STATE OF WISCONSIN
Department of Health and Family Services

In the Matter of

(petitioner)

DECISION

MED-40/68266

The proposed decision of the hearing examiner dated May 12, 2005 is hereby amended as follows and as such is adopted as the final order of the Department.

PRELIMINARY RECITALS

Pursuant to a petition filed January 28, 2005, under Wis. Stat. §49.45(5) and Wis. Admin. Code §HA 3.03(1), to review a decision by the Milwaukee County Department of Human Services in regard to Medical Assistance (MA), a hearing was held on April 19, 2005, at Milwaukee, Wisconsin. The hearing record was held open for 14 days for submission of briefs by the parties; a brief on behalf of the petitioner was received.

The issue for determination is whether the county agency correctly discontinued the petitioner's SSI-related (Elderly-Blind-Disabled) MA effective February 1, 2005, for failure to satisfy his MA deductible. More specifically, the question is whether the agency correctly declined to apply itemized statements of deferred billing for MHC inpatient services against the petitioner's deductible.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

(petitioner)

Respondent:
Wisconsin Department of Health and Family Services
Division of Health Care Financing
1 West Wilson Street, Room 250
P.O. Box 309
Madison, WI 53707-0309
By: Ms. Chris Sobczak, ES Supr.

Milwaukee County Dept. of Human Services
1220 W. Vliet St., 2nd floor
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Nancy J. Gagnon
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (SSN xxx-xx-xxxx, CARES #xxxxxxxxxx) is a resident of Milwaukee County. He has been certified for SSI-related/Elderly-Blind-Disabled MA, and receives mental health services through the Milwaukee County Mental Health Complex (MHC).

2. On January 13, 2005, the county agency issued written notice to the petitioner advising that his MA certification was subject to satisfying a $2,293.98 deductible, and that his certification would end effective February 1, 2005, for failure to meet that deductible.

3. Prior to hearing, the petitioner did submit deferred billing documentation from the MHC to the county agency that purported to satisfy the entire amount of his deductible. Prior to 2005, the agency had accepted this type of documentation, consisting of itemized statements of services and deferred charges from the MHC, for purposes of MA deductible satisfaction. However, the agency rejected this documentation for the petitioner's current deductible.

4. In November, 2004, the county agency rejected the MHC itemized statement from patient C.R. (see DHA Decision MED-40/68304) as adequate documentation of deductible satisfaction for the upcoming six-month deductible period. The county agency's action had its genesis in a letter from the Department's Vicki Jessup to the county agency, dated October 6, 2004. See Exhibit 1. In that letter, the Department referenced an earlier deductible period for C.R., observed that the deductible had been correctly calculated, but asserted that the documentation of deductible satisfaction was unacceptable. Specifically, the Department objected to the use of an MHC itemized statement for deferred inpatient charges:

> We were unable to obtain consistent information from the Milwaukee County Mental Health Division about whether the "deferred charges" are considered still owed or written off. Therefore, we have determined that this expense is allowable only if Ms. [redacted] provides a written off date that meets the above criteria OR submits a current bill from Milwaukee County Mental Health Division that clearly indicates the charges are **currently owed**. For Medicaid eligibility purposes, charges that are in deferred status cannot be used to satisfy a deductible unless the provider bills the client or provides a written-off date.

The county agency filed its disagreement with this Department determination, arguing that the itemized statements represented charges that are still owed to MHC by C.R. The Department's position on this case remained unchanged.

5. On January 11, 2005, the Department amended its main policy document, the *Medicaid Eligibility Handbook*, to include language rejecting deferred bills for the purpose of deductible satisfaction, subject to some exceptions.

DISCUSSION

At issue in the instant case is whether the Department incorrectly instructed the county agency to disallow submissions from MHC for purposes of documenting the petitioner's satisfaction of his MA deductible for the February 1 through July 31, 2005, deductible period. An MA applicant or recipient whose income exceeds the MA "medically needy" income limit must pay a deductible that equals the increment of income over the limit, multiplied by six for the six-month duration of the deductible period. Wis. Stat. §49.47(4)(c)2; *MEH*, 4.9.1.- 4.9.2. There is no dispute as to the correctness of the agency's calculation of the deductible amount here.

