therefore they are not counted in the category of medical and remedial expenses.) However, any health insurance premiums that are not separately deducted are a countable medical and remedial expense.

Checklist: Medical or Remedial Expense Deduction

Preliminary check for eligibility

☐ The Medicaid member owes, or is expected to owe, a patient liability or cost share.

If there is no patient liability or cost share, a medical/remedial expense deduction will not help. This deduction is the lowest priority, after the personal needs allowance, health insurance premiums, any community spouse income allocation, and any other income deductions.

☐ The Medicaid member has an allowable medical or remedial expense.

See reverse for what is an allowable expense. An expense incurred as a result of a divestment penalty period is not allowed.

Checklist for verifying a medical/remedial expense

☐ Get basic information about the expense from the client:

Amount of the expense: _____

Who the expense was for: _____

When the expense was incurred: _____

☐ Document the expense.

This will usually be a copy of a bill or invoice, but it could also be a letter or other official document.

- ☐ Document shows exact amount of the expense
- ☐ Document shows the date of service or purchased item
- ☐ Document shows the amount any third party (insurance, usually) is liable for
- ☐ Document shows who the expense was incurred for

☐ If needed, get a repayment agreement.

The agency may or may not insist on a repayment agreement; you will need to learn the practice in your area. This is most likely to be needed if the expense is a large balance due from a nursing home, assisted living facility, or hospital.

- ☐ The agreement is signed by the institution and the client
- ☐ The agreement states the total amount to be repaid and a monthly payment amount
- ☐ The agreement states the anticipated repayment period

☐ Submit verification of the expense and any repayment agreement to the consortium with a cover letter requesting the medical/remedial expense deduction.

☐ Follow up with the consortium as needed to ensure the request is processed timely.

☐ After the deduction is approved, review the official notice for accuracy. Note when the reduction in patient liability or cost share will be effective (it should be the month following the mandatory 10-day minimum notice period).

☐ Instruct the client to use the reduced patient liability or cost share to actually pay the expense, starting the month the reduction is effective.

Checklist: Medical or Remedial Expense Deduction

What is an allowable medical or remedial expense

Any medical or remedial expense must be (a) out-of-pocket, not reimbursable by insurance or any other source; (b) owed by the member, not anyone else; and (c) for the member, not for anyone else.

In general, a **medical expense** is any item or service provided or prescribed by a licensed medical practitioner for the diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body.

In general, a **remedial expense** is any item or service provided for the purpose of relieving, remedying, or reducing a medical or health condition.

Specific examples:

Health insurance, including premiums, deductibles, copayments, coinsurance, and long-term care riders on life insurance
Dental care, except for services only intended to approve appearance
Vision care, including eye exams, prescription glasses/sunglasses, contact lenses, and contact lens cleaning supplies
Prescription drugs, including prescribed over-the-counter drugs and supplements, not covered by Medicaid, other health insurance, or any other third party
Over-the-counter medical supplies, disposable or reusable, including incontinence supplies, skin care products, rubbing alcohol, antiseptics, bandages, enema apparatus and kits, hydrogen peroxide, lemon or glycerin swabs, lubricating jellies, tinctures of benzoin, cotton balls and applicators, gloves, catheters, syringes and needles, irrigation solutions, stoma care products, tracheotomy care components, tube feeding components, tongue depressors, bedpans, thermometers, rubber pants, etc.
Program costs charged by a CBRF, AFH, or RCAC, other than room and board
Case management services
Day care and respite care services
Supportive home care services needed to meet daily living needs, ensure adequate functioning in the home, and safely access the community, including assistance with ADLs, attendant care and supervision, reporting changes in the member's condition, assistance with medication and self-administered medical procedures, extension of therapy services, ambulation and exercise, and essential household chores (lawn care, snow removal, cleaning, changing storm or screen windows, etc.)
Home modifications for accessibility needed because of a medical condition or disability, but only to the extent the cost exceeds any increase in the home's value
Vehicle modifications needed because of a medical condition or disability
Medical and community transportation, except transportation that is purely for recreational or diversional purposes
Nutritional products needed because of a medical condition or functional limitation
Exceptional food costs incurred because of a medical condition, but only to the extent they exceed the cost of a normal diet
Exceptional energy costs incurred because of a medical condition, but only to the extent they exceed typical energy costs and only to the extent the member's calculated maintenance needs allowance exceeds the maximum permitted
Phone and electronics, including equipment and service, needed for the operation of a personal emergency response system, medication monitoring device, or other remote monitoring technologies, but only to the extent not in prior use or for personal use
Housing and board costs of a live-in attendant paid out-of-pocket, but housing costs only to the extent the member's calculated maintenance needs allowance exceeds the maximum permitted

Specific exclusions:

Any expense **incurred as a result of a divestment penalty period**
Any **unpaid patient liability or cost share**
Any expense that has **previously been deducted as a medical/remedial expense** (you get only one shot)
Any **unverified** expense
Any expense that was **previously used to meet a Medicaid deductible**
Medicaid **overpayments**

January 16, 2026

Addressee name
Address1
Address2

Re: How to document your medical/remedial expense

Dear ____:

You have a bill for ___ that needs to be paid. Thankfully, the Wisconsin Medicaid program will allow you to pay it if we verify it as a medical or remedial expense.

To do that, you must get a document from ____ verifying the expense. This document should be an invoice or bill, or if those are not available for some reason, an informational letter on official letterhead. **This document must show all of the following:**

A. The exact amount of the expense;
B. The date of the service or purchased item;
C. The amount paid by any insurance or other third party, if anything; and
D. Who the expense was incurred for (in other words, it should indicate in some way that the service or item was for [the person enrolled in Medicaid]).

If you already have an invoice or bill meeting these requirements, please send it to me. If not, I recommend calling ___'s billing office at [phone number] or requesting the document in person. Bring this letter with you for reference and make sure the document meets all of the above requirements. If you run into any problems or have questions about how to do this, call my office at [phone number].

Once you have the document, please drop it off at my office in person, fax it to [fax number], email a scanned copy to [email address], or mail it to us at [mailing address]. I will then submit it to the consortium and request the deduction.

Once the consortium approves the deduction, your [patient liability / cost share] will be temporarily reduced so you can keep more of your income each month. You must use that income to pay the bill for ___. I will contact you with more detailed instructions after the deduction is approved.

Best regards,

Atty. Name

January 16, 2026

Addressee name
Address1
Address2

Re: MA Case No. _____, medical/remedial expense

Dear ___ Consortium:

Enclosed is verification of a medical/remedial expense under Medicaid Eligibility Handbook §§ 15.7.3, 20.3.6, and 27.7.7.

Please note:

- The total amount of the expense is $____.
- Based on the current [patient liability / cost share], we expect a deduction of $____ for [number] months to allow us to pay the expense in full.
- [If you think the consortium might dispute that this is an allowable medical/remedial expense, include a brief argument here citing to MEH §§ 15.7.3, 20.3.6, 27.7.7, and any relevant fair hearing decisions.]

Best regards,

Atty. Name

January 16, 2026

Addressee name
Address1
Address2

Re: You can now pay your medical/remedial expense

Dear ____:

We recently asked the consortium for a medical/remedial expense deduction to allow you to pay your bill for ___. That deduction has now been approved and now you can actually pay the bill.

Here's what you need to know:

- Your [patient liability / cost share] will be reduced by $____ starting [month, year].
- Starting [month, year] you must pay the $____ each month towards your bill for ___ until it is fully paid. You should not use this money for anything else or allow it to accumulate in your account. If you do not actually pay the bill, there may be no money to pay it in the future.
- Once enough time has passed to fully pay the bill, your [patient liability / cost share] will go up again.

If you have any questions or concerns, please let me know.

Best regards,

Atty. Name

Repayment Agreement

The parties, _____ (Patient) and _____ (Facility), agree to the following repayment plan:

A. Patient currently owes an outstanding balance of $_____ to Facility for services from [start date] to [end date].
B. Facility will provide Patient with an invoice, bill, statement, or other official document that shows the exact amount of the outstanding balance, the dates of service, the amount paid by any insurance or other third party (if anything), and that the services were incurred for Patient.
C. Patient will then request a medical or remedial expense deduction from the Wisconsin Medicaid program to allow Patient to pay the outstanding balance.
D. Beginning the month the medical/remedial expense deduction becomes effective, Patient will pay the amount of the allowed deduction (expected to be $_____) to Facility until the outstanding balance is paid or the medical/remedial expense deduction ends, whichever occurs first.
E. The parties expect the term of repayment to be approximately [month, year] to [month, year], but recognize that this may change due to errors and delays caused by the Wisconsin Medicaid program, fluctuations in income, or other factors beyond the control of the parties.

Signature of Patient:	Signature of Facility:
Dated: _____	Dated: _____
Signed: _____	Signed: _____
[Name]	[Name, Title]

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

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

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]

FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION ON REMAND
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. On March 28, 2023, a Decision was issued. On April 17, 2023, the Division received petitioner's request for fair hearing (MGE 208326). On May 3, 2023, petitioner filed its Amended Request for Rehearing asking that its April 17, 2023 request be treated as a request for rehearing in this matter, based on an assertion of material error of law, in addition to its request, filed the same day, for a new hearing (MGE 208326). On May 17, 2023, the rehearing request was granted. On May 31, 2023 the rehearing was convened, by telephone. This Decision on Remand replaces in its entirety the final Decision previously issued on March 28, 2023.

