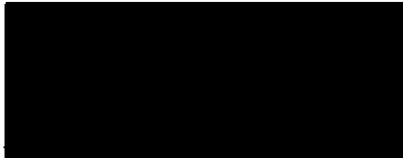




**STATE OF WISCONSIN
Division of Hearings and Appeals**

In the Matter of



DECISION

MGE/173712

The attached proposed decision of the hearing examiner dated June 10, 2016, is modified as follows and, as such, is hereby adopted as the final order of the Department.

PRELIMINARY RECITALS

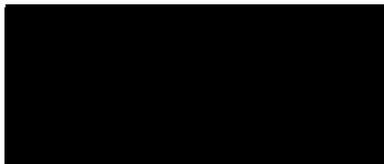
Pursuant to a petition filed April 18, 2016, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Waukesha County Health and Human Services in regard to Medical Assistance (MA), a hearing was held on May 12, 2016, at Waukesha, Wisconsin.

The issue for determination is whether the agency correctly denied the petitioner's application for institutional MA coverage.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:



Petitioner's Representative:

Attorney W Ryan Zenk
909 N Mayfair Rd Suite 202
Wauwatosa, WI 53226

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

By: Julie Miller

Waukesha County Health and Human Services
514 Riverview Avenue
Waukesha, WI 53188

ADMINISTRATIVE LAW JUDGE:

Corinne Balter
Division of Hearings and Appeals

FINDINGS OF FACT

1. The petitioner (CARES # [REDACTED]) is a resident of Waukesha County. She currently resides at [REDACTED]. This is a skilled nursing facility.
2. On February 19, 2016 the petitioner submitted an application for institutional MA coverage.
3. The petitioner's monthly income is \$9,456.81 consisting of \$7,905.91 from an annuity, \$270 from a pension, and \$1,176 from social security. The petitioner pays \$104.90 for Medicare Part B.
4. The cost of the petitioner's skilled nursing facility is \$9,410 each month.
5. The average cost for a private pay skilled nursing facility in Wisconsin is \$7,693.90.
6. On March 22, 2016 the agency sent the petitioner a notice stating that they denied her application for Institutional MA coverage because she was over the income limit.
7. The Division of Hearings and Appeals received the petitioner's Request for Fair Hearing on April 21, 2016.

DISCUSSION

Wisconsin Medicaid (MA) is a State and Federal program that provides health coverage for Wisconsin residents who are elderly, blind, or disabled. *Medicaid Eligibility Handbook (MEH)*, § 1.1.1. A person must also meet financial eligibility standards to qualify for MA. *MEH* § 1.1.3. Different MA subprograms have different financial eligibility standards. *MEH*, Chapters 15-19.

Institutional long term care (ILTC) is an MA subprogram. *MEH*, § 1.1.1. A person can qualify for ILTC if the person qualifies under categorically needy MA or medical needy MA. *MEH*, § 25.5.2. Both programs have a \$2,000 asset limit for an unmarried or widowed person. *MEH*, § 39.4.1. The income limit for institutions categorically needy MA is \$2,199. *MEH*, § 39.4.1. Please note that this is monthly gross income. The medical needy MA limit for a person in an institution is calculated using the ILTC monthly need as follows:

27.6.1 ILTC Monthly Need Introduction

Monthly need is the amount by which the institutionalized person's expenses exceed his or her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (39.4 EBD Assets and Income Tables).
2. **Cost of institutional care (use private care rate).**
3. Cost of health insurance (27.6.4 Health Insurance).
4. Support payments (15.7.2.1 Support Payments).
5. Out-of-pocket medical costs.
6. Work related expenses (15.7.4 Impairment Related Work Expenses (IRWE)).
7. Self-support plan (15.7.2.2 Self-Support Plan).
8. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other medical expenses.
10. Other deductible expenses.

The "monthly average private pay nursing home rate" is \$7,693.90. *MEH*, § 39.4.3.