When the county agency was presented with an MHC itemized statement of deferred inpatient charges for the petitioner, the agency followed the instruction in the Department's January 11, 2005, *MEH* amendment, and declined to accept the deferred charges statement as evidence that the petitioner's then-upcoming deductible had been satisfied. The rationale for this action appears to be a policy decision that, in general, a statement of deferred charges is unacceptable for this purpose. The policy language is as follows:

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a member of the applicant/recipient's FFU (4.8.1) or FTG (5.1.5)

   Expenses may be counted if incurred for someone the client is legally responsible for if that individual could be counted in the client's FTG or FFU. The medical bill may be used even if the family member is no longer living or no longer in the current FTG or FFU.

   ...

2. Meet the Definition of Medical or Remedial expense as defined in (4.9.8.1.1)

3. Meet one of the following four conditions

   A. Still be owed to the medical service provider sometime during the current deductible period.

      Note: Charges that are in deferred status cannot be used to satisfy a deductible unless the provider bills the client or provides a write-off date.

      Example2: From May- July 2003 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2004, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for MA on Helen's behalf.

      Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $ 14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred", she explained, means that the client would never be billed for the charges, but if s/he happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

      Helen can not use this "deferred" charge toward her deductible. Charges in deferred status cannot be used to satisfy a deductible unless the provider bills the client, with an expectation that they will pay the bill or, writes off the bill and provides a write-off date.

   B. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

   C. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

   D. Paid or written off some time during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

MEH, 4.9.8.1 (1-11-05).

By way of comparison, the rather limited legal authority on this topic is as follows:

§435.831 Income eligibility.

...

(d) *Deduction of incurred medical expenses.* If countable income exceeds the income standard, the agency must deduct from income medical expense incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) *Determination of deductible incurred expenses: Required deductions based on kinds of services.* ...

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

...

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income in establishing eligibility, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses

42 C.F.R. §435.831(d)-(f).

49.47 **Medical assistance; medically indigent.** ...

(4) ELIGIBILITY. ...

(c) ... 2. Whenever an applicant has excess income under subd. 1. or par. (am), no certification may be issued until the excess income above the applicable limits has been obligated or expended for medical care or for any other type of remedial care recognized under state law or for personal health insurance premiums or both.

Wis. Stat. §49.47(4)(c)2. Thus, these two authorities allow the deductible to be satisfied with an allowable medical bill that has been "incurred" by the patient, even though it has not been paid. Neither of these authorities calls for periodic payments against the incurred bill. The state code throws in an extra wrinkle regarding the need for periodic payments.

(3) EXCESS INCOME CASES. ...

(b) When an SSI-related or AFDC-related fiscal test group is found ineligible as medically needy and excess income is the only reason, the group may expend or incur obligations to expend the excess income above the appropriate medically needy income limit pursuant to s.49.47(4)(c)2. and 3., Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s.49.47(6), Stats., and chs. HFS 101 to 108 for the balance of the spend-down period.

(c) Health insurance premiums actually incurred or paid, plus any medical service recognized by state law received by a member of the MA or fiscal test group shall be counted toward fulfilling the excess income expenditure or incurrence requirement when the service is prescribed or provided by a medical practitioner who is licensed by Wisconsin or another state and if either or both of the following conditions are met:

1. The service is received during the spend-down period; or

2. The expense was incurred prior to the spend-down period and a fiscal test group member is still legally responsible for the debt and is consistently making payments, in which case the payments made during the spend-down period shall be counted.

Wis. Admin. Code § HFS 103.04(3)(b)-(c) (February, 2002).

The above authorities authorize the Department to disallow, for MA deductible satisfaction purposes, a medical expense that is characterized as "deferred" by the MHC. The hearing record demonstrates that bills are deferred when MHC determines the patient has no ability to pay. Exhibit 10, a memo from the Milwaukee County Behavioral Health Division, states that "[c]lients are billed based on their ability to pay, based upon Wisconsin Administrative Code, Chapter HFS 1, Uniform Fee System." The memo further indicates that "for accounts with inpatient services, which are *deferred based on the client's ability to pay*, a claim will also be filed against their estate after their death, if there is an estate." [Emphasis added.]

