



FH
[REDACTED]

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

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

CWA/148335

PRELIMINARY RECITALS

Pursuant to a petition filed March 25, 2013, under Wis. Admin. Code § HA 3.03, to review a decision by the Burnett County Department of Social Services in regard to Medical Assistance, a hearing was held on April 18, 2013, at Siren, Wisconsin.

The issue for determination is whether the county agency correctly determined the petitioner's share of his medical costs for the IRIS program.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

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

By: Michelle Brown

Burnett County Department of Social Services
7410 County Road K, #280
Siren, WI 54872

ADMINISTRATIVE LAW JUDGE:

Michael D. O'Brien
Division of Hearings and Appeals

FINDINGS OF FACT

1. The petitioner (CARES # [REDACTED]) is a resident of Burnett County.
2. The petitioner's gross income is \$3,123.90 per month from social security and a pension. His wife earns \$4,449.60 per month.
3. The petitioner's medical expenses are \$4,032.85 per month.

4. The petitioner's 21-year-old son lives with him and is listed as a dependent on his federal income tax return. He does not earn any money.
5. The petitioner's housing costs are \$1,130.02 per month.
6. The county agency set the petitioner's share of his medical costs at \$2,333.90.

DISCUSSION

Institutionalized medical assistance recipients must “apply their available income toward the cost of their care.” Wis. Adm. Code § DHS 103.07(1)(d). Those participating in an MA-Waiver program are considered institutionalized. *Medicaid Eligibility Handbook*, § 27.4.1. The petitioner challenges the amount that he must contribute toward his medical costs to participate in Wisconsin IRIS, a Medical Assistance-Waiver program. IRIS, which stands for Include, Respect, I Self-Direct, is a fee-for-service alternative to Family Care, PACE, or Partnership for individuals requesting a long-term care, self-directed support program in Family Care counties. *Medicaid Eligibility Handbook*, § 37.1.1. As with any MA-Waiver program, those seeking eligibility must be financially and non-financially eligible for medical assistance. *Medicaid Eligibility Handbook*, § 28.1. Financial eligibility refers to having income and assets within the program's limits. Non-financial eligibility refers to other criteria required to participate in the program, such as disability or age. No one disputes that the petitioner meets the non-financial criteria of the program.

Those potentially eligible for MA-Waiver benefits fall into one of three groups, A, B, or C. *Medicaid Eligibility Handbook*, § 28.8. Group A includes those who are functionally eligible for the Waivers program and are eligible for SSI or a full-benefit Medicaid subprogram. *Medicaid Eligibility Handbook*, §§ 28.8.2 and 21.2. The parties agree that the petitioner meets this requirement because he requires care equivalent to that found in a nursing home. However, as will be discussed, his income exceeds that required to be eligible for the relevant full-benefit Medicaid subprogram, Home and Community Based Waivers Long Term Care.

Group B members are those not in Group A who have gross income at or below the nursing home institutions categorically needy income limit. *Medicaid Eligibility Handbook*, § 28.8.3. That amount is currently \$2,130. *Medicaid Eligibility Handbook*, § 39.4; *DHS Operations Memo 12-63*.

Group C applies to those who meet the medically needy income test for Waiver members. *Medicaid Eligibility Handbook*, § 28.8.4. A person is medically needy if he meets only the program's non-financial conditions. Wis. Admin. Code § HFS 101.03(97). As noted, the petitioner meets the non-financial conditions of the program because he requires the care generally found in a nursing home. He does not meet the program's financial conditions because his income is \$3,123.90 per month, which exceeds the program's \$2,130 limit. The medically needy income limit is \$591.67 for a one or two-person household, which is determined by a complex formula found in Wis. Stat. § 49.47(c)(1). *Medicaid Eligibility Handbook*, Appendix, § 39.4. The petitioner falls into Category C once he reduces his income to the \$561.67. He must do this by incurring and being responsible for at least \$2,521.23 in medical expenses each month, the amount equal to the difference between his \$3,123.90 income and the \$591.67 income limit. *See Medicaid Eligibility Handbook*, § 28.5.2. This responsibility is known as a spenddown. The agency agrees that his medical expenses are \$4,032 per month and that he meets this requirement. I assume that these costs are assessed at the beginning of the month, because the agency's presentation at that hearing implied that he was eligible the entire month.