The issue for determination is whether the agency correctly required verification of payment of a medical expense in order to apply it to reduce to the institutionalized person'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. 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. Petitioner failed to provide any evidence of an agreement or obligation to pay the medical expense in any particular amount or by any particular date.
9. 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 payments will actually be made to correspond to the monthly patient liability deduction requested.

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 Sec. 27.7.7.1 as prior to allowing the deduction we must verify that the expense is being actually paid, not just owed.'

At hearing, petitioner maintained that it had met the requirements in the Medicaid Handbook Sec. 27.7.7.1 that "(t)he institutionalized person must provide verification of the allowable expense." Petitioner's position was that it is sufficient to provide proof that the medical expense was incurred and that no legally liable third party is responsible for the expense. Those facts were not in dispute. The dispute was that the agency took the position that it must verify that the incurred expense had been, was being or would be actually paid by the petitioner while petitioner's position was that "actual payment" meant that "no one else will be paying the bill."

The Decision issued following the hearing on March 1, 2023 dismissed the appeal based on findings that the agency's medical expense deduction verification requirement was consistent with its Medicaid Handbook. On rehearing, the petitioner asserted that the agency's verification requirement in its Medicaid Handbook and as imposed by the agency representative, Nathaniel Wissell, is prohibited by relevant federal law.

At rehearing, petitioner did not present authority for an express prohibition of verification of actual payment or for the idea that "actual payment" means that there is no legally liable third party. The petitioner's legal argument at rehearing, presented orally and contained in its May 12, 2023 submission, is that federal law prohibits the agency from verifying that the incurred expense is actually paid.

Federal statute regarding the medical expense deduction from patient liability cited by petitioner provides that incurred expenses for medical or remedial care without a third party legally liable for payment "shall be taken into account" (42 USC Sec. 396(a)(r)(l)(A)). This is not disputed. It states that these deductions are "subject to reasonable limits the state may establish on the amount of these expenses." Id. In this case, there is no dispute about the total incurred expense. The agency does not seek to limit the amount.

Petitioner further cites 42 CFR Sec. 435.725 regarding the rules regarding determination of medical expenses, addressing methods for projecting medical expenses. 43 CFR Sec. 435.725 (f). This is not relevant to the current dispute. The medical expense in this is not being projected. It has been incurred and the amount is not in dispute. Petitioner cites Wisconsin Admin. Code Sec. DHS 103.07(1)(d) for the idea that necessary medical or remedial care expense is included in calculation of cost of care. This is not disputed.

The law relevant to the dispute in this case is the definitions of "medical expense" and "remedial expense" in Wis. Admin. Code Sec. DHS 101.03. "'Medical expense' means a cost paid by a Medicaid purchase plan recipient for goods or services that have been prescribed or provided by a medical practitioner licensed in Wisconsin or another state. The cost is not reimbursable by another source such as Medicare, medical assistance, private insurance, or an employer." Wis. Admin. Code DHS Sec. 101.03(94r). The definition for "remedial expense" similarly requires that the cost be "paid". Wis. Admin. Code Sec. DHS 101.03(152m).

These definitions are consistent with the agency's position that there is a requirement for actual payment. There is nothing in these definitions that prohibits verification of the fact that the expense has been, is being or will be paid. No federal law prohibits the agency from requiring verification that the expense is or will be paid. There is no law cited by petitioner that prohibits the agency from requiring a written repayment agreement or similar evidence of obligation to make payments, and to vary the specific verification requirement on a case-by-case basis. No proof of a monthly payment obligation corresponding to the requested monthly deduction was offered. No explanation was offered for petitioner's inability or refusal to provide such an agreement and petitioner did not show that the request was unreasonable or unduly burdensome.

The petitioner failed to show that the agency's Medicaid Handbook, or its interpretation of that Handbook, is in any way inconsistent with relevant federal law. It is reasonable and permissible for the agency to require evidence that an enforceable payment agreement actually exists between petitioner and the creditor in order to determine that the relevant medical expense meets the definition of being "paid" included in the definition of medical expense in Wis. Admin. Code 101.03(94r), before applying it as a deduction to patient liability for the period of time requested.

CONCLUSIONS OF LAW

The agency acted within its authority under its Medical Handbook and all relevant Wisconsin and federal law in refusing to apply deductions to monthly patient liability in the amounts requested, without evidence of obligation to make corresponding payment toward the incurred medical expense.

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 21st day of June, 2023

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

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on June 21, 2023.

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

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

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-7709
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

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]

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 217939

PRELIMINARY RECITALS

Pursuant to a petition filed on April 18, 2025, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the La Crosse County Department of Human Services regarding Medical Assistance (MA), a hearing was held on June 4, 2025, by telephone.

The issue for determination is whether Petitioner is eligible for a reduction of his monthly patient liability to allow him to repay unpaid prior patient liability amounts.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Dana Lee
La Crosse County Department of Human Services
300 N. 4th Street
PO Box 4002
La Crosse, WI 54601

ADMINISTRATIVE LAW JUDGE:
Teresa A. Perez
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of La Crosse County who has resided at [redacted], a skilled nursing facility, since at least July 1, 2024.

2. Petitioner has been eligible for Institutional Medical Assistance since July 1, 2024.

3. Petitioner's brother, [redacted], was Petitioner's financial power of attorney from at least July 1, 2024 through March 2025. Throughout that time period, Petitioner had a patient liability that his brother paid only a portion of. His brother has since been criminally charged in connection with his expenditure of Petitioner's funds.

4. By April 8, 2025, Petitioner owed $22,504.56 to [redacted] as a result of his brother's failure to fully pay Petitioner's monthly patient liability amount from July 1, 2024 through March 2025.

5. [redacted], in its capacity as representative for Petitioner, requested the local income maintenance consortium to reduce Petitioner's patient liability so that Petitioner could afford to enter into a payment plan to reduce his outstanding balance.

6. The agency denied the request to reduce Petitioner's patient liability because Medical Assistance program policy prohibits unpaid patient liability amounts to be used as a deductible medical expense when calculating a Medical Assistance recipient's current patient liability.

7. Petitioner filed an appeal of the agency's denial of his request to reduce his patient liability.

DISCUSSION

Institutionalized individuals who receive Medicaid must generally pay a "cost of care" each month. This amount is referred to as a patient liability. See *Medicaid Eligibility Handbook* §27.7.1.

The following amounts may be subtracted from an individual's income when calculating the patient liability.

1. $65 and ½ earned income disregard
2. Monthly cost for health insurance
3. Support payments
4. Personal needs allowance (typically $45 per month)
5. Home maintenance costs, if applicable
6. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees
7. Medical or remedial expenses.

Id. at 27.7.1.

Petitioner's representative, the nursing facility where he resides, did not dispute the agency's calculation of Petitioner's past monthly patient liability; rather, they asked for an exception to be made given Petitioner's unfortunate circumstances. I understand the rationale for that request. Petitioner was the victim of, at best, mismanagement of his funds and, at worst, theft. As a result, the nursing facility has not been fully compensated for the care they have provided Petitioner.

However, the agency correctly observed that Medicaid program policy explicitly prohibits the following type of expense to be used as a deduction when calculating a Medicaid recipient's current patient liability: "a patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period." *Id.* at 27.7.7.2. The policy

provides no exception and Petitioner did not point to any legal authority to support his request to reduce his patient liability.

As an administrative law judge, I must apply the relevant legal authority as written and reasonably interpreted and have no discretion to grant exceptions or to fashion equitable remedies, which is what Petitioner seeks here.

CONCLUSIONS OF LAW

The agency correctly denied Petitioner's request to reduce his monthly patient liability to allow him to repay unpaid prior patient liability amounts.

THEREFORE, it is **ORDERED**

That Petitioner's appeal 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.

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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 3rd day of July, 2025

\s_____
Teresa A. Perez
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-7709
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on July 3, 2025.

La Crosse County Department of Human Services
Division of Health Care Access and Accountability

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 216220

PRELIMINARY RECITALS

Pursuant to a petition filed on December 11, 2024, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Door County Department of Social Services regarding Medical Assistance (MA), a hearing was held on April 17, 2025, by telephone. At the request of the Petitioner's representative, the hearing was rescheduled from January 23, 2025; February 20, 2025; March 5; 2025; March 11, 2025; and April 2, 2025.

The issue for determination is whether the agency correctly determined the Petitioner's 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: Jessica Ingersoll
Door County Department of Social Services
Door County Government Center
421 Nebraska Street
Sturgeon Bay, WI 54235-0670

ADMINISTRATIVE LAW JUDGE:
Jason M. Grace
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Door County.