The conclusion that deferral of billing in this case is based on a determination the patient had no ability to pay is consistent with MHC's billing and collection responsibilities under state law governing collection of uniform fees for patient cost of care liability. Wis.Stat. §§ 46.10 and 46.03 (18); Wis.Adm.Code ch. HFS 1. County departments are delegated the responsibility for collection of patient fees for services other than those provided at state facilities. Wis.Stat. § 46.10 (16). A person receiving services from a county department is liable for the cost of the services in accordance with the fee schedule established by the department. Wis.Stat. §§ 46.10 (2) and 46.03 (18) (a). County departments are required to determine each patient's ability to pay based upon a formula established by the Department, and to bill the patient based on his or her ability to pay. Wis.Adm.Code §§ HFS 1.03 (11) and HFS 1.05 (6) (c) 2. Patients with no ability to pay, on the other hand, "shall not be pursued for payment." Wis.Adm.Code § HFS 1.05 (6) (b). While there are other circumstances under which a county department is permitted or required not to pursue collection of the uniform fee, there is no indication in the record that this case fits within any of them.[1] Unless a patient has no ability to pay or one of the other circumstances obtains, billing statements must reflect "total outstanding charges to date," Wis. Adm. Code § HFS 1.05 (8) (d), and monthly billing must continue until "liability has been met." Wis.Adm.Code § HFS 1.03 (20).

Under applicable law, charges that are "deferred" based on the county's determination that the petitioner had no ability to pay cannot be counted toward satisfaction of his MA deductible. Because the county is prohibited from pursuing collection from a patient with no ability to pay, charges that are "deferred" for this reason cannot properly be considered to be "owed" within the meaning of the applicable Handbook provision, nor do such charges represent expenses "incurred" within the meaning of the federal regulation or "obligated or expended" within the meaning of the state statute.

Thus, after reviewing the above authorities, I conclude that the Department's instruction at *MEH* §4.9.8.1, item #3A, to disallow deferred MHC charges for deductible satisfaction, is ~~in~~correct. The itemized statements of deferred charges establish that the patient has incurred a medical expense for which he remains liable.

CONCLUSIONS OF LAW

The Department correctly declined to accept incurred, deferred MHC inpatient charges to satisfy the petitioner's deductible for the February 1 – July 31, 2005, period.

NOW, THEREFORE, it is **ORDERED**

[1] See, e.g., Wis.Adm.Code § HFS 1.02 (7) [accrual of liability may be voided for a period if accomplishing the purpose of a service would be significantly impaired by imposing liability]; Wis.Adm.Code § HFS 1.03 (14) (b) [lower monthly payment rate may be authorized when payment at maximum rate would create a documentable hardship]; Wis.Adm.Code § HFS 1.03 (15) [agency may arrange extended payment plan if payment at monthly payment rate would place a burden on the patient's family].

That the petition herein be dismissed.

REQUEST FOR A REHEARING

This is a final fair hearing decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a new hearing. You may also ask for a new hearing if you have found new evidence which would change the decision. To ask for a new hearing, 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 must explain what mistake the examiner 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.

Your request for a new hearing must be received no later than twenty (20) days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in sec. 227.49 of the state statutes. 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 filed no more than thirty (30) days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one). The appeal must be served on the Wisconsin Department of Health and Family Services, P.O. Box 7850, Madison, WI 53707-7850.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for Court appeals is in sec. 227.53 of the statutes.

Given under my hand at the City of Madison,
Wisconsin, this 27th day of June, 2005.

/s
Helene Nelson, Secretary
Department of Health and Family Services

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

(petitioner)

PROPOSED DECISION

MED-40/68266

PRELIMINARY RECITALS

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There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:
(petitioner)

Represented by:
Atty. Shirin Cabraal
6737 West Washington Street
#3230
Milwaukee, WI 53214

Respondent:
Wisconsin Department of Health and Family Services
Division of Health Care Financing
1 West Wilson Street, Room 250
P.O. Box 309
Madison, WI 53707-0309

By: Ms. Chris Sobczak, ES Supr.
Milwaukee County Dept. Of Human Services
1220 W. Vliet St., 2nd floor
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:

Nancy J. Gagnon
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (SSN xxx-xx-xxxx, CARES #xxxxxxxxxx) is a resident of Milwaukee County. He has been certified for SSI-related/Elderly-Blind-Disabled MA, and receives mental health services through the Milwaukee County Mental Health Complex (MHC).

2. In January, 2005, the county agency issued written notice to the petitioner advising that his MA certification was subject to satisfying a $1,729.98 deductible, and that his certification would end effective February 1, 2005, for failure to meet that deductible.