Generally in spenddown, or what is often referred to as deductible, cases, the recipient's obligation toward his medical costs is the difference between his countable income and the \$591.67 limit. The worksheet workers fill out to determine eligibility and cost sharing requirements, Worksheet F-20919, determines cost sharing for Group B participants but says nothing about cost sharing in regard to Group C

participants. Instead, it gives directions on determining the amount of the spenddown. This suggests that, in general, Group C participants' contribution toward their medical care is the difference between their countable income and \$591.67. However, the worksheet does instruct workers to complete an income allocation worksheet for all spousal impoverishment cases. The petitioner is married, and the agency used Worksheet 7, the Spousal Impoverishment Income Allocation Worksheet, to determine his share of his medical costs. Its action is consistent with *Medicaid Eligibility Handbook*, § 28.2.2., which instructs workers that “[s]pousal impoverishment policy applies to waiver participants with a community spouse. As its name implies, the community spouse refers to the spouse who continues to live in the community while the other spouse is in a nursing home or participating in an MA-Waiver program.

The spousal impoverishment provisions of the medical assistance program are federal and state laws meant to prevent the community spouse of an institutionalized person from falling into poverty. *See* Wis. Stat. § 49.455 and 42 U.S.C. §13964-5. Medical assistance's financial standards are strict, and before these provisions were passed a couple would often lose all of their assets and most of their income to ensure that one of them received proper medical care. The spousal impoverishment provisions allow a couple to protect both income and assets, but in this matter only the protection of income is relevant. The provisions protect income by granting the community spouse an allowance, called the minimum monthly needs allowance, that is the lesser of \$2,898 or \$2,521.67 plus excess shelter costs. *Medicaid Eligibility Handbook*, § 18.6.2; *DHS Operations Memo 12-63*. Excess shelter costs are shelter costs above \$756.50. *Id.* If the community spouse's income falls short of this allowance, the institutionalized spouse can allocate whatever portion of his income is needed to bring the community spouse's income up to the allocation. Thus, if the community spouse's income were \$1,000, the institutionalized spouse could allocate up to \$1,898 of his income to bring his spouse's income up to \$2,898. In petitioner's matter, his spouse earns \$4,449.60 per month. Because this exceeds her minimum monthly needs by more than \$1,500, she is not entitled to any further allocation from him.

Section C of Worksheet 7 is designed to determine the amount MA-Waiver and other persons considered institutionalized must contribute toward their medical care in spousal impoverishment situations. The instructions for that worksheet, which are found at *Medicaid Eligibility Handbook*, § 18.6.4., state the following:

1. Enter the institutionalized person's gross monthly income on Line 1. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.
2. Enter his/her personal allowance on Line
 - a. Personal Needs Allowance ([39.4.2 EBD Deductions and Allowances](#)) for a person in a medical institution, **or**
 - b. Personal Maintenance Allowance for a person in community waivers. This is the Community Waivers Basic Needs Allowance ([39.4.2 EBD Deductions and Allowances](#)) plus other applicable deductions ([28.8.3.1 Personal Maintenance Allowance](#)) up to the EBD Maximum Personal Maintenance Allowance amount ([39.4.2 EBD Deductions and Allowances](#)). [\$2,130]
3. Enter on Line 4 the income allocation amount (Section A, Line 3) that is actually allocated to the community spouse.
4. Enter on Line 6 the dependent family member allowance from Section B, Line 4.
5. Enter on Line 8 any court-ordered guardian or attorney fees ([27.6.6 Fees to Guardians or Attorneys](#)).
6. Enter on Line 10 the institutionalized person's medical/remedial expenses and the cost of his/her health insurance premiums.
7. Do the math from Line 1 through Line 11. The result on Line 11 is the amount the institutionalized spouse must pay toward cost of care.

The agency subtracted the \$890 basic needs allowance from the petitioner's \$3,123.90 income and determined that his share of his medical costs is \$2,239 per month. This calculation overstates the petitioner's required contribution because it does not give him all of the deductions he is entitled to.

As the agency correctly stated, the petitioner's income is \$3,123.90 per month. But his personal needs allowance consists of more than just the basic needs allowance. The complete list of costs that go into the personal needs allowance is found in *Medicaid Eligibility Handbook*, § 28.8.3.1. These costs include the following:

1. Community Waivers Basic Needs Allowance [\$890. *Medicaid Eligibility Handbook*, § 39.4.2; *DHS Operations Memo 12-63*.]
2. \$65 and ½ earned income deduction
3. Special housing amount. This is an amount of the person's income set aside to help pay housing costs. If the waiver applicant's housing costs are over \$350, add together the following costs:
 - a. Rent.
 - b. Home or renters insurance.
 - c. Mortgage.
 - d. Property tax (including special assessments).
 - e. Utilities (heat, water, sewer, electricity).
 - f. "Room" amount for members in a Community Based Residential Facility (CBRF), Residential Care Apartment Complex (RCAC) or an *Adult Family/Foster Allowance*.) Home (AFH). The case manager determines and provides this amount.