2. The Petitioner was enrolled in Nursing Home Long Term Care-MA as of February 2024.

3. On August 28, 2024, the agency set the Petitioner a notice containing the following information:

> When you enrolled in Medicaid, we were able to use a portion of the balance owed to [redacted] nursing home (June and July 2023, prior to the divestment period, $11,340) to decrease your patient lability to zero. Your portion of the cost of care for Medicaid is $1239 per month at this time. That cost is decreased to zero, until the $11,340 is reduced to zero. The freed up patient liability ($1239) funds are meant to be given to the nursing home, to decrease the bill for that time frame so that it can get to zero. Per discussion with [redacted] you owe $44,000 and no payment have been made. We also reviewed you bill with [redacted] and you owe a balance of $25081.48, with no payments being made. We will need to verify how you have been spending your social security income for the time period from 8/1/23 to 7/3/24, as you should have been giving at least the equivalent of your patient liability (1239) to the nursing home to pay down the balance owed.
>
> When someone resides in a nursing home and they express intent to return home, they are allowed a 6 month period where expenses such as rent or mortgage, tax., WPS, etc. are allowed as a deduction form countable income, to decrease patient liability for Medicaid. This period was allowed from Feb 2024-July 2024. Going forward, there is no deduction to maintain the home. Those expenses will not be allowable from your funds going forward. Again, you will need to provide detailed and chronological receipts to verify how her funds have been being spent down from 8/1/23-7/31/24. The receipts you provided previously are not all for the time period in question, do not all verify as paid and are not in order.
>
> …

4. The Petitioner had no patient liability for February 2024 through November 2024.

5. On November 19, 2024, notice was issued to the Petitioner that indicated her patient liability for December 2024 was $454.16. This was based on income from social security in the amount of $1,284 and medical/remedial bills of $774.84 for December 2024.

6. On December 9, 2024, notice was issued to the Petitioner that her monthly patient liability had increased to $1,261.00 as of January 1, 2025, as her social security income increased to $1,316.00.

7. The Petitioner appealed her patient liability.

DISCUSSION

After an institutionalized person is determined eligible for MA, a county 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. This is referred to as the person's "patient liability." The calculation begins with gross income, and only a few items may be subtracted as deductions. These include the statutory $55 personal needs allowance deduction, necessary medical or remedial care expense deduction, a health insurance expense deduction and, in some cases, a home maintenance deduction. Wis. Admin. Code §DHS 103.07(1)(d). The formula for calculating the patient liability amount is set out at Medicaid Eligibility Handbook (MEH), §27.7, found online at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm#t=policy_files%2F27%2F27.7.htm.

> Calculate the cost of care in the following way:
>
> 1. For a Medicaid member in a medical institution who does not have a community spouse, subtract the following from the person's monthly income:
>
> a. $65 and ½ earned income disregard (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).
>
> b. Monthly cost for health insurance (see SECTION 27.6.4 HEALTH INSURANCE).
>
> c. Support payments (see SECTION 15.7.2.1 SUPPORT PAYMENTS).
>
> d. Personal needs allowance (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES)
>
> e. Home maintenance costs, if applicable (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT).
>
> f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (see SECTION 27.6.6 FEES TO GUARDIANS OR ATTORNEYS).
>
> g. Medical or remedial expenses (see SECTION 27.7.7 MEDICAL OR REMEDIAL EXPENSES AND PAYMENTS FOR NONCOVERED SERVICES).
>
> …
>
> If the cost of care amount is equal to or more than the medical institution's Medicaid rate, the individual is responsible for the entire cost of his or her institutional care. He or she would be entitled to keep any overage without restriction. He or she would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

MEH §27.7.1. The personal needs allowance is $55.00. MEH, § 39.4.3.

There is no evidence in the record that the Petitioner has earned income, monthly health insurance costs, support payments, or any expenses associated with a court-ordered guardianship or protective placement. The record does indicate that she had medical/remedial expenses from unpaid nursing home stay prior to enrolling in Nursing Home Long Term Care-MA. See MEH, §§ 27.7.7.1 and 27.7.7.2. A monthly deduction for that expense helped reduce her patient liability to $0.00 for the months of February 2024 through November 2024.

In determining the Petitioner's December 2024 patient liability, it was found that she had social security income of $1,284.00. The agency provided a person needs allowance deduction of $55.00 and the remaining portion of the nursing home expense of $774.84 as a medical/remedial expense deduction. This resulted in a December 2024 patient liability of $454.16. The agency also found that the Petitioner's patient liability would increase to $1,261.00 as of January 2025. Her social security income increased to $1,316.00 in January 2025, and the only deduction she qualified for is the personal needs allowance of $55.00. The record supports the agency's patient liability determinations.

At hearing, the Petitioner's representative argued that a home maintenance deduction should be applied as the Petitioner plans on returning to her home. MEH§ 27.7.1 indicates that the cost of home maintenance is to be deducted from the patient liability under the following circumstances:

> If a person residing in a medical institution (see SECTION 27.1.1 INSTITUTIONS INTRODUCTION) has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from their income to allow for maintaining the home, apartment, or room at the assisted living facility that does not exceed the Institutions Home Maintenance Allowance Maximum (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES). The amount is in addition to the $55 personal needs allowance. It should be enough for mortgage, rent, property taxes (including special assessments), home or renters' insurance, utilities (heat, water, sewer, electricity), and other incidental costs. If the member was residing at an assisted living facility prior to institutionalization, use the facility's room and board rate, up to the maximum, for the home maintenance deduction.
>
> Make the deduction only when both the following conditions are met:
>
> - A physician provides a statement (verbally or in writing) certifying that the person is likely to return to the home or apartment within six months.
> - The person's spouse is not living in the home or apartment.
>
> *Deduct this amount for no more than six months. If the person is re-admitted to the institution, grant a six-month continuance.* A physician must again certify that the person is likely to return to the home or apartment within six months.
>
> The home maintenance allowance can be granted at any time. It is not limited to the first six months the person resides in the medical institution.

MEH, § 15.7.1 (*emphasis added*).

My understanding is that the cost of maintaining the Petitioner's home was already granted when determining her patient liability for the first 6 months of her nursing home stay from February 2024 through July 2024. The Petitioner's representative argued she should qualify for the 6 month continuance noted in the policy above as she was scheduled to be discharged from the nursing home but an accident occurred that prolonged that stay. I agree with the agency that the Petitioner does not qualify for the 6 month continuance of the home maintenance deduction as she did not leave and later be re-admitted to the nursing home or other institutionalized setting as required by MEH § 15.7.1.

Finally, I note that a separate decision is being issued in DHA Case No. MGE-215302 addressing her disenrollment from Nursing Home Long Term Care MA.

CONCLUSIONS OF LAW

1. There was no patient liability imposed on the Petitioner for the months of February 2024 through November 2024.

2. The agency correctly found the Petitioner to have a patient liability of $454.16 for December 2024.

3. The agency correctly found the Petitioner's patient liability increased to $1,261.00 starting January 2025.

THEREFORE, it is ORDERED

That the Petitioner's appeal 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 27th day of May, 2025

\s_____
Jason M. Grace
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-7709
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on May 27, 2025.

Door County Department of Social Services
Division of Health Care Access and Accountability
[redacted]

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 211474

PRELIMINARY RECITALS

Pursuant to a petition filed on December 18, 2023, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Milwaukee Enrollment Services regarding her monthly cost share to participate in IRIS, a Medical Assistance (MA) come and community-based long term care program, a hearing was held on April 24, 2024, by telephone. Hearings scheduled for January 24, 2024, February 21, 2024, March 27, 2024, and April 10, 2024 were rescheduled at the request of the petitioner or her representative. The case was reassigned to the instant administrative law judge on or about March 28, 2024.

The issues for determination are whether Petitioner's appeal is timely and, if so, whether the Department of Health Services, by its agents, properly calculated Petitioner's cost share.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Kathleen Miller
BOALTC
1402 Pankratz St Suite 111
Madison, WI 53704

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Kyra Oberg
Milwaukee Enrollment Services
1220 W Vliet St
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Jason M. Grace
Division of Hearings and Appeal

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Milwaukee County. She has been enrolled in the IRIS program since August 13, 2023, with First Person her IRIS consultant agency.

2. On May 10, 2023, the Petitioner signed an IRIS Authorization form that indicated she would have a monthly cost share of $557.10. On that same date, the Petitioner signed a Medical and Remedial Expenses (MRE) Checklist used in determining the cost share. The MRE reflected monthly medical and remedial expenses of $0.00.

3. On or about July 20, 2023 the IRIS consultant agency (ICA) verbally reminded the Petitioner and her POA of the $557.10 monthly cost share. At that time, an offer by the ICA to complete a new MRE was declined by the Petitioner and her POA.

4. On August 16, 2023, an About Your Benefits notice was issued to the Petitioner. The notice indicated she was enrolled in Community Waivers as of August 13, 2023. It further directed she had a monthly cost share of $557.10 as of August 13, 2023. It directed she must pay the cost share to keep getting benefits. She was also directed to check with your Care Manager about how and when to pay this amount. The notice informed of the right and process to request a Fair Hearing if she thought there had a been a wrong decision about her application or benefits. The deadline to request a hearing was indicated to be October 2, 2023

5. On September 11, 2023 and December 12, 2023, the Petitioner and/or her representative informed the ICA of concerns regarding the amount of the cost share.

6. On December 15, 2023, the Petitioner's POA again apprised the ICA of concerns over the amount of the cost share. The ICA failed to review or complete a new MRE to ensure all relevant medical and remedial expenses were captured in determining the cost share.

7. On December 18, 2023, the petitioner filed an appeal with the Division of Hearings and Appeals contesting her cost share.

8. On March 11, 2024, the petitioner's POA met with a representative of the ICA and filled out a new MRE. This reflected monthly expenses of $373.50 for health insurance and $2,121.00 for privately paid personal care. Verification was forwarded to the IRIS consultant agency, and the MRE was signed on or about March 12, 2024. The IRIS consultant agency forwarded the MRE and verification to IM to redetermine the petitioner's monthly cost share.

