**STATE OF WISCONSIN**
**DEPARTMENT OF JUSTICE**

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October 14, 2009 OAG-4-09

Ms. Karen Timberlake
Secretary
Department of Health Services
1 West Wilson Street
Madison, WI 53707

Dear Ms. Timberlake:

¶ 1. You indicate that a group of counties is giving consideration to establishing a commission under Wis. Stat. § 66.0301. You advise that the commission would be a separate governmental legal entity that would lease a unit in an existing county-owned skilled care nursing home facility that currently provides specialized care to the developmentally disabled and to persons with mental illness. You state that the primary purpose of the commission would be to assure that this specialized unit continues to operate, thereby ensuring the continued availability of specialized services to residents of these counties. You also state that the commission would defray losses that are currently incurred solely by the county ("County") in which the specialized unit is located. My understanding is that both the County and all other counties that currently have residents in the specialized unit desire to voluntarily become commission members.

## BACKGROUND

¶ 2. Medicaid is a cooperative federal-state program created under Title XIX of the Social Security Act that provides reimbursement for certain kinds of medical care given to persons with limited financial resources. *Harris v. McRae*, 448 U.S. 297, 308-09 (1980). Although the federal and state governments share the costs of the Medicaid program, the primary responsibility for its administration lies with a designated single state agency in each state. 42 U.S.C. §§ 1396a(a)(5) and 1396b (2009). In Wisconsin, the Division of Health Care Access and Accountability ("DHCAA") in the Department of Health Services ("DHS") serves as the single state Medicaid agency under 42 C.F.R. Part 431 (2007). DHCAA reimburses health care providers for covered medical services received by persons who have qualified for Medicaid. Under Wis. Stat. § 49.45(2)(a)11., DHCAA certifies nursing homes and other health care providers to participate in the state Medicaid program. The Division of Quality Assurance ("DQA") in DHS licenses nursing homes. A nursing home licensed by DQA under Wis. Stat. § 50.03 qualifies as a Wisconsin Medicaid provider. Wis. Admin. Code § HFS 105.08. The legal entity that is named on the Wis. Stat. ch. 50 license issued by DQA is certified by DHCAA under the Medicaid

program as a nursing home provider. That legal entity receives Medicaid reimbursement from DHCAA.

¶ 3. Each county has "the primary responsibility for the well-being, treatment and care of the mentally ill, [and] developmentally disabled" who are residents of the county. Wis. Stat. § 51.42(1)(b). That "responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds." *Id.* Consequently, in protective placement proceedings "[e]xcept as provided in s. 49.45(30m), the county may not be required to provide funding, in addition to its funds that are required to be appropriated to match state funds, in order to provide protective placement or protective services to an individual." Wis. Stat. § 55.12(5).

¶ 4. You advise that few private nursing homes have programs or facilities for the specialized treatment and supervision of individuals with significant behavioral problems due to mental illness or developmental disabilities. You state that certain counties do operate nursing homes with dedicated units that provide such specialized services, but most counties lack the financial resources to establish such units. You indicate that a county that is responsible for the care of a resident who needs such specialized nursing home services therefore often contracts for the placement of that resident in another county in which there is a county nursing home that does have such a specialized services unit. You also state that most but not all residents to whom counties provide care and treatment under Wis. Stat. § 51.42 have qualified for Medicaid. A county nursing home that admits a Medicaid-eligible resident of another county bills the Medicaid program for the care that the nursing home provides. The authorized Medicaid reimbursement rate is normally significantly less than the full cost of providing specialized care for persons with mental illness or developmental disabilities. All Medicaid providers, including nursing homes, are precluded by federal and state statutes and regulations from billing otherwise legally or financially responsible third parties for any amount in excess of the applicable Medicaid reimbursement rate, even where the full cost of providing care to the patient substantially exceeds the amount of government reimbursement received. A county that operates a nursing home with a dedicated unit that provides specialized services to persons with mental illness or developmental disabilities must therefore use funds from its own county treasury to cover any deficits generated as a result of providing services to Medicaid recipients who are residents of other counties.

