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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 175387

PRELIMINARY RECITALS

Pursuant to a petition filed on July 7, 2016, 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 August 9, 2016, by telephone.

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

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]
Milwaukee Enrollment Services
1220 W Vliet St
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Peter McCombs
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of [redacted]. This is a skilled nursing facility.

2. On or about June 1, 2016, the petitioner submitted an application for institutional MA coverage.

3. The petitioner's gross monthly income is $10,366.81 consisting of $8,528.51 from an annuity, $330 and 506.30 from pension/other retirement, and $1,087.00 from social security ($1,002.00 plus $85.00).

4. The cost of the petitioner's skilled nursing facility is $10,740.00 each month.

5. The average cost for a private pay skilled nursing facility in Wisconsin is $7,693.90.

6. On June 30, 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 July 7, 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 ILTC 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. I 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:
> l. Personal needs allowance (39.4 EBD Assets and Income Tables).
> 2. Cost of institutional care (use private care rate).
> 3. Cost of health insurance (27.64 Health Insurance).
> 4. Support payments (15 .7.2.l Support Payments).
> 5. Out-of-pocket medical costs.
> 6. Work related expenses (15.7.4 Impairment Related Work Expenses (IRWE)).
> 7. Self-support plan (l5.7.2.2 Self-Support Plan).
> 8. Expenses for establishing and maintaining a court- ordered guardian ship 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 $10,740.00 each month. The petitioner's gross monthly income is $10,366.81. She argues that because this amount is less than the actual cost of her particular nursing home, she is eligible for institutional MA coverage.

In a recent Division of Hearings and Appeals (DHA) Proposed Decision adopted by the respondent, it was determined that:

> 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 hosed 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.

See, *DHA Decision MGE/173712*, September, 2016.

As noted in the referenced decision, MA is intended to cover only basic and necessary medical care. In 1935, House Report 265, 99th Cong, lst Sess., pt.l, 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 arc 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 $10,366.81, 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 more expensive nursing home.

As cautioned in *DHA Decision MGE/173712, "e*nrollment 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, **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 September, 2016

\s_____
Peter McCombs
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 September 27, 2016.

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