9. By notice dated March 19, 2024, the IM found that petitioner had a monthly cost share of $0.00 as of March 1, 2024.

DISCUSSION

The Include, Respect, I Self-Direct (IRIS) program is a Medical Assistance long term care waiver program that serves elderly individuals and adults with physical and developmental disabilities. IRIS is an alternative to Family Care, Partnership, and PACE—all of which are managed long term care waiver programs. The IRIS program, in contrast, is designed to allow participants to direct their own care and to hire and direct their own workers. The broad purpose of all of these programs, including IRIS, is to help participants design and implement home and community based services as an alternative to institutional care. See IRIS Policy Manual §1. (available at https://www.dhs.wisconsin.gov/publications/p0/p00708.pdf.

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. Medicaid Eligibility Handbook, §28.6.4. The cost share amount is calculated in agency's computer system by applying the cost share deductions to members' gross income. The possible deductions include the personal maintenance allowance, family maintenance allowance, health insurance, special exempt income, and MREs. Id.

Petitioner seeks to have her cost share reviewed from August 2023 through February 2024. DHA can only hear cases on the merits if there is jurisdiction to do so. There is no jurisdiction if an appeal is untimely. The Petitioner's appeal was not filed until December 18, 2023.

The first issue that must be addressed is whether Petitioner's appeal is timely as to her cost share determination. Medical assistance (MA) appeals, which include appeals regarding IRIS cost shares, must be filed within 45 days of the date of the negative action. See, 42 C.F.R. § 431.221(d); Wis. Stat. § 49.45(5); Wis. Admin. Code § DHS 104.01(5)(a)3; Wis. Admin. Code § HA 3.05(3). A hearing request that is not received within the 45-day time period must be dismissed for lack of jurisdiction. Wis. Admin. Code § HA 3.05(4)(e).

The argument that the Petitioner lacked notice of the cost share was not found persuasive. She was issued an About Your Benefits notice on August 16, 2023 that apprised of the cost share and the right and process to file an appeal. Compelling evidence was not presented that rebutted the presumption of delivery and receipt of that notice. Moreover, she had been informed when she signed the IRIS Authorization there would be a monthly cost share and the amount thereof. She and her representatives were also verbally informed by the ICA of the cost share. The About Your Benefits notice of August 13, 2023, set forth the deadline to file an appeal. The Petitioner failed to meet that deadline. Thus, I lack the jurisdiction to address the cost share for the months prior to the filing of the appeal in December 2023. I have jurisdiction, however, to address the cost share as of December 2023.

The cost share for the months of December through February 2024 will be addressed below. Her cost share as of March 2024 was not contested. This is because a new MRE was forwarded by the ICA to IM on March 12, 2024 reflecting significant remedial expenses not previously considered. Upon factoring in those expenses, her cost share was determined by IM to be $0.00 as of March 1, 2024. The remedial expenses were privately paid personal care expenses. Petitioner argued that her cost share calculation prior to March 2024 should have included the privately paid personal care expenses that ultimately were factored in the re-calculation of March 12, 2024. I agree.

According to the record, the Petitioner was privately paying for personal care services at all relevant times involved here. For unknown reasons that expense was not reflected in the first MRE completed by the ADRC in May 2023. The Petitioner and her representatives then declined the ICA's July 2023 offer to conduct a new MRE. My understanding is that offer was declined due to the recency of completing the MRE with the ADRC. However, on at least three occasions thereafter the Petitioner and/or her representatives expressed concerns to the ICA about the amount of the cost share. That occurred on September 11, 2023; December 12, 2023; and December 15, 2023. At no time during those interactions did the ICA offer to revisit the MRE or review relevant expenses captured by the MRE.

A significant change reflected in the most recent HCBS Waiver renewal is that ICAs now must maintain participant long-term care and MA eligibility. See Application for 1915(c) Home and Community-Based Services Waiver (HCBS Waiver): WI.0484.R0300 – Jan 01, 2021, page 2, found on-line at: https://www.dhs.wisconsin.gov/iris/hcbw.pdf. Of note, an IRIS participant can be involuntarily disenrolled from the IRIS program for falling into cost share arrears. Id. at pg. 202.

IRIS program policy further provides that the ICA has the following responsibilities: (1) to document the participant's cost share obligation as determined by the income maintenance agency at the time of initial referral; (2) to monitor a participant's ongoing MREs; and (3) to report any changes to medical or remedial expense payments to the income maintenance agency. IRIS Policy Manual (04/2024), § 2.2B.2.2.1. IRIS policy also indicates that the ICA is to be informed of the monthly status of the cost share payment and is to discuss any concerns with the participant at the next consultant visit. Id at § 2.2B.3.3.1. The ICA also is tasked with providing support to the participant to ensure the cost share obligation is understood. Id. at § 2.2D.3. Finally, the IRIS Provider Agreement between the Department and the ICAs indicates the ICA "is responsible for assisting a participant with the determination of medical/remedial expenses, as necessary." IRIS Provider Agreement with the Department of Health Services, effective 1/1/2023 – 12/31/2024, pg 79, found online at: https://www.dhs.wisconsin.gov/iris/iris-2023-provider-agreement-generic-final.pdf. I

Based on the foregoing and the record before me, I find that the ICA erred by failing to offer to review the MRE with the Petitioner (or her representatives) at or after the December 15, 2023 meeting. While the ICA may not calculate the cost share, it is aware that qualifying medical and remedial expenses impact the cost share calculation conducted by IM. Given that the cost share amount was an issue being repeatedly raised by the Petitioner and that the ICA and Petitioner had never reviewed the MRE together, the ICA erred for failing to offer to conduct that review to ensure all relevant medical and remedial expenses were captured. I do appreciate that the Petitioner had declined a July 2023 offer by the ICA to review the MRE. However, five months had lapsed since that offer and the Petitioner (or her representatives) continued to express to the ICA issues over the amount of the cost share. This should have triggered a MRE review. That review ultimately did occur but not until March 11, 2024. It should have occurred at or immediately after the December 15, 2023 meeting.

The Petitioner's cost share for December 2023 through February 2024 does not reflect her significant remedial expense associated with the privately paid personal care services provided during this time. Verification of that expense was previously provided to IM when her cost share was recalculated in March 2024, resulting in a cost share of $0.00 as of March 1, 2024. As the verification of the medical and remedial expenses at issue already was provided to IM, I am remanding this matter to IM to calculate the cost share for the month of December 2023 through February 2024 using the MRE that was ultimately used to determine the March 2024 cost share.

CONCLUSIONS OF LAW

1. Petitioner failed to timely appeal her cost share for the months of August through November 2023.

2. Petitioner timely appealed her cost share for December 2023 through February 2024.

3. The Department did not correctly determine the Petitioner's cost share for the months of December 2023 through February 2024, as the IRIS consultant agency failed to properly review the Petitioner's medical remedial expenses and forward that it to the income maintenance agency.

4. The Department properly calculated Petitioner's cost share as of March 2024.

THEREFORE, it is ORDERED

The matter is remanded to the Department to, by its agents, to recalculate Petitioner's December 2023 through February 2024 cost share after factoring in the remedial expense associated with privately paid personal care expenses for those months, using the verification previously submitted to calculate the cost share as of March 2024. The Department shall comply with this order within ten (10) days of the date of this decision. In all other regards the Petitioner's appeal 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 20th day of May, 2024

\s_____
Jason M. Grace
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-7709
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on May 20, 2024.

Milwaukee Enrollment Services
Division of Health Care Access and Accountability
[redacted]

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 211383

PRELIMINARY RECITALS

Pursuant to a petition filed on December 12, 2023, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Marathon County Department of Social Services regarding Medical Assistance (MA), a hearing was held on February 28, 2024, by telephone. The hearing was first set for January 31, 2024 but rescheduled at the request of petitioner to accommodate the schedule of a third party she wished to assist her at the hearing.

The issue for determination is whether the agency properly declined to deduct a home maintenance allowance when calculating Petitioner's patient liability as of April 2021.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Shoua Lor
Marathon County Department of Social Services
400 E. Thomas Street
Wausau, WI 54403

ADMINISTRATIVE LAW JUDGE:
Teresa A. Perez
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a 71-year old unmarried resident of Marathon County who has resided in a skilled nursing facility since July 2023. She was found eligible for Institutional Medical Assistance at that time.
2. In 2023, Petitioner received monthly gross Social Security payments of $1,331. Following an annual Cost of Living Adjustment, that amount increased to $1,373 per month. She has no other monthly income.
3. Petitioner is eligible for SLMB+ and therefore no Medicare Part B premium is withheld from her Social Security benefit.
4. Petitioner was required to begin paying a patient liability as of July 1, 2023. At that time, her patient liability was calculated to be $1,256 per month. As of August 1, 2023, it increased to $1,286 per month.
5. Via notice dated November 27, 2023, the agency informed Petitioner that her patient liability would increase to $1,328 as of January 2024. This increase occurred because of the increase in Petitioner's monthly Social Security payment.
6. On December 12, 2023, Petitioner filed an appeal of her patient liability amount.