¶ 5. According to the information you have provided, the County owns and operates a nursing home that does include a dedicated unit which provides specialized services to persons with mental illness and developmental disabilities. You advise that the County has determined that it can no longer afford to cover substantial deficits that it is incurring in connection with the operation of the specialized unit, and that it therefore may be forced to close that unit. You state that the deficits result primarily from treating Medicaid patients who require specialized care for mental illness or developmental disabilities. My understanding is that the human services

departments of certain other counties currently contract with the facility to receive care for individual residents of those counties in the specialized unit of the nursing home and that those counties have proposed entering into an intergovernmental agreement under Wis. Stat. § 66.0301 to create a commission that would lease the specialized unit from the County. You indicate that the County would also be a party to the intergovernmental agreement and a member of the commission. It is my understanding that the specialized unit would not be governed by a multi-county human services department, as has been done in other counties that share costs of medical facilities. *See, e.g.*, *http://www.norcen.org/*. My understanding is that the human services department in each of these other counties would therefore continue to be required to enter into a contract with the facility for the care of each individual resident in the specialized unit. *See* Wis. Stat. § 51.42(3)(as)1r.

¶ 6. You state that the commission would be licensed and certified as a skilled Medicaid facility and would be responsible for all costs, including capital costs, necessary to maintain the specialized unit and keep it operational. You advise that the County would retain ownership of the land, building, fixtures, equipment, and personal property and would continue to provide all labor, materials, and related services necessary to operate the specialized unit. You indicate that the County would continue to hire, pay, supervise, and discharge all employees, would continue to maintain all financial accounts, and would continue to collect all patient charges.

¶ 7. You state that the commission would make payments to the County for rental of the facility. You advise that the rental payments would consist of reimbursement for all costs that could have been reported on Medicaid Program Nursing Home Cost Reports by the County had it not entered into the lease. You have not inquired about the Medicaid reimbursement aspects of the proposed lease arrangement.

¶ 8. You state that the commission would also pay additional funds to the County for the various services that the County agrees to continue to provide. You indicate that all state and federal funds that the commission receives in connection with the operation of the facility and all assessments made by the commission against its member counties would be remitted to the County by the commission.

¶ 9. You advise that the proposed annual assessments against the other counties would be entirely prospective and would take into consideration required lease payments, operational costs, anticipated patient days per member, capital costs, and any other expenses that the commission anticipates would be incurred in the ensuing fiscal year in order to maintain the facility in appropriate operating condition. You state that the assessments would be made against these counties on a uniform prorated basis. Although you have provided no specific examples, you advise that the proposed assessments would also take into consideration the prorated expenses to be incurred by the commission that are associated with a member county's

residents in the facility.[1] Because most persons who receive services in the specialized unit are Medicaid recipients, a substantial portion of the proposed assessments against the other member counties would therefore necessarily be used to defray deficits anticipated to occur as a result of providing care to Medicaid patients for whom each such county is responsible under Wis. Stat. § 51.42(1)(b).

¶ 10. You advise that annual assessments against the County would consist of two components. You indicate that one component of those assessments would be computed at the same uniform, prorated rate and upon the same bases that annual assessments are made against the other counties. My understanding is that this first component of the annual assessment would therefore take into consideration the prorated expenses to be incurred by the commission that are associated with the County's own residents in the facility. You advise that the second component of the annual assessment against the County would be a retroactive assessment that is the difference between the proceeds of all prospective assessments made against all counties at the uniform prorated rate and the actual costs of the commission's operations, as determined in its Medicaid cost reports. You have not inquired about the Medicaid reimbursement aspects of the commission's payment of all of the assessments to the County.

¶ 11. The materials you have provided indicate that a county could be expelled from the commission by a two thirds vote of all member counties. Those materials also indicate that a county could withdraw from the commission at the close of any fiscal year by providing timely notice to the commission. They also indicate that a condition of commission membership for the other counties would be that upon withdrawal or expulsion each such county must take all actions necessary to remove all of its residents who are patients of the facility in a manner that is consistent with federal and state law. You state that, by prior agreement, assessments against a county that withdraws or is expelled from the commission would continue as long as the county has residents in the facility.

