



FH
[REDACTED]

**STATE OF WISCONSIN
Division of Hearings and Appeals**

In the Matter of

[REDACTED]

DECISION

MOP/143390

PRELIMINARY RECITALS

Pursuant to a petition filed August 27, 2012, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Calumet County Department of Human Services in regard to Medical Assistance, a hearing was held on November 6, 2012, by telephone.

The issue for determination is whether the petitioner was overpaid \$2,014 in Medicaid benefits for the April 1, 2012 through May 31, 2012 period.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703

By: Lynn Brenner, ES Supr.
Calumet County Department of Human Services
206 Court Street
Chilton, WI 53014-1198

ADMINISTRATIVE LAW JUDGE:

Nancy J. Gagnon
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Calumet County.
2. IRIS is a Wisconsin Medicaid waiver program for persons residing in the community who wish to self-direct their care. The petitioner was certified for IRIS from at least February 1, 2012 through May 30, 2012. He was living in the community prior to February 13, 2012. On February 13,

2012, he was admitted to a nursing home, and remained there or at another institution until September 7, 2012.

3. The petitioner should have reported the change in his living arrangement to the agency by February 23 (10 day reporting requirement), which would have ended his IRIS eligibility by April 1, 2012.
4. The admission to the nursing home was not reported until May 17, 2012. The agency then discontinued the petitioner's IRIS certification effective May 31, 2012. Medicare and Medicaid then paid the petitioner's nursing home bill for April and May 2012, without deducting a patient liability amount.
5. On July 26, 2012, the county agency issued a *Medicaid/BadgerCare Overpayment Notice* (claim # [REDACTED]) to the petitioner. The Notice advises the petitioner that he was overpaid \$2,014 in Medicaid benefits for April and May, 2012.
6. The agency arrived at the \$1,007 monthly (x 2 months) overpayment figure by assessing the petitioner's nursing home patient liability amount. When a person on Medicaid is in the nursing home, his income after a few specified deductions must be paid to the nursing home. This amount is his "patient liability." The unpaid nursing home bill above the patient liability amount is then paid for by Medicaid.
7. The agency computed the monthly patient liability amount as follows: \$1,052 in gross unearned income, minus the \$45 statutory personal need allowance, equals \$1,007.
8. The petitioner has a \$708 verified monthly home mortgage payment. This expense was verified prior to April, 2012. On May 17, 2012, the county agency issued a request that the petitioner verify his expectation that he would be returning to his home; that verification was not received.

DISCUSSION

The petitioner had an IRIS certification that had to be changed to an Institutional/Long-Term Care Medicaid (MA) certification when he entered the nursing home in February 2012. As noted above, a patient liability amount is computed for nursing home residents on MA. The formula for calculating the patient liability amount is set out at *Medicaid Eligibility Handbook (MEH)*, §27.6 - .7, found online at <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>.

The petitioner does not contest the date of his nursing home admission or his gross income amount. He does question why his mortgage expense was not subtracted in the patient liability computation, because the mortgage expense can be subtracted in certain circumstances:

15.7.1 Maintaining Home or Apartment

If an institutionalized person has a home or apartment, deduct an amount from his/her income to allow for maintaining the home or apartment that does not exceed the SSI  payment level plus the E supplement for one person (See 39.4.1). The amount is in addition to the personal needs allowance (See 39.4.2 EBD Deductions and Allowances). 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.

Make the deduction only when the following conditions are met:

1. A physician certifies (verbally or in writing) that the person is likely to return to the home or apartment within six months, and

- 2. 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 s/he is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time as long as the person is institutionalized. It is not limited to the first six months of institutionalization.

MEH, §15.7.1.

Because the petitioner did not provide the agency with written confirmation that he was expected to return to his home within six months, the agency acted correctly in declining to subtract his home expense in the patient liability computation.

CONCLUSIONS OF LAW

- 1. The county agency correctly declined to subtract the petitioner’s home expense in his patient liability computation for April and May 2012, because the petitioner did not supply certification of his likely return home within six months of institutionalization.

THEREFORE, it is

ORDERED

That the petition is dismissed.

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, 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 Madison,
Wisconsin, this 20th day of November, 2012

\sNancy J. Gagnon
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 November 20, 2012.

Calumet County Department of Human Services
Public Assistance Collection Unit
Division of Health Care Access and Accountability