DISCUSSION

Institutionalized individuals who receive Medicaid must generally pay a "cost of care" each month. This amount is referred to as a patient liability. See *Medicaid Eligibility Handbook* (*MEH*) §27.7.1. Family Care and IRIS members who are in, or who are likely to be in a medical institution for 30 or more days, are considered to be institutionalized and must therefore pay a patient liability. *Id.*

Because Petitioner was admitted to a skilled nursing facility in June 2023 and has remained there since that time, the agency properly determined that her cost of care must be calculated according to the formula for patient liability. The following income deductions may be applied when calculating the patient liability.

1. $65 and ½ earned income disregard
2. Monthly cost for health insurance
3. Support payments
4. Personal needs allowance (typically $45 per month)
5. Home maintenance costs, if applicable
6. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees
7. Medical Remedial Expenses.

Id. at *§27.7.1.*

Medical expenses include the costs for services or goods that (1) have been prescribed or provided by a professional medical practitioner for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body, and (2) are not reimbursable by any other source, such as Medicaid, private insurance. Remedial expenses include costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. *Id. at §15.7.3*

The agency correctly increased Petitioner's patient liability as of January 2024 because her Social Security benefit increased. Petitioner testified that the $45 personal needs allowance is not enough to allow her to purchase clothing, snacks, and shoes or to pay her telephone bill. Although I am sympathetic to Petitioner, the legal authorities that I am bound by do not give me the discretion to make any exceptions or to devise a different formula for calculating patient liability. And, there are no dedicated deductions for clothing, snacks, or phone bills.

Petitioner's shoes might qualify as a medical or remedial expense but Petitioner did not offer sufficient documentation at hearing to establish that. If the shoes have been prescribed by a health care provider or if she needs particular style or type of shoes to relieve a health condition, she may provide that information directly to the agency. The agency would then be able to make a determination as to whether it is or is not allowable under Medicaid policy.

Based on the evidence in the record, the agency's patient liability calculation was consistent with the applicable laws and policies, as detailed above.

CONCLUSIONS OF LAW

The agency properly calculated Petitioner's patient liability effective January 2024.

THEREFORE, it is ORDERED

That the petition 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.

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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, 2024

\s_____
Teresa A. Perez
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

Telephone: (608) 266-7709
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on March 28, 2024.

Marathon County Department of Social Services
Division of Health Care Access and Accountability

FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

MGE/162960

PRELIMINARY RECITALS

Pursuant to a petition filed December 31, 2014, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Waukesha County Health and Human Services in regard to Medical Assistance, a hearing was held on February 26, 2015, at Waukesha, Wisconsin.

The issues for determination are:

1) Whether the agency correctly denied the Petitioner's request to backdate his benefits to October 1, 2014, based upon the inclusion of assets that were later documented to be for a funeral fund, and

2) Whether the agency correctly refused to allow a deduction for health insurance premiums paid by the Petitioner's spouse when determining the Petitioner's patient liability.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Nicholas Kusch, Economic Support Specialist
Waukesha County Health and Human Services
514 Riverview Avenue
Waukesha, WI 53188

ADMINISTRATIVE LAW JUDGE:
Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Waukesha County.

2. On November, 19, 2014, the Petitioner submitted an application for Institution Long Term Care Medicaid benefits, seeking enrollment beginning October 1, 2014. (Exhibit 10)

3. In section 7 of the November 19, 2014 application, the Petitioner indicated that he and his spouse had burial assets valued at $34,733.52. (Id.)

4. On or about November 19, 2014, the Petitioner's spouse and power of attorney signed a designation of burial funds indicating that assets from an [redacted] account and a [redacted] were intended for use as a burial fund. The total value of the two items was stated to be $34,788.00; or $17,394.00 for each spouse. (Exhibit 4)

5. On December 23, 2014, Waukesha County Health and Human Services (the agency) sent the Petitioner a notice indicating that he was enrolled in Nursing Home Long Term Care Medicaid effective November 1, 2014 with a patient liability of $2,614.00 per month. (Exhibit 7)

6. The Petitioner filed a request for fair hearing that was received by the Division of Hearings and appeals on December 31, 2014. (Exhibit 1)

7. Petitioner's spouse has health insurance through her employer. She is enrolled in an employee + one plan, which also covers medical expenses for the Petitioner. Petitioner's spouse pays for the insurance premium through a payroll deduction. (Testimony of [redacted])

8. In 2014, there was a difference of $191.00 per month between the premiums paid for an employee only plan and an employee + one plan. In 2015, the difference between the premiums is $230.00 per month. (Exhibit 2, attachment 7G)

9. Similarly, the Petitioner is enrolled in a dental/vision plan as employee + one. In 2014, the difference in the premiums between an employee only plan and an employee + one plan was $64.00 per month; in 2015, it is $68.00 per month. (Id.)

DISCUSSION

I. Backdating Petitioner's Benefits.

Medicaid benefits may be backdated up to three months prior to the application month. *Medicaid Eligibility Handbook (MEH)§ 2.8.2* An applicant may be "certified in any backdate month in which s/he would have been eligible had s/he applied in that month." *Id.*

In the case at hand, the Petitioner seeks backdated eligibility to October 1, 2014.

It is the agency's position that when the value of the Petitioner's [redacted] stocks and [redacted] insurance are counted for October 2014, the Petitioner is ineligible.

It is the Petitioner's position that those assets should not be counted, because they were designated as a burial asset.

The Petitioner has a community spouse; as such, the spousal impoverishment rules apply in determining countable assets. *MEH §27.5.1.*

Under spousal impoverishment rules, "Any/all assets designated for burial purposes are exempt. Any unreasonable amount should be supported by documentation of the burial related costs or contract." *MEH §18.4.1, ¶3*

The Petitioner and his spouse formally designated $34,788.00 in stocks and insurance as a burial fund in November 2014. Consequently, the agency exempted the assets and the Petitioner was found eligible for Medicaid benefits effective November 1, 2014.

It is undisputed that if the assets in question are counted, that Petitioner is over the asset limit and ineligible for Medicaid benefits. However, Petitioner's attorney argued that the stocks and insurance did not need to be specifically designated as burial funds in October 2014. Petitioner's attorney argues that the November 2014 designation is enough and that it is unreasonable to expect people to designate burial funds before they apply for Medicaid benefits. Petitioner's attorney also argues that the intent to designate the assets as a burial fund existed in October 2014.

First, Petitioner's attorney has cited to no administrative rule or provision in the Medicaid Eligibility Handbook that allows for a retroactive designation of burial funds. Second, while it is true that many people are taken by surprise by a need to apply for Medicaid benefits when an unforeseen tragedy strikes, it is also true that some people engage in estate planning and have burial funds set aside before they ever need to apply for Medicaid. Other individuals have been known to purchase burial insurance or to set up burial trusts as part of this planning. Third, Petitioner's spouse could not offer any testimony establishing exactly when the Petitioner and she decided to use the [redacted] stocks and [redacted] as a burial fund. She could only testify to some non-specific discussions with her attorney about which assets, out of all the assets Petitioner and she owned, should be designated as a burial fund.

Because there is no evidence that the stocks and insurance policy in question were specifically designated as burial funds in October 2014, the agency was correct to count them as an asset when making its eligibility determination for October 2014. Accordingly, the agency correctly denied the Petitioner's request to back date his benefits to October 2014.

II. Patient Liability

Petitioner's attorney filed an appeal concerning the calculation of Petitioner's patient liability, arguing that a portion of the insurance premiums paid by the Petitioner's spouse for Petitioner's health insurance should be allowed as a deduction when calculating the Petitioner's patient liability.

A patient liability is the amount an institutionalized Medicaid patient will pay each month to offset the cost of his/her care. *MEH §27.7.1*. It is referred to as a cost share when applied to a community waivers / Family Care client. *Id.*

In calculating a patient liability there is, in fact, a deduction for health insurance premiums and medical / remedial expenses. *MEH §27.7.1* It should be noted that health insurance premiums are considered a medical expense. *MEH §15.7.3*

In order to use a medical expense as an income deduction, "the institutionalized individual must be legally liable for the payment of the incurred medical/remedial expense." *MEH §27.8.1* The Petitioner is not legally liable for paying the insurance premiums in question. His spouse is the liable party. As such, the Petitioner may not use those premiums as a deduction in the patient liability calculation.

This conclusion is consistent with the Monthly Need[1] provisions, which state under *MEH §27.6.4,* that health insurance costs are allowed in Monthly Need calculations only if the "primary person is the owner of the policy and billed for the premium". The only reasonable interpretation of "primary person" is the applicant. *See Example 1 under MEH §27.6.4* Thus, health insurance costs are only allowed if the applicant is the owner of the policy and billed for the premium. The Petitioner is not billed for the premium, his wife is.

Based upon the foregoing, it is found that the agency correctly excluded the insurance premiums paid by the spouse for Petitioner's private health insurance when calculating the Petitioner's patient liability.

---

[1] Monthly need is the amount by which the institutionalized person's expenses exceed his/her income. It is computed by adding together certain costs. (See MEH §27.6.1)

It should be noted, however, that because the entire insurance premium is something the community spouse is obligated to pay, that it should be counted as an expense when determining whether the Minimum Monthly Maintenance Needs Allowance should be raised.[2]

CONCLUSIONS OF LAW

1) The agency correctly denied the Petitioner's request to backdate his benefits to October 1, 2014.