## QUESTION PRESENTED AND BRIEF ANSWER

¶ 12. You ask whether the mandatory assessments by the commission would violate federal and state statutory and regulatory provisions prohibiting Medicaid supplementation.

¶ 13. In my opinion, counties may enter into joint agreements to collectively furnish and fund nursing home services if the agreements do not violate federal and state Medicaid statutes and regulations prohibiting supplementation. Assessments resulting from such agreements that

[1] *Compare* Wis. Stat. § 46.20(6)(b) (prescribing a specific method of proration for joint county institutions using "the percentage which the aggregate cost of keeping the inmates at public charge from each such county bears to the aggregate cost of keeping the inmates at public charge from all such counties," and "adopting as the unit of cost the total average cost per capita per week of keeping all the inmates, at public charge or otherwise, in said institution.").

are computed without reference to and that are not attributable to purchase of services contracts involving Medicaid patients would not constitute supplementation. Assessments that are computed with reference to or are attributable to purchase of services contracts involving particular Medicaid patients are not permissible. The validity of hybrid assessments that do not fit solely within either one of those two categories must be determined on a case-by-case basis.

¶ 14. You have not specifically inquired whether any county could be forced to join the commission in order to have its residents served by the specialized unit. I decline to provide an opinion concerning that issue because I understand that a similar issue is in civil litigation between two counties. *See* 77 Op. Att'y Gen. Preface No. 3.D. (1988).

## ANALYSIS

¶ 15. The term "supplementation" refers to "the practice by which [Medicaid] providers [attempt to] augment th[e] [Medicaid] reimbursement rate by billing other sources." 73 Op. Att'y Gen. 68, 68 (1984). In my opinion, the formation of a commission to fund the operation of the specialized unit would be permissible even though the commission could make mandatory assessment that would be used in part to cover deficits incurred in providing care to Medicaid recipients.

¶ 16. Wisconsin Stat. § 66.0301(2) authorizes counties to contract with each other for "the joint exercise of any power or duty required or authorized by law." Counties have "primary responsibility for the well-being, treatment and care of the mentally ill, [and] developmentally disabled" who are county residents. Wis. Stat. § 51.42(1)(b). Counties possess statutory authority to establish facilities that provide various forms of medical care, including nursing home care and mental health care. *See* Wis. Stat. §§ 49.70, 49.71, 49.72, 49.73, and 51.09. *See also* Wis. Stat. § 46.20 (authorizing the establishment of joint county institutions). Counties may therefore contract with each other under Wis. Stat. § 66.0301(2) to collectively provide nursing home and related mental health services to their residents. Any such contract may contain "provisions as to proration of the expenses involved" and may provide for "creation of a commission[.]" Wis. Stat. § 66.0301(3). A single county that owns or leases a nursing home that provides direct care including mental health services must cover all of the costs associated with the upkeep and operation of the facility, including all deficits incurred as a result of providing direct care to Medicaid patients. The formation of a commission under Wis. Stat. § 66.0301(3) appears to be designed to permit the counties that are commission members to jointly share all costs associated with the upkeep and operation of a multi-county specialized nursing home unit and to determine how those costs should be prorated among member counties. Costs associated with the upkeep and operation of a multi-county facility necessarily include any deficits incurred as a result of providing care to patients who are Medicaid recipients. Cost-sharing between counties is specifically authorized by statute.