3. Prior to hearing, the petitioner did submit deferred billing documentation from the MHC to the county agency that purported to satisfy the entire amount of his deductible. Prior to 2005, the agency had accepted this type of documentation, consisting of itemized statements of services and deferred charges from the MHC, for purposes of MA deductible satisfaction. However, the agency rejected this documentation for the petitioner's current deductible.

4. In November, 2004, the county agency rejected the MHC itemized statement from patient C.R. (see DHA Decision MED-40/68304) as adequate documentation of deductible satisfaction for the upcoming six-month deductible period. The county agency's action had its genesis in a letter from the Department's Vicki Jessup to the county agency, dated October 6, 2004. See Exhibit 1. In that letter, the Department referenced an earlier deductible period for C.R., observed that the deductible had been correctly calculated, but asserted that the documentation of deductible satisfaction was unacceptable. Specifically, the Department objected to the use of an MHC itemized statement for deferred inpatient charges:

> We were unable to obtain consistent information from the Milwaukee County Mental Health Division about whether the "deferred charges" are considered still owed or written off. Therefore, we have determined that this expense is allowable only if Ms. Rau provides a written off date that meets the above criteria OR submits a current bill from Milwaukee County Mental Health Division that clearly indicates the charges are **currently owed**. For Medicaid eligibility purposes, charges that are in deferred status cannot be used to satisfy a deductible unless the provider bills the client or provides a written-off date.

The county agency filed its disagreement with this Department determination, arguing that the itemized statements represented charges that are still owed to MHC by C.R. The Department's position on this case remained unchanged.

5. On January 11, 2005, the Department amended its main policy document, the *Medicaid Eligibility Handbook*, to include language rejecting deferred bills for the purpose of deductible satisfaction, subject to some exceptions.

DISCUSSION

At issue in the instant case is whether the Department incorrectly instructed the county agency to disallow submissions from MHC for purposes of documenting the petitioner's satisfaction of his MA deductible for the February 1 through July 31, 2005, deductible period. An MA applicant or recipient whose income exceeds the MA "medically needy" income limit must pay a deductible that equals the increment of income over the limit, multiplied by six for the six-month duration of the deductible period. Wis. Stat. §49.47(4)(c)2; *MEH*, 4.9.1.- 4.9.2. There is no dispute as to the correctness of the agency's calculation of the deductible amount here.

When the county agency was presented with an MHC itemized statement of deferred inpatient charges for the petitioner, the agency followed the instruction in the Department's January 11, 2005, *MEH* amendment, and declined to accept the deferred charges statement as evidence that the petitioner's then-upcoming deductible had

been satisfied. The rationale for this action appears to be a policy decision that, in general, a statement of deferred charges is unacceptable for this purpose. The policy language is as follows:

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> 1. Be an expense for a member of the applicant/recipient's FFU (4.8.1) or FTG (5.1.5)
>
>   Expenses may be counted if incurred for someone the client is legally responsible for if that individual could be counted in the client's FTG or FFU. The medical bill may be used even if the family member is no longer living or no longer in the current FTG or FFU.
>
>   ...
> 2. Meet the Definition of Medical or Remedial expense as defined in (4.9.8.1.1)
>
> 3. Meet one of the following four conditions
>
>   B. Still be owed to the medical service provider sometime during the current deductible period.
>
>   **Note**:. Charges that are in deferred status cannot be used to satisfy a deductible unless the provider bills the client or provides a write-off date.

Example2: From May- July 2003 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2004, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for MA on Helen's behalf. Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $ 14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred", she explained, means that the client would never be billed for the charges, but if s/he happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt. Helen can not use this "deferred" charge toward her deductible. Charges in deferred status cannot be used to satisfy a deductible unless the provider bills the client, with an expectation that they will pay the bill or, writes off the bill and provides a write-off date..

> C. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.
>
> D. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.
>
> E. Paid or written off some time during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

MEH, 4.9.8.1 (1-11-05).

By way of comparison, the rather limited legal authority on this topic is as follows:

§435.831 Income eligibility.

...

(d) *Deduction of incurred medical expenses.* If countable income exceeds the income standard, the agency must deduct from income medical expense incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) *Determination of deductible incurred expenses: Required deductions based on kinds of services.* ...

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

...