2) The agency correctly refused to allow a deduction for health insurance premiums paid by the Petitioner's spouse for Petitioner's private health insurance coverage, when determining the Petitioner's patient liability.

THEREFORE, it is **ORDERED**

That the petition 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, 5005 University Avenue, Suite 201, 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, Madison, Wisconsin 53703, **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 Milwaukee,
Wisconsin, this 6th day of March, 2015

\sMayumi M. Ishii
Administrative Law Judge
Division of Hearings and Appeals

[2] It would certainly make for good public policy to encourage couples to pay for private insurance for the institutionalized spouse, since Medicaid is a payer of last resort. Of course, lucky couples who can afford the private insurance may want it, anyway, since the quality of coverage might be better than what is otherwise offered by Medicaid.

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
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Madison, WI 53705-5400

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FAX: (608) 264-9885
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Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on March 6, 2015.

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

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 210319

PRELIMINARY RECITALS

Pursuant to a petition filed September 13, 2023, under Wis. Stat., §49.45(5), to review a decision by the Great Rivers IM Consortium to discontinue Medical Assistance (MA), a hearing was held on October 18, 2023, by telephone.

The issue for determination is whether petitioner's assets are over the MA limit.

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Atty. Peter E. Grosskopf
Grosskopf Law Office LLC
1324 West Clairemont Avenue, Suite 10
Eau Claire, WI 54701

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Kristen Burstad
Great Rivers IM Consortium
1316 North 14Th Street
Superior, WI 54880

ADMINISTRATIVE LAW JUDGE:
Brian C. Schneider
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES #[redacted]) is a resident of Pepin County. It is noted that Douglas County is the lead county in the consortium, and Polk County, where Ms. Burstad works, is also part of the consortium.

2. Petitioner has been eligible for nursing home MA while residing in the [redacted] In August, 2023, the agency processed a renewal after informing petitioner that MA would end September 1 unless the renewal was completed.

3. At the time of the renewal, petitioner had $18,522.95 in her bank account (the actual amount was higher but the agency did not count the monthly social security deposit). Most of the funds were from a lump sum [redacted] payment made in April, 2023. By a notice dated August 22, 2023, the agency informed petitioner that MA would be denied beginning September 1, 2023 because assets were over the limit.

4. In July, 2023, petitioner's son and attorney-in-fact was notified by the [redacted] that there likely was an overpayment of [redacted] benefits, and the amount of the overpayment was not yet determined. As of the date of this hearing the [redacted] still had not informed him of an overpayment amount.

5. On September 12, 2023, petitioner's son wrote a check to the [redacted] for $10,500 to cover September, 2023 costs. He placed $9,520 in petitioner's attorney's trust account after they estimated that to be the amount of the [redacted] overpayment.

6. After being informed of those transactions, the agency still considered the $9,520 to be available as an asset, and the denial of MA remained in place.

DISCUSSION

The MA asset limit for an individual is $2,000. Wis. Stat., §49.47(4)(b)3g. If assets are above that limit, the person is not eligible for MA. The statute does not allow for outstanding debts to be deducted from assets, nor does it provide any exceptions for unusual situations.

Therein lies the problem for petitioner. Her attorney-in-fact knows that an overpayment claim could be made by the [redacted]. However, that has not occurred, and the asset is still in petitioner's control and is available for her care. It does not matter that the money is in Atty. Grosskopf's trust account; as he stated during the hearing, he must follow the directive of the client as to the disbursement of the money, and petitioner's son could request the money back at any time. As noted by the Department's expert, the agency cannot act on future changes. See Agency Exhibit D. I must conclude that the agency correctly determined that the $9,650 remains an available asset, putting petitioner over the MA limit.

During the hearing I noted that if the money is spent down and the [redacted] claim comes later, it is possible that the repayment could reduce petitioner's cost of care. After reviewing the MA Handbook, I am uncertain if I was correct. §27.7.7 of the Handbook allows a deduction from cost of care for medical or remedial expenses and payments for noncovered services. I am uncertain whether a repayment of [redacted] funds would be considered remedial expenses; that will have to be determined if and when the recovery actually occurs. For purposes of this appeal, the only issue is whether the money in the trust account is an available asset countable against the MA asset limit. It is.

CONCLUSIONS OF LAW

Funds available to petitioner cannot be excluded from the MA asset calculation because the [redacted] might seek recovery of funds in the future.

THEREFORE, it is ORDERED

That the petition for review is hereby 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.

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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 20th day of October, 2023

\s_____
Brian C. Schneider
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 October 20, 2023.

Douglas County Department of Human Services
Division of Health Care Access and Accountability
Attorney Peter Grosskopf

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 207580

PRELIMINARY RECITALS

Pursuant to a petition filed on January 30, 2023, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Milwaukee Enrollment Services regarding Medical Assistance (MA), a hearing was held on March 15, 2023, by telephone.

The issues for determination are (1) whether the petitioner's appeal of the agency's patient liability determination is timely, and (2) whether the petitioner's husband is entitled to an increase in his community spouse income allocation.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
Milwaukee Enrollment Services
1220 W Vliet St
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Jason M. Grace
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Milwaukee County. She is enrolled in nursing home-long term care. Her husband lives in their community residence.

2. On September 19, 2022, an About Your Benefits notice was issued to petitioner. It indicated that her monthly patient liability for June 1, 2022 to August 31, 2022 was $889.84, and decreased to $862.84 as of September 1, 2022. The notice indicated she had until November 4, 2022, to file a request for Fair Hearing to contest the matter.

3. On December 5, 2022, an About Your Benefits notice was issued to petitioner. It indicated that her patient liability would increase to $961.84/month as of January 1, 2023. The notice indicated she had until February 16, 2023 to file a request for Fair Hearing to contest the matter.

4. On January 30, 2023, the petitioner filed an appeal with the Division of Hearings and Appeals.

5. As of January 1, 2023, petitioner's (institutionalized spouse) monthly unearned income is $1,198.74. Petitioner's husband (community spouse) has monthly gross income of $906.97 in pension and $2,358.90 in social security, totaling $3,265.87.

6. The agency determined petitioner's patient liability by taking her unearned income of $1,198.74 and reducing that by a personal needs allowance ($45.00) and health insurance premiums ($191.90), resulting in a monthly patient liability of $961.84, as of January 1, 2023.

7. At hearing, the agency's representative indicated that petitioner's patient liability as of February, 2023 was $0.00.

8. The husband has the following monthly expenses:
    - Mortgage: $517.39
    - Property taxes: $113.63
    - Auto loan: $429.44
    - Auto insurance: $125.75
    - Life insurance: $397.46
    - Gas and electric: $204.00
    - Cable: $157.04
    - Phone: $107.42
    - Part B medical premium: $164.90
    - Food and gasoline: $400.00

      Total: $ 2,617.03

9. The husband presented a medical bill for himself totaling $635.00. A monthly payment plan had not been established.

10. The husband also provided a medical bill for his wife of $1,750.29, with a monthly payment plan of $100.00.

DISCUSSION

If a request for a hearing is not received within that the appeal period set forth, the Division of Hearings

and Appeals must dismiss the hearing request. Wis. Admin. Code §HA 3.05(4)(e). Here, Petitioner seeks to appeal the agency's patient liability determination all the way back to June 1, 2022. However, a notice was issued September 19, 2022 regarding the patient liability as of June, 2022, with an appeal deadline of November 4, 2022 (i.e., 45 days from the effective date of the notice). Even if the deadline were deemed to be 90 days from the date of the notice, the deadline to appeal would have been December 19, 2022. Petitioner did not file his appeal until January 30, 2023, approximately a month after the deadline. Because petitioner did not file an appeal regarding her patient liability until after the deadline, her appeal as to that determination prior to January 1, 2023, must be dismissed pursuant to Wis. Admin. Code §HA 3.05(4)(e).

However, on December 5, 2022, the agency issued a notice as to an increase in patient liability as of January 1, 2023. The appeal deadline to contest that determination was indicated to be February 16, 2023. Petitioner's appeal was timely filed as to the January 1, 2023 patient liability determination. As such, I have the authority to address the patient liability as of January 1, 2023.

After an institutionalized person is determined eligible for MA, a county 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. This is referred to as the person's "patient liability." The calculation begins with gross income, and only a few items may be subtracted as deductions. These include the statutory $45 personal needs allowance deduction, a health insurance expense deduction and, in some cases, a home maintenance deduction. Wis. Admin. Code §DHS 103.07(1)(d), and the federal rule at 42 C.F.R. §435.725 - .832. The formula for calculating the patient liability amount is set out at Medicaid Eligibility Handbook (MEH), §27.7.1, found online at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm#t=policy_files%2F27%2F27.7.htm.

Calculate the cost of care in the following way:

1. For a Medicaid member in a medical institution who does not have a community spouse, subtract the following from the person's monthly income:

   a. $65 and ½ earned income disregard (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).

   b. Monthly cost for health insurance (see SECTION 27.6.4 HEALTH INSURANCE).

   c. Support payments (see SECTION 15.7.2.1 SUPPORT PAYMENTS).

   d. Personal needs allowance (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES)

   e. Home maintenance costs, if applicable (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT).

   f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (see SECTION 27.6.6 FEES TO GUARDIANS OR ATTORNEYS).

   g. Medical or remedial expenses (see SECTION 27.7.7 MEDICAL OR REMEDIAL EXPENSES AND PAYMENTS FOR NONCOVERED SERVICES).