¶ 17. Although Wis. Stat. § 66.0301(3) does provide statutory authorization for the proration of expenses among counties, it does not permit counties to prorate expenses in a manner that violates prohibitions upon Medicaid supplementation. *See* 73 Op. Att'y Gen. at 70. For purposes of the Medicaid program, transactions that lack economic substance and are entered into to avoid Medicaid statutes and regulations can be disregarded as sham transactions. *See Estate of Hagenstein v. Wisc. Health & Family Servs.*, 2006 WI App 90, ¶ 29, 292 Wis. 2d 697, 715 N.W.2d 645; *Cox v. Secretary, Louisiana Dept. of Health and Hospitals*, 939 So.2d 550, 554 (La. App.), *writ denied*, 944 So.2d 1274 (La. 2006); *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1104 (8th Cir. 2000), *cert. denied*, 534 U.S. 992 (2001). *See also Cedar Hill Manor, L.L.C. v. Dep't of Social Serv.*, 145 S.W.3d 447 (Mo. App. 2004). *Cf. Credit Recovery Systems, LLC v. Heike*, 158 F. Supp. 2d 689, 696 (E.D. Va. 2001); *Illinois Council for Long Term Care v. Miller*, 503 F. Supp. 1091, 1096 (N.D. Ill. 1980); *Moehle v. Miller*, 513 N.E.2d 612, 614 (Ill. App. 1987), *appeal denied*, 520 N.E.2d 387 (Ill. 1988). These cases consider all of the facts and circumstances when determining whether a transaction is a sham for purposes of the Medicaid program. *Compare Milwaukee Reg'l Med. Ctr. v. City of Wauwatosa*, 2007 WI 101, ¶ 35 n.8, 304 Wis. 2d 53, 735 N.W.2d 156 ("court evaluates all the facts and circumstances surrounding the case" when determining whether an entity is the beneficial owner of property).[2]

¶ 18. One form of supplementation involves seeking payments from Medicaid recipients that are in addition to reimbursement received from the Medicaid program for providing medical care. Subject to certain limited exceptions, Wis. Stat. § 49.49(3m) provides that it is a felony for a Medicaid provider to knowingly seek payments from a Medicaid recipient that are in addition to payments received by the provider under the Medicaid program. Similar language is contained in 42 U.S.C. § 1396a(a)(25)(C) (2009). As proposed, the assessments would not impose any additional charges upon Medicaid recipients themselves and therefore would not violate provisions such as 42 U.S.C. § 1396a(a)(25)(C) (2009) or Wis. Stat. § 49.49(3m) insofar as they prohibit Medicaid providers from seeking additional payments for covered services from Medicaid recipients.

¶ 19. Another form of supplementation involves seeking financial or other remuneration in addition to that provided by the Medicaid program as a precondition to admitting a Medicaid-eligible patient to a nursing home or as a requirement for a Medicaid-eligible patient's continued stay in a nursing home. Under 42 U.S.C. § 1320a-7b(d)(2)(A) and (B) (2006), it is a felony for a Medicaid provider to knowingly and willfully "charge[], solicit[], accept[], or receive[], in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration" either as a precondition to admitting a Medicaid patient to a nursing home or as a requirement for a Medicaid-eligible patient's continued stay in a nursing home. An exception is provided in

[2]To any extent that *Cox* employs a different approach, it provides no authority for departing from an examination of all the facts and circumstances.

42 U.S.C. § 1320a-7b(d)(2) (2006) for "a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient[.]" Virtually identical criminal felony provisions are contained in Wis. Stat. § 49.49(4)(a). Once a county chooses to become a member of the commission, the assessments against the county would be mandatory and not voluntary. They would not constitute charitable, religious, or philanthropic contributions. Member counties would be required to pay assessments resulting in part from anticipated Medicaid deficits generated as a result of operating and maintaining the facility.

¶ 20. Prior attorney general opinions are not helpful in determining the applicability of these criminal provisions because those opinions involve distinguishable fact situations. 73 Op. Att'y Gen. 68 concluded that these federal and state criminal statutes precluded a county from conditioning admission to its nursing home facility upon agreement by other counties to accept direct billing for certain services provided to Medicaid nursing home patients who were residents of those counties. In that situation, a group of counties was purchasing care from a particular county nursing home. In their capacity as purchasers of services, those counties were being required to enter into agreements to make additional purchases of services from the nursing home as a precondition to the admission of their residents who were Medicaid recipients. There was no attempt by the counties involved to establish a direct funding mechanism to defray the costs of operation of an entire nursing home facility, as there apparently is in the situation you describe.