(6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income in establishing eligibility, to the extent that such expenses are unpaid and are:

(i) Described in paragraphs (e)(1) through (e)(3) of this section; and

(ii) Carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses

42 C.F.R. §435.831(d)-(f).

49.48 **Medical assistance; medically indigent.** ...

(4) ELIGIBILITY. ...

(c) ... 2. Whenever an applicant has excess income under subd. 1. or par. (am), no certification may be issued until the excess income above the applicable limits has been obligated or expended for medical care or for any other type of remedial care recognized under state law or for personal health insurance premiums or both.

Wis. Stat. §49.47(4)(c)2. Thus, these two authorities allow the deductible to be satisfied with an allowable medical bill that has been "incurred" by the patient, even though it has not been paid. Neither the federal rule nor state statute treats a "deferred" bill differently than any other unpaid bill for which the patient remains liable. Also, neither of these authorities calls for periodic payments against the incurred bill.

The state code throws in an extra wrinkle regarding the need for periodic payments, but does not call for the disallowance of "deferred" bills:

(3) EXCESS INCOME CASES. ...

(b) When an SSI-related or AFDC-related fiscal test group is found ineligible as medically needy and excess income is the only reason, the group may expend or incur obligations to expend the excess income above the appropriate medically needy income limit pursuant to s.49.47(4)(c)2. and 3., Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s.49.47(6), Stats., and chs. HFS 101 to 108 for the balance of the spend-down period.

(c) Health insurance premiums actually incurred or paid, plus any medical service recognized by state law received by a member of the MA or fiscal test group shall be counted toward fulfilling the excess income expenditure or incurrence requirement when the service is prescribed or provided by a medical practitioner who is licensed by Wisconsin or another state and if either or both of the following conditions are met:

1. The service is received during the spend-down period; or

2. The expense was incurred prior to the spend-down period and a fiscal test group member is still legally responsible for the debt and is consistently making payments, in which case the payments made during the spend-down period shall be counted.

Wis. Admin. Code §HFS 103.04(3)(b)-(c) (February, 2002).

None of the above authorities authorize the Department to disallow, for MA deductible satisfaction purposes, a medical expense that was incurred by the petitioner, and which is now characterized as "deferred" by the MHC. The first sentence of the quoted paragraph from the Department's October 6, 2004, letter in Finding #4 suggests to me that the Department may have experienced difficulty in getting an explanation of MHC's practice regarding inpatient charge deferrals. However, my hearing record is very clear with respect to this practice. MHC first determines whether a patient has insurance, and bills the insurer where applicable. When it is learned that the patient does not have insurance coverage for the service, MHC sends bills to the patient, followed by a pre-collection letter 30 days later. If there is no response, the bill is referred to the Tax Return Intercept Program (TRIP). Additionally, the charge is categorized as a deferred charge. A deferred charge is not a written-off charge, and the patient remains liable for its payment. A claim for the deferred charges will be filed against the patient's estate, if there is an estate. See Exhibit 10.

Thus, after reviewing the above authorities, I conclude that the Department's instruction at *MEH* §4.9.8.1, item #3A, to disallow deferred MHC charges for deductible satisfaction, is incorrect. The itemized statements of deferred charges establish that the patient has incurred a medical expense for which he remains liable, and that has not been paid. That is what the federal rule and state statute require. None of the above authorities carve out an exception to acceptance of "incurred" charges for such charges where active billing has been deferred.

As a footnote, the submitted documentation may not satisfy the state code requirement that the recipient be "consistently making payments" against the debt. Although I suspect that the petitioner has not been consistently making payments, no evidence was taken on the frequency or amount of payment that this recipient may have made against the bill. Also, failure to make consistent payments was not cited by the agency as a reason for MA discontinuance, and was not argued by the parties herein. Thus, I did not address the implications of the state code provision in this decision.

CONCLUSIONS OF LAW

1. The Department incorrectly declined to accept incurred, deferred MHC inpatient charges to satisfy the petitioner's deductible for the February 1 – July 31, 2005, period.

NOW, THEREFORE, it is **ORDERED**

That the petition herein be remanded to the county agency with instructions to redetermine the petitioner's MA financial eligibility in accord with Conclusion #1 above. This action shall be taken within 10 days of the date of this 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."

Given under my hand at the City of Madison, Wisconsin, this 12th day of May, 2005.

/s

Nancy J. Gagnon
Administrative Law Judge
Division of Hearings and Appeals
313/NJG MEDdeducM