> 2. For a Medicaid member in a medical institution who has a community spouse, follow the directions in SECTION 18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION.
>
> 3. For a community waivers member with or without a community spouse, follow the directions in SECTION 28.6.4 COST SHARE AMOUNT.
>
> 4. There is no cost of care for SSI recipients.
>
> 5. For a Medicaid member who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.
>
> …
>
> If the cost of care amount is equal to or more than the medical institution's Medicaid rate, the individual is responsible for the entire cost of his or her institutional care. He or she would be entitled to keep any overage without restriction. He or she would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

MEH §27.7.1.

The petitioner does not have earned income, and thus is not entitled to an earned income disregard. See, MEH §15.4 and 15.5 (for what qualifies as earned and unearned income). She also did not qualify for the home maintenance costs reduction as she has a community spouse living in their residence. See, MEH §15.7.1. The record also does not contain any expenses associated with establishing or maintaining a court-ordered guardianship or protective placement. The agency did, however, applied deductions for a personal allowance and health insurance premiums (my understanding was the premiums were for Part B and Part D premiums). No other health expenses were provided to the agency.

At hearing, the agency representative indicated that petitioner's patient liability would be $0.00 as of February 1, 2023. Thus, the only month of patient liability at issue is January, 2023. The petitioner and her husband did not contest the agency's calculation of the patient liability. Instead, they were seeking an increase in the community spouse's monthly income allocation on grounds of financial duress of the community spouse.

While it was not contested by the petitioner, I am remanding this matter back to the agency to redetermine petitioner's patient liability due to a medical bill provided to DHA shortly before the hearing. The petitioner has established a monthly repayment plan of $100.00 for medical expenses from [redacted], which do not appear to have been previously disclosed to the agency. The bill is included with this decision for the agency's review. The date of service is not reflected in the bill but the statement date is January 3, 2023.

Moving on to the next issue, a married institutionalized Medical Assistance recipient may allocate income to his or her spouse who resides in the community to guard against that "community spouse" from falling into poverty. See Wis. Stat. §49.455 and Medicaid Eligibility Manual (MEH) §§18.1 and 18.6. The institutionalized spouse may allocate some of his/her income to the community spouse if the community spouse's gross monthly income does not exceed the Maximum Community Spouse Income Allocation (MCSIA), which is the lesser of $3,051.66 plus excess shelter allowance up to a maximum of $3,715.50. See MA Eligibility Handbook (MEH), §18.6.2 and 39.4.4. In this case, the agency did not provide any evidence an income allocation calculation was conducted. Based on the record before me, the husband's allowable shelter expenses amounted to $1,102.02, comprised of $517.39 mortgage, $113.63 property

taxes, and $471.00 HSUA standard utility allowance. See, MEH 18.6.2. The excess shelter allowance was the difference between the shelter expense ($1,102.02) and the shelter base amount ($915.50), amounting to $186.52. See, MEH §§ 18.6.2. and 39.4.4. The next step is to determine the sum of the Community spouse Lower Income Allocation Limit ($3,051.66) and the excess shelter allowance ($186.52), which amounts to $3,238.18. See, MEH § 18.6. Last, is to take the lesser of that amount ($3,238.18) and the Community Spouse Income Allocation Maximum, which is currently set at $3,715,50. Id. The lesser amount is $3,238.18. As the husband's gross income ($3,265.87) exceeded that amount, no allocation from the wife to the husband was able to be authorized by the agency.

The issue for me is whether I can order any of petitioner's income to be allocated to her husband. I have some limited discretion. Because any additional amount given to the community spouse is a taxpayer-financed subsidy in the form of medical assistance, the law restricts the administrative law judge's ability to raise the limit. Wisconsin law provides the following test for the exception:

> (c) If either spouse establishes at a fair hearing that, due to exceptional circumstances resulting in financial duress, the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance determined under sub. (4)(c), the department shall determine an amount adequate to provide for the community spouse's needs and use that amount in place of the minimum monthly maintenance needs allowance in determining the community spouse's monthly income allowance under sub.(4)(b).

Wis. Stat. §49.455(8)(c) (emphasis added). An administrative law judge (ALJ) may increase the maximum income allocated to the community spouse only by amounts needed to alleviate financial duress, to allow the community spouse to meet necessary and basic maintenance needs. Also see, Medicaid Eligibility Handbook § 18.6.2.

The husband submitted a list of some of his monthly expenses. See Findings of Fact 8 and 9 above. While petitioner and her husband did not address their property taxes, I applied the amount reflected in the September 19, 2022 notice that was introduced in the record. While the expenses were to meet necessary and basic needs, I did not closely scrutinize the cable bill. The result was that the total monthly expenses amounted to $ 2,617.03. The lone expense not included was a medical bill connected to the husband. A monthly repayment plan had not been established, but the petitioner also had a medical bill from the same hospital and was able to establish a repayment plan of $100.00/month. If a similar repayment plan for the husband's medical bill was established, this would increase his monthly expenses to $2,717.03. His income exceeds his expenses by over $500.00.

Based on the evidence before me, I cannot order that income from the wife (the institutionalized spouse) be allocated to the husband (the community spouse) in this case it has not been shown that such is needed for the husband to avoid financial duress.

I would note that petitioner is free to file a new appeal requesting a review of the community spouse allocation at any point in the future. If such an appeal is filed, it would behoove the party appearing at the hearing to be prepaid to present a more complete list of expenses.

CONCLUSIONS OF LAW

1. Petitioner's appeal of the agency's determination of his patient liability for June, 2022 through December, 2022 was untimely.

2. Petitioner's appeal of the agency's January 1, 2023 patient liability determination was timely.

3. Based on a new medical bill provided shortly before the hearing, the agency's patient liability determination as of at least January 1, 2023 was not correct.

4. The record does not establish that the petitioner's community spouse needs to have his monthly community spouse income allotment increased to avoid financial duress.

THEREFORE, it is ORDERED

That the matter be remanded to the county agency with instructions to redetermine petitioner's monthly patient liability, with consideration provided to the $100.00/month medical bill from [redacted] (which is included with this decision), and to change the monthly patient liability accordingly. The county agency shall take all necessary steps to complete the action within 10 days of this decision.

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 14th day of April, 2023

\s_____
Jason M. Grace
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
5th Floor North
4822 Madison Yards Way
Madison, WI 53705-5400

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FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: http://dha.state.wi.us

The preceding decision was sent to the following parties on April 14, 2023.

Milwaukee Enrollment Services
Division of Health Care Access and Accountability

FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

FCP/155113

PRELIMINARY RECITALS

Pursuant to a petition filed January 29, 2014, under Wis. Admin. Code § DHS 10.55, to review a decision by the Community Care Inc. in regard to Medical Assistance, a hearing was held on March 13, 2014, at Kenosha, Wisconsin. The record was held open for 30 days post-hearing to allow the parties to submit additional information. The agency submitted additional information on March 14, 2014. The Petitioner's representative responded in writing on March 28, 2014. The agency submitted an additional reply on April 10, 2014. The record closed on April 10, 2014.

The issues for determination are:
1. Whether certain expenses for supportive home care services incurred by the Petitioner should be allowed as a deduction from her income as remedial expenses for the purpose of determining her cost share liability for the Family Care (FC) program; or, in the alternative,
2. Whether the requested services should be included in the Petitioner's plan of care and paid by FC.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Petitioner's Representative:

Attorney Angela E. Canellos
631 North Mayfair Road
Wauwatosa, WI 53226

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Terri Ramage
Community Care Inc.
205 Bishops Way
Brookfield, WI 53005

ADMINISTRATIVE LAW JUDGE:
Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Kenosha County. She lives at home with two sons. One of her sons is disabled due to a stroke and is unable to provide any hands-on care to the Petitioner. The other son travels extensively and is home to provide care approximately two days/week.

2. The Petitioner's FC Member Centered Plan includes supportive home care (SHC) services and personal care services as part of the FC program for 6 hours/day, 7 days/week.

3. The Petitioner's son (who is also her Power of Attorney) arranged for additional supportive home care services so that Petitioner has 24 hour care and supervision. Petitioner requires assistance overnight to ensure that she can safely transfer and toilet when necessary. This additional care has been paid by the Petitioner. The cost is $3000-4500/month.

4. On December 17, 2013, the Inter-Disciplinary Team (IDT) conducted a six month review with the Petitioner. Petitioner's son/POA was present. The assessment included use of the Long Term Care Functional Screen (LTCFS), In-Home assessment tool (IHAT), an RN assessment and a Social Services assessment. Based on these assessments, the agency determined the Petitioner had not experienced any change in condition from her previous review on June 21, 2013. A determination was made that the Petitioner would continue to receive SHC and personal care for 6 hours/day, 7 days/week. Petitioner's son agreed to continue to provide informal natural family supports as needed. It was also noted in the plan that additional supportive home care or personal care would be provided as desired and paid for by the Petitioner.

5. On December 31, 2013, the agency issued a Notice of Decision to the Petitioner informing her that her monthly cost share for the FC program was $910.16/month effective January 1, 2014. This was based on gross monthly income of $2,020 and $105.04 in counted assets.

6. On January 2, 2014, Petitioner's son inquired about additional services for the Petitioner from Visiting Angels.

7. On January 29, 2014, an appeal was filed on behalf of the Petitioner based on the issue of whether "the payments to caregivers are remedial expenses."