¶ 21. In 76 Op. Att'y Gen. 295 (1987), these criminal provisions were construed to prohibit nursing homes from imposing guarantor requirements upon private parties to the extent that the guarantees would have been applicable to persons eligible for Medicaid. The guarantees described in that opinion ran afoul of those criminal provisions because they could have compelled private parties to make payments to nursing homes as purchasers of services at rates in excess of the Medicaid reimbursement rate. The payments required of the private parties were patient specific and would not have been made to directly fund and continue to maintain the operation of the nursing home in its entirety.

¶ 22. In 75 Op. Att'y Gen. 14, 24-26 (1986), these criminal provisions were construed to prohibit nursing homes from requiring patients to enter into agreements to remain on private pay status for a specified period of time before applying for Medicaid. The effect of those agreements would similarly have been to compel nursing home patients or related persons as purchasers of services to pay money to the nursing homes for nursing home services in excess of the amount that the nursing homes would have been entitled to receive from the Medicaid program. These requirements were also patient specific and would not have been made to directly fund and continue to maintain the operation of the nursing home in its entirety.

¶ 23. You have not specifically inquired whether any county could be forced to join the commission in order to have its residents served by the specialized unit. I decline to provide any opinion concerning the applicability of these criminal felony provisions under those

circumstances because I understand that a similar issue involving two counties is currently in civil litigation. Other legal issues under these criminal felony statutes are similar to the legal issues presented by third-party "balance billing," which is discussed below.

¶ 24. 42 U.S.C. § 1396a(a)(25)(C) (2009) generally precludes a Medicaid provider from attempting to collect from "any financially responsible relative or representative" of the patient any amount in excess of the amount of Medicaid reimbursement that the provider receives. That practice is referred to as third-party balance billing. It often involves direct billing of an entity that would otherwise have some legal or financial responsibility to provide medical care for a person but for the fact that he or she is a Medicaid patient. Wisconsin Stat. § 51.42(1)(b) is not an insurance or direct liability statute. A Medicaid provider cannot rely upon Wis. Stat. § 51.42(1)(b) as a basis for billing a county unless the county has entered into an agreement to purchase services from that provider. Counties purchase services from Medicaid providers only if they choose to do so. Third-party balance billing is more likely to occur where the cost of providing care to the patient substantially exceeds the Medicaid reimbursement rate, which apparently is the case in the situation you describe.

¶ 25. The federal implementing regulation, 42 C.F.R. § 447.15 (2007), is extremely broad: "A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual." Restrictions similar to those found in 42 C.F.R. § 447.15 (2007) are contained in Wis. Admin. Code § DHS 106.04(3), which provides:

> A [Medicaid] provider shall accept payments made by the department in accordance with sub. (1) as payment in full for services provided a recipient. A provider may not attempt to impose a charge for an individual procedure or for overhead which is included in the reimbursement for services provided nor may the provider attempt to impose an unauthorized charge or receive payment from a recipient, relative or other person for services provided, or impose direct charges upon a recipient in lieu of obtaining payment under the program, except under any of the following conditions [none of which is relevant to your inquiry.]

¶ 26. Court decisions have interpreted the phrase "any financially responsible . . . representative" in 42 U.S.C. § 1396a(a)(25)(C) (2009) in combination with the requirement in 42 C.F.R. § 447.15 (2007) that a Medicaid provider must "accept, as payment in full, the amounts paid by the [Medicaid] agency" to mean that billing the Medicaid program or accepting payment under the Medicaid program precludes collection of any additional funds from any third party for costs incurred as the result of treating a patient. *See, e.g.*, *Evanston Hosp. v. Hauck*, 1 F.3d 540, 543 (7th Cir. 1993), *cert. denied*, 510 U.S. 1091 (1994); *Spectrum Health Continuing Care Group v. Bowling*, 410 F.3d 304 (6th Cir. 2005); *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994), *cert. denied*, 516 U.S. 811 (1995); *Rybicki v.*