The agency denied the petitioner's application for institutional care using the monthly average pay nursing home rate of \$7,693.90. The petitioner argues that the agency should have used "[the petitioner's] actual cost of care." Her nursing home costs \$9,410 each month. The petitioner's monthly

income is \$9,456.81, however, she also pays \$104.90 for Medicare Part B, and when this is deducted, she is left with \$9,351.90. She argues that because this amount is less than the actual cost of her particular nursing home, she is eligible for institutional MA coverage.

There is a prior fair hearing decision, MGE/145639, in which an ALJ used the actual cost of care to determine institutional MA eligibility. In that case the petitioner's actual nursing home cost was \$7,056.66. The decision was issued in 2013. Effective July 1, 2013 the average private pay nursing home rate was \$7,406. (2013 DHS Operations Memo 13-19). Thus, the petitioner's actual cost of care was less than the private pay nursing home rate. This issue was not contested, and both parties agreed to use the actual cost of the petitioner's care. Because of this difference in the relative cost of care, however, this previous decision does not provide any beneficial insight for this case.

The MEH requirement to use 'the private care rate' is subject to two different interpretations, and is thus minimally ambiguous. It could refer to the private care rate at the nursing home where the applicant actually resides or intends to reside, as the petitioner contends, or the state-wide average rate/cost for nursing home services, as the agency contends. While the County's position is a reasonable understanding of the requirement, the use of the actual rate charged by the nursing home where an applicant for institutional medical assistance lives is the correct cost to use in this calculation.

Individuals, such as the petitioner, who meet the functional eligibility for Medicaid but have incomes in excess of the financial eligibility threshold are referred to as 'medically needy'. The federal rules for determining financial eligibility for the medically needy state:

(e) Determination of deductible incurred expenses: Required deductions based on kinds of services. Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

...

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration, or scope of services [emphasis added].

42 C.F.R. § 435.831(e)

Nursing home services are covered services in the Wisconsin State Plan for Medicaid services. Thus, the federal rule requires that the actual expense incurred by the individual, rather than a state-wide average cost for nursing home services, be used in establishing financial eligibility for the medically needy for institutional Medicaid.

This is also consistent with the requirement for monthly 'spend down' required for the medically needy to retain eligibility for Medicaid. When the individual has excess income, the spend down requirement looks to the actual and allowable monthly expenses incurred by the enrollee. It would be inconsistent to use a state-wide cost to establish initial Medicaid eligibility and then a potentially very different individual cost in order to retain eligibility for Medicaid.

I feel compelled to state that MA pays for only basic and necessary medical care. Back in 1985 House Report 265, 99th Cong., 1st Sess., pt.1, at 72, which recommended passage of the earlier version of a law pertaining to the treatment of trusts in Medicaid matters, stated:

The Committee feels compelled to state the obvious. Medicaid is, and always has been, a program to provide basic health coverage to people who do not have sufficient income or resources to provide for themselves. When affluent individuals use Medicaid qualifying

trusts and similar “techniques” to qualify for the program, they are diverting scarce Federal and State resources from low income elderly and disabled individuals, and poor women and children. This is unacceptable to the Committee.

Quoted with approval in *Gonwa v. Department of Health and Family Services*, 2003 WI App 152¶ 36. Here, although the petitioner did not use an MA qualifying trust, the principal in the same. With a monthly income of \$9,456.81, and the State average private pay nursing home cost of \$7,693.90, the petitioner can afford a nursing home. Instead of finding a nursing home that she can afford, she argues that MA should cover her very expensive nursing home.

Enrollment in Medicaid does not mean that the petitioner may simply rely on the program to pay for her full expenses in her current nursing home. The nursing home has the authority to decide not to continue to serve the petitioner, given the lower MA-rate of reimbursement. If the petitioner is required to relocate, her eligibility will be reviewed and the cost of any new nursing home used to compute her financial eligibility. If the nursing home decides to continue to serve the petitioner, her income is sufficiently large that her monthly spend down will cover the full amount due the nursing home at the MA rate, and presumably leave an additional sum that must be spent down monthly on allowable medical costs in order for her to retain MA eligibility. Enrollment in institutional MA comes with limitations and responsibilities, such as a limited personal needs allowance, divestment penalties, and an estate recovery obligation that an individual with assets must consider when enrolling in the program.