The total of the items listed in subsection 3 minus \$350 equals the special housing amount. *Id.*

As the agency found, the petitioner is entitled to the \$890 basic needs allowance but is not entitled to the earned income deduction because all of his income comes from SSI and a pension, which are considered unearned income. He does have housing costs. His mortgage, property tax, and house insurance total \$688.05 per month. It is unclear what his utility costs are, but the spousal impoverishment policy concerning this expense instructs workers to use the standard FoodShare utility allowance found at *FoodShare Wisconsin Handbook*, § 8.1.3. See *Medicaid Eligibility Handbook*, § 18.6.2. The instructions for determining housing costs as part of the personal needs allowance do not specifically call for the use of the FoodShare amount, but, like its use in determining the spousal allocation, using it reduces the need to verify a cost that varies widely from month to month and household to household. Because the rationale for using the standard allowance is the same when determining special household costs as when determining a spousal allocation, and because workers from the same department drafted both *Medicaid Eligibility Handbook* policies, it is reasonable to use the FoodShare utility allowance to determine special housing utility costs. The FoodShare utility allowance is \$442 per month. This brings the petitioner's total housing costs to \$1,130.02, which exceeds \$350 by \$780.02. Adding this to the \$890 basic needs allowance brings his personal needs allowance to \$1,670.02. I am aware that his wife lives in the house and has income to pay these costs, but nothing in the rules and regulations prohibits him from claiming these expenses under these circumstances.

The next item in Section C of Worksheet 7 is the amount of income the petitioner can allocate to his wife. As found earlier, the petitioner is not entitled to claim this allocation because his wife's income is too high.

The spousal allocation is followed by the dependent family member allowance. The agency contends that the petitioner does not have any dependent family members, apparently because his only child living at home is 21 years old. But whether one can be considered a dependent family member does not depend solely upon age. According to *Medicaid Eligibility Handbook* § 18.6.1., adult children who live with the recipient or his spouse and are claimed on their federal income tax returns are considered dependent

family members. The amount of the deduction allowed for a dependent family member is determined by subtracting the child's monthly income from \$630.42. *Medicaid Eligibility Handbook*, § 18.6.3. The petitioner's child does not hold a job or earn any money because he cares for the petitioner. Therefore, the petitioner is allowed the full \$630.42 deduction for him.

As for the other expenses the agency must enter on the worksheet, the petitioner does not have any guardian or attorney's fees or pay for his own insurance. He does seek credit for a number of other expenses, including clothing, food, household supplies, vehicle costs, savings, and leisure. None of these can be deducted because they are not specifically allowed by the program's rules. His total deductions are \$2,300.02. Subtracting this from his \$3,123.90 gross income means he must contribute \$823.88 toward his medical care each month.

In making this decision, I point out that it is unclear if those drafting these laws and policies intended the result reached here. The problem is that determining the cost share requires one to navigate a labyrinth of policies that, in the words Justice Shirley Abrahamson used to describe medical assistance statutes, "are characterized by ambivalence and ambiguity" and "are extremely complex and may fairly be described as incomprehensible." *Tannler v. Wisconsin DHSS*, 211 Wis. 2d 179, 191, 564 N.W. 2d 735 (1997). I sent an earlier version of this decision to four colleagues. Each has reviewed medical assistance matters as an administrative law judge for at least 20 years. (I have been doing so for nearly 16 years.) No two came to the same conclusion in the same way. If the Department does not intend recipients living with a spouse to receive all of these deductions, it should rewrite the policies so that they are less ambiguous and more comprehensible.

Moreover, the petitioner's condition has caused his family significant financial hardship. Because this matter falls under the spousal impoverishment rules, I could have increased the minimum monthly needs allowance of the petitioner's spouse as is allowed under Wis. Stat. § 49.455(8)(c). The petitioner submitted a budget before the hearing. Although I have not analyzed it in detail and did not question him or his family members about it at the hearing, it appears that if I had increased the allowance consistent with the expenses described in his budget, the result would have been similar to the one reached in this decision.

CONCLUSIONS OF LAW

The agency incorrectly determined the petitioner's share of his medical costs because it failed to consider his allowable housing and dependent family member costs.

THEREFORE, it is

ORDERED

That this matter is remanded to the county agency with instructions that within 10 days of the date of this decision it reduce the petitioner's IRIS cost share to \$823.88 per month. This reduction shall be retroactive to March 1, 2013, the date the petitioner became eligible for the program.

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 16th day of May, 2013

\sMichael D. O'Brien
Administrative Law Judge
Division of Hearings and Appeals



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The preceding decision was sent to the following parties on May 16, 2013.

Burnett County Department of Social Services
Bureau of Long-Term Support