*Hartley*, 792 F.2d 260, 261 (1st Cir. 1986); *Lizer v. Eagle Air Med. Corp.*, 308 F. Supp. 2d 1006, 1009 (D. Ariz. 2004); *Mallo v. Pub. Health Trust of Dade County*, 88 F. Supp. 2d 1376 (S.D. Fla. 2000); *Olszewski v. Scripps Health*, 69 P.3d 927, 941-42 (Cal. 2003); *Dunlap Care Center v. Iowa Dept. of S.S.*, 353 N.W.2d 389, 394 (Iowa 1984); *Pub. Health Trust v. Dade County Sch. Bd.*, 693 So.2d 562, 566 (Fla. App. 1997); *Serafini v. Blake*, 213 Cal. Rptr. 207, 209-11 (Cal. App. 1985); *Palumbo v. Myers*, 197 Cal. Rptr. 214, 222-23 (Cal. App. 1983); *Nickel v. W.C.A.B. (Agway Agronomy)*, 959 A.2d 498, 506-07 (Pa. Cmwlth. 2008).

¶ 27. The prohibition upon third-party balance billing is stringent. The phrase "*payment in full*" in 42 C.F.R. § 447.15 (2007) means exactly what it says. *Spectrum*, 410 F.3d at 318 (italics by the court). 42 C.F.R. § 447.15 (2007) "prevents providers from billing *any* entity for the difference between their customary charge and the amount paid by Medicaid." *Lizer*, 308 F. Supp. 2d at 1009 (italics by the court).

¶ 28. Prior attorney general opinions do not address attempted third-party balance billing in connection with efforts to jointly fund the operation of an entire facility. 77 Op. Att'y Gen. 287 (1988) concluded that what is now 42 C.F.R. § 447.15 (2007) and what is now Wis. Admin. Code § DHS 106.04(3) precluded a county and a visiting nursing home association from entering into a contract under which that county would have been required to reimburse the association the difference between the association's cost of providing services to the residents of that county who were Medicaid recipients and the Medicaid reimbursement rates paid to the association for providing services to those persons. Such a contract would have enabled the association to "'impose an unauthorized charge or receive payment from . . . [an]other person for services provided,'" contrary to what is now Wis. Admin. Code § DHS 106.04(3). 77 Op. Att'y Gen. at 290. The county, acting as a purchaser of services, would have been required to "creat[e] a legal obligation to supplement the [Medicaid] amounts paid by the department [now DHS][.]" 77 Op. Att'y Gen. at 290. The opinion noted that the county was free to make independent gifts or grants to the association under what is now Wis. Stat. § 59.53(15). *See* 77 Op. Att'y Gen. at 288. No direct funding mechanism was proposed or examined in that opinion. The intergovernmental agreement proposed in 73 Op. Att'y Gen. 68 would have authorized direct billing to counties as purchasers of services for the difference between the applicable Medicaid reimbursement rate and the cost of nursing home care provided to residents of those counties. That opinion specifically declined to address the issue of whether direct funding would have been permissible. *See* 73 Op. Att'y Gen. at 72.

¶ 29. The third-party balance billing issue is complex because the mandatory assessments you describe possess aspects of a direct funding mechanism to defray the cost of operation of the entire facility, but the human services departments of the other counties apparently would also be purchasers of services under Wis. Stat. § 51.42(3)(as)1r. for individual residents who are patients in the specialized unit. The vast majority of those patients would be Medicaid recipients.

¶ 30. Mandatory prospective proportional assessments would not necessarily constitute knowing and willful acceptance of financial remuneration that is "in addition to any amount otherwise required to be paid under a State plan" within the meaning of 42 U.S.C. § 1320a-7b(d)(2) (2006) or within the meaning of similar language contained in Wis. Stat. § 49.49(4)(a). Mandatory assessments that are unrelated to purchase of services contracts involving Medicaid patients do not involve supplementation. For example, if each of the other counties that voluntarily joined the commission agreed in advance to an assessment of 1% of the annual operating and capital costs necessary to continue to maintain the facility, such assessments would have no relationship to individual purchase of services contracts and involving Medicaid patients and would not violate federal and state prohibitions upon supplementation. Assessments computed with reference to or attributable to purchase of services contracts involving particular Medicaid patients are likely to be considered sham transactions to facilitate third-party balance billing. For example, even if the assessments against the other counties are prospectively computed, they could not be prorated by using either percentages or dollar amounts if the proration depended solely upon the number of each such county's Medicaid recipients in the facility at the close of the previous fiscal year.