8. On February 7, 2014, another home visit was conducted with the Petitioner. On March 3, 2014, the agency completed additional assessments. As a result of the additional assessments, the agency added 1.3 hours/day to the Petitioner's supportive home care services in her plan for a total of 7.3 hours/day that is part of the FC plan.

DISCUSSION

The Family Care program, which is supervised by the Department of Health Services, is designed to provide appropriate long-term care services for elderly or disabled adults. It is authorized under Wisconsin Statutes, § 46.286, and is described comprehensively in the Wisconsin Administrative Code, Chapter DHS 10. See also, Medicaid Eligibility Handbook at §29.1 et seq., available at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm.

In this case, the Petitioner has been found eligible for FC at the comprehensive level. An eligible person's income is reviewed to determine if the recipient has enough income to be responsible for payment of a monthly "cost share." See, http://www.dhs.wisconsin.gov/mltc/2012/2012Contract.htm (the FCP standard contract), and the MEH, § 29.3. A recipient may request a hearing on the determination of the cost share amount. Wis. Stat. §46.287(2)(a)1b.

A person who receives both a Medical Assistance card and Family Care, and is not on "regular MA" because of excess income, is classified as being in Group A, Group B, or Group C. Group A is for person who receives SSI or certain other benefits that are not relevant here. The petitioner does not fit within Group A. Group B status is available to a person who has gross income below the Community Waivers MA income limit of $2,163. MEH, § 39.4.1. A Group B recipient may have health insurance premiums, certain medical/remedial expenses and a Personal Maintenance Allowance (possibly including housing expenses) subtracted from her income before a cost share is computed. 42 C.F.R. §435.726; Wis. Admin. Code §DHS 103.07(1)(d). The Petitioner's gross income of $2,020 places her under the income limit for Group B status. Therefore, she is entitled to have health insurance premiums, certain medical/remedial expenses and a personal maintenance allowance subtracted from income to compute the cost share. Remedial expenses are defined in the Medicaid Eligibility Handbook:

> Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.
>
> Some examples of remedial expenses are:
>
> 1.Case management.
>
> 2.Day care.
>
> 3.Housing modifications for accessibility.
>
> 4.Respite care.
>
> 5.Supportive home care.
>
> 6.Transportation.
>
> 7.Services recognized under s.46.27, Wis. Stats.
>
> 8.Community Options Program, that are included in the person's service plan.

Medicaid Eligibility Handbook (MEH), § 15.7.3.

The issue is whether the additional services the Petitioner pays for overnight supervision and assistance meet the definition of a remedial expense, specifically whether these services are "reimbursable by any other source, such as Medicaid, private insurance, or employer."

The agency asserts that the services at issue are SHC services. The FC benefit package includes SHC services as a covered benefit. The agency has determined that the Petitioner needs 7.3 hours/day of SHC and has included that number of hours as part of her FC plan. Therefore, the agency reasons, because SHC services is a covered benefit in the FC package, any SHC services not included in the Petitioner's plan that are paid by the Petitioner cannot be used as a remedial expense.

In determining that the cost of the additional supervision is not a remedial expense, the agency relies on a Department of Health Services Memo, DLTC Numbered Memo 2010-05 in denying the additional SHC expense as a medical/remedial expense in determining the cost share. Specifically, that Memo indicates that a medical/remedial expense is defined on pages 2 and 3 as follows:

> An item can be counted as a medical or remedial expense for the purposes of determining Medicaid eligibility and cost share amount for individuals when:
>
> 1. The person pays for the item out-of-pocket; and
> 2. The item or support is effective in diagnosis, cure, treatment, or prevention of disease (medical expense) or in relieving, remedying, or reducing a medical or health condition (remedial expense); and
> 3. The expense of the item is the responsibility of the person and cannot be reimbursed by any other source available to the person, such as Medicaid, Family Care, IRIS, or private insurance.

The Memo goes on to state at page 3:

> . . .
>
> Any item included in the Family Care, Family Care Partnership, PACE or IRIS benefit packages cannot be considered a medical or remedial expense.
>
> Aging and Disability Resource Centers, Managed Care Organizations, and IRIS Consultants will begin using the criteria listed above when providing local Economic Support/Income Maintenance Units with the dollar amount of medical and remedial expenses for the purposes of determining Medicaid eligibility and cost share amounts.
> . . .
>
> In order for a program to provide an item/service to a participant that is included in the program's benefit package, that item must be included in the care plan developed with the program participant. *Any item/service that is included in a benefit package, but is not included in an individual's care plan, will not be provided by the program and may not be counted as a medical or remedial expense should the individual choose to buy the item out-of-pocket.*
>
> In managed care, the care team, which includes the member, determines supports, supplies and items, including any over the counter supplies and medications that will support the member's desired outcomes. Supports/services that are determined to be the most effective and cost-effective way to support outcomes will be included in the care plan. Any supports or services that do not meet those standards will not be included in the plan and also cannot be counted as medical or remedial expenses. Any denial, reduction or termination of a good or service, including decisions regarding inclusion or exclusion of a good or service in a care plan, are subject to appeal and consumers will receive appropriate notice.

Wisconsin Department of Health Services Memo, DLTC Numbered Memo 2010-05. (Emphasis added).

The Petitioner argues that the additional supervision and assistance expense that is paid by the Petitioner meets the definition of a remedial expense and should be considered as such in determining the Petitioner's cost share. The Petitioner asserts that the agency's action in not including a service in the plan makes that service one that is not covered by the FC program and thus meets the definition of a remedial expense when the Petitioner pays privately for that service. The Petitioner argues that the agency interprets the definition of "remedial expense" too expansively, noting that the FC benefit package is so broad that virtually any medical or remedial service is a service that may be reimbursed under the FC program. Thus, any medical or remedial service that the agency decides not to include in the FC plan

and the individual decides to pay for privately may not be used as a medical or remedial expense under the agency's interpretation even if it is a service that reduces or alleviates a health or medical condition.

In this case, the agency does not dispute that the Petitioner is a fall risk and that she needs assistance with transfers and toileting to ensure she can complete the task safely. The agency does not dispute that the Petitioner needs such assistance at night if she needs to use the toilet. However, the agency argues that the Petitioner's current 7.3 hours/day of care is sufficient to cover the time at night when she would need direct assistance with transfers and toileting. The agency notes that inactive supervision is not a service that the FC program covers and that it doesn't pay for a caregiver "in case" assistance is needed. The Petitioner's son testified that the Petitioner requires such assistance at least two times each night. However, the schedule and frequency is unpredictable. Therefore, the Petitioner's son argues that she needs a caregiver present 24/7 to ensure that she can get the assistance when she needs it.

The 2014 Family Care Programs Contract defines "supportive home care" as follows:

> Supportive home care (SHC) is the provision of services to directly assist persons with daily activities and personal needs to meet their daily living needs and to insure adequate functioning in their home. Services include:
>
> a. Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, toileting, assistance with ambulation (including the use of a walker, cane, etc.), care of hair and care of teeth or dentures.
> . . .

2014 Family Care Programs Contract, Addendum X, Section A20.

The agency asserts that the expense for overnight supervision for the Petitioner is SHC which is a covered service under the FC benefit package. Because it is a covered benefit that is not included in the Petitioner's FC plan, it cannot be considered a remedial expense. At the same time, the agency also asserts that FC does not cover inactive or indirect supervision or supervision of the Petitioner "in case" she needs assistance and that it only covers hands-on assistance.

I conclude that the evidence demonstrates that the Petitioner's health condition makes it important for her to have overnight supervision and a caregiver to assist her with transfers and toileting when it is necessary. The portion of caregiver expense that the Petitioner incurs for inactive supervision at night is not a covered benefit of the FC program. Therefore, it meets the definition of a remedial expense and must be considered as such in determining the Petitioner's cost share.

With regard to the Petitioner's argument that the services should be included in the Petitioner's FC plan, the evidence is not sufficient to determine whether the Petitioner's son requested 24/7 SHC services. The evidence demonstrates that there was some discussion between the Petitioner's son and the agency about increasing the SHC hours in or about February, 2014. The agency did increase the hours based on additional assessments. Therefore, it is not clear that there was any agency action to deny requested services. No Notice of Action was issued denying services. Therefore, I conclude that there is insufficient evidence to demonstrate that there has been any action by the agency to deny inclusion of a service in the Petitioner's FC plan for which there is an appeal right at this time.

CONCLUSIONS OF LAW

1. The Petitioner's out-of-pocket expenses for indirect or inactive supervision from Visiting Angels to assist the Petitioner meet the definition of remedial expenses that must be considered in determining the Petitioner's cost share.

2. There is insufficient evidence to conclude that the agency denied any requested services to be included in the Petitioner's FC plan. Therefore, there is no right of appeal at this time on that issue.

THEREFORE, it is **ORDERED**

That this matter is remanded to the agency to take all administrative steps necessary to re-calculate and re-determine the Petitioner's cost share considering the Petitioner's out-of-pocket expense for indirect and inactive supervision from Visiting Angels as a remedial expense. This action shall be taken within 10 days of the date of this decision.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found 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 served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 14th day of May, 2014

\sDebra Bursinger
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 May 14, 2014.

Community Care Inc.
Office of Family Care Expansion
Attorney Angela Canellos