CONCLUSIONS OF LAW

The term ‘private care rate’ in MEH § 27.6.1 refers to the private pay rate an applicant for institutional long term care Medicaid actually pays the nursing home, rather than a state-wide average cost for nursing home services.

THEREFORE, it is

ORDERED

That the matter is remanded to the respondent with instructions to re-evaluate the petitioner’s financial eligibility for institutional Medicaid using the actual cost of the petitioner’s current nursing home. This action shall be taken within 10 days of the date 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, 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.

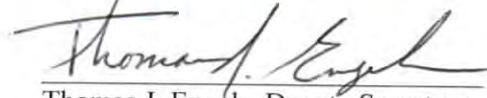
The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

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, WI, 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 request (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 7th day
of September, 2016.



Thomas J. Engels, Deputy Secretary
Department of Health Services



FH
[REDACTED]

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

In the Matter of

[REDACTED] PROPOSED DECISION

MGE/173712

PRELIMINARY RECITALS

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Division of Hearings and Appeals

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was less than the private pay nursing home rate. This issue was not contested, and both parties agreed to use the actual cost of the petitioner's care.

Having closely reviewed the regulations, policies, and the prior fair hearing decision I agree with the agency's position that the cost of institutional care listed in *MEH*, § 27.6.1 is the monthly average private pay nursing home rate. The policy section states "cost of institutional care (use private care rate)." It does not state the actual cost of care as the petitioner argues. This policy language, although not exact, is very close to "monthly average private pay nursing home rate."

I feel compelled to state that MA pays for only basic and necessary medical care. Back in 1985 House Report 265, 99th Cong., 1st Sess., pt.1, at 72, which recommended passage of the earlier version of a law pertaining to the treatment of trusts in Medicaid matters, stated:

The Committee feels compelled to state the obvious. Medicaid is, and always has been, a program to provide basic health coverage to people who do not have sufficient income or resources to provide for themselves. When affluent individuals use Medicaid qualifying trusts and similar "techniques" to qualify for the program, they are diverting scarce Federal and State resources from low income elderly and disabled individuals, and poor women and children. This is unacceptable to the Committee.

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The only expenses presented were the petitioner's actual nursing home cost and Medicare Part B. The petitioner's monthly need is as follows:

\$45.00 (Personal Needs Allowance <i>MEH</i> , § 39.4.2)
\$7,693.90 (Private care rate for cost of institutional care)
\$104.90 (Medicare Part B)
<hr/>
\$7,843.80

The petitioner's monthly gross income is far more than \$7,843.80. Thus, she is ineligible for institutional MA coverage.

CONCLUSIONS OF LAW

The agency correctly denied the petitioner's application for institutional MA coverage.

THEREFORE, it is **ORDERED**

That the petition is dismissed if the Secretary chooses to adopt this decision as the final decision

NOTICE TO RECIPIENTS OF THIS DECISION:

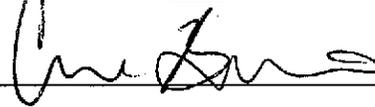
This is a Proposed Decision of the Division of Hearings and Appeals. IT IS NOT A FINAL DECISION AND SHOULD NOT BE IMPLEMENTED AS SUCH.

If you wish to comment or object to this Proposed Decision, you may do so in writing. It is requested that you briefly state the reasons and authorities for each objection together with any argument you would like to make. Send your comments and objections to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy to the other parties named in the original decision as "PARTIES IN INTEREST."

All comments and objections must be received no later than 15 days after the date of this decision. Following completion of the 15-day comment period, the entire hearing record together with the Proposed Decision and the parties' objections and argument will be referred to the Secretary of the Department of Children and Families for final decision-making.

The process relating to Proposed Decision is described in Wis. Stat. § 227.46(2).

Given under my hand at the City of Milwaukee,
Wisconsin, this 10 day of June, 2016

A handwritten signature in black ink, appearing to read "Corinne Balter", is written over a horizontal line.

Corinne Balter
Administrative Law Judge
Division of Hearings and Appeals