¶ 31. The proposed assessments you describe are hybrid assessments that do not fit solely within either one of these two categories. Certain aspects appear to be unrelated to purchase of services contracts involving Medicaid patients. The proposed assessments apparently would defray all costs necessary to operate the specialized unit. Such costs apparently include both operating and capital costs, and would encompass items such as utilities, insurance, repairs, taxes, certain capital improvements, and any other expenses that the commission anticipates would be incurred in the next fiscal year. While a substantial portion of the proposed assessments would defray deficits to be generated from treating Medicaid patients for whom the counties are responsible under Wis. Stat. § 51.42, those costs are necessarily a component part of all costs that must be incurred in order to operate a nursing home. Other aspects of the proposed assessments appear to be more closely attributable to purchase of services contracts involving particular Medicaid patients. You advise that the proposed assessments against the other counties are intended to take into consideration the expenses to be incurred by the commission that are associated with that county's residents, and that each such county is likely to have a substantial number of residents who are Medicaid recipients. You provide no specific examples of how this would be done. The more closely such hybrid assessments are computed with reference to or attributable to purchase of services contracts involving particular Medicaid recipients, the more likely a trier of fact would consider such assessments to be sham transactions used as a device to facilitate third-party balance billing. Whether a hybrid assessment constitutes a disguised form of third-party balance billing necessarily requires a highly fact-specific determination. Such determinations could vary from year to year and from assessment to assessment. An opinion of the Attorney General is not an appropriate vehicle for such fact-specific determinations. *See* 77 Op. Att'y Gen. Preface No. 3.C.

¶ 32. Other requirements that do not directly involve the manner in which the proposed assessments are computed may also be attributable to purchase of services contracts involving particular Medicaid patients. The proposed requirement that a county that withdraws or is expelled from the commission must agree to continue to pay assessments while any of its residents remain in the facility could be attributable to purchase of services contracts involving particular Medicaid patients. Additional requirements that involve financial considerations cannot be imposed upon a human services department that has entered into such a contract for care of an individual Medicaid recipient. Although I understand that any requirement involving a county's removal of its residents would be conditioned upon compliance with federal and state law, various federal and state statutes and regulations prohibit the transfer or removal of a patient from a nursing home that is capable of providing appropriate treatment unless the patient or guardian consents to the transfer or removal. *See* 42 U.S.C. §§ 1395i-3(c)(2) and 1396r(c)(2) (2006); 42 C.F.R. § 483.12 (2007); Wis. Stat. §§ 49.498(4) and 50.09(1)(j); Wis. Admin. Code § DHS 132.53. Even if there are limited circumstances under Wis. Stat. § 51.35[3] in which these provisions would be inapplicable to the human services departments of the other counties, patient removal is not a direct funding mechanism. Any patient removal requirement would also relate directly to any Medicaid patient with respect to whom a county human services department has entered into an individual contract under Wis. Stat. § 51.42(3)(as)1r.

## CONCLUSION

¶ 33. I therefore conclude that counties may enter into joint agreements to collectively furnish and fund nursing home services if the agreements do not violate federal and state Medicaid statutes and regulations prohibiting supplementation. Assessments resulting from such agreements that are computed without reference to and that are not attributable to purchase of services contracts involving particular Medicaid patients would not be considered supplementation. Assessments that are computed with reference to or are attributable to purchase of services contracts involving particular Medicaid patients are not permissible. The validity of hybrid assessments that do not fit solely within either one of those two categories must be determined on a case-by-case basis.

Sincerely,

J.B. Van Hollen
Attorney General

JBVH:FTC:cla

[3]Wisconsin Stat. § 51.35 does contain various provisions authorizing a county human services department to transfer the patient in situations where the care provided by a particular facility is no longer appropriate to the patient's medical condition. A county human services department has a statutory obligation to transfer the patient in those circumstances.