



FH
[REDACTED]

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

In the Matter of

[REDACTED]
[REDACTED]
c/o [REDACTED]
[REDACTED]
[REDACTED]

DECISION

CWA/154372

PRELIMINARY RECITALS

Pursuant to a petition filed December 23, 2013, under Wis. Admin. Code § HA 3.03, to review a decision by the Bureau of Long-Term Support/Include, Respect, I Self-Direct (IRIS) in regard to Medical Assistance, a telephonic hearing was held on February 25, 2014.

The issue for determination is whether the Washington County Department of Social Services (the agency) correctly terminated petitioner’s IRIS benefits.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
c/o [REDACTED]
[REDACTED]
[REDACTED]

Petitioner's Representative:

Attorney Heather B. Poster
401 East Kilbourn Avenue, Suite 403
Milwaukee, WI 53202-3212

Respondent:

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

By: Alana Brown
Bureau of Long-Term Support
1 West Wilson
Madison, WI

ADMINISTRATIVE LAW JUDGE:

Peter McCombs
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Milwaukee County, and has been enrolled in IRIS since June of 2013.

2. On June 5, 2013, petitioner received a notice notifying her of her Community Waivers application approval and her “monthly cost.” The monthly cost section of the notice references petitioner’s “spend down.” Exhibit E.
3. Petitioner’s representative was informed by her “Orientation Consultant” that she would not need to pay a spend down because of the high amount of her costs of care.
4. On November 20, 2013, petitioner was notified that she had a spend down requirement of \$1,762.19 per month. Exhibit C.
5. On November 26, 2013, petitioner was notified that her IRIS benefits were to be terminated effective January 1, 2014, due to her failure to pay the required monthly spend down amount. Exhibit D.
6. Petitioner’s attorney filed a request for Fair Hearing that was received by the Division of Hearings and Appeals on December 23, 2013. (Exhibit 1)

DISCUSSION

IRIS is a waiver program built to allow self-directed supports. The petitioner receives benefits through this program, which stands for Include, Respect, I Self-Direct. It is a fee-for-service alternative to Family Care, PACE, or Partnership for individuals requesting a long-term care support program in Family Care counties that was developed pursuant to waiver obtained through section 6087 of the Deficit Reduction Act of 2005 (DRA) and section 1915(j) of the Social Security Act. The waiver document providing the program’s authority is available at:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>.

The federal government’s general guidance for the program is found at 42 C.F.R. § 441.450 – 484. Those regulations require the Department’s agent to assess the participant’s needs and preferences, and then develop a service plan based on the assessed needs. *Id.*, § 441.466. The service plan may include personal care and homemaker services. *Id.*, §440.180(b). Further, “all of the State’s applicable policies and procedures associated with service plan development must be carried out ...” *Id.* § 441.468. Wisconsin IRIS policies are found online at:

<http://www.dhs.wisconsin.gov/bdds/iris/IRISPolicySummary.pdf>.

A person who receives both a Medical Assistance card and Family Care, and is not on “regular MA” because of excess income, is classified as being in Group A, Group B, or Group C.

Group A is, in part, for people who are 18 and over, who meet full benefit Elderly, Blind & Disabled (EBD) Medicaid financial and non-financial requirements and who are also functionally eligible for Family Care at either the nursing home or non-nursing home level of care. *Medicaid Eligibility Handbook (MEH) §29.3.1.*

Group B status is available to people 18 and over, who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for Family Care at the nursing home level of care, and whose income is at or below the Community Waivers Special Income Limit, which for a group of 1, is \$2,130. *MEH, §§29.3.1 and 39.4.1*

Group C status is for those people 18 and over, who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for Family Care at the nursing home level of care, whose income is above the Community Waivers Special Income Limit (\$2,130 for a group of 1) and whose allowable monthly expenses are sufficient to reduce their income to the medically needing income limit. *MEH, §§29.3.1 and 39.4.1*

It is undisputed that Petitioner falls into Group C status.

In order to be eligible for family care, a person in Group C status must expend income that exceeds the monthly medically needy income limit of \$591.67. *MEH*, §29.3.1. This amount is known as a spend down amount:

The spend down obligation is the amount a Group C waivers participant must incur monthly in medical/remedial expenses and/or Medicaid card services to lower countable income to the Medically Needy Income limit (See [39.4 EBD Assets and Income Tables](#)) The care manager monitors and documents that this occurs monthly.

A single Group C waivers participant must:

1. Incur, **and**
2. Be held financially responsible for the spend down amount on a monthly basis.

A married Group C waivers participant must:

1. Incur the spend down amount, **and**
2. Pay the cost share monthly, if applicable.

MEH §28.5.2

The spend down amount is calculated by subtracting the Medically needy income limit from an applicant's countable income. See *worksheet F-20919*; *MEH* §28.8.1. Countable income is determined using the following formula:

Gross Earned Income	
-\$65 and ½ earned income disregard	
+ Total Unearned Income	
-\$20 disregard	
-Special Exempt Income	
-Health Insurance Premiums	
-Excess Self Employment Expenses	
Countable Income	

Id.

The spend down amount should not be confused with the cost share, which is the amount a Family Care participant must pay to the State, via the managed care organization, to partially offset the cost of his Medicaid services. *MEH* §§27.7.1; 28.8.3.6

Wisconsin IRIS policies allow the program to end a participant's enrollment when one or more of these conditions exist:

- The participant's health and safety is at risk.
- Purchasing authority is mismanaged. For example, this includes but is not limited to:
 - Fraud.
 - Misrepresentation or willful inaccurate reporting of information.
- The participant moves to an ineligible living arrangement.

- The participant resides in a hospital, skilled nursing facility or state institution for longer than three months after the admission date to the facility. Note that if the participant informs the IRIS Program one of these settings will be a permanent living setting, then this is considered a voluntary disenrollment. The participant receives a Fair Hearing Notice related to his or her appeal rights.
- Failure to comply with Medicaid functional or financial requirements. This includes participating in the minimal number of required Support and Service Plan reviews.
- **Failure to pay a Medicaid cost share or to meet Medicaid spend-down obligations.**
- The participant does not identify a need for any IRIS Program service or support.

Id. (Emphasis added).

1. Spend Down Obligation June, 2013, through November, 2013.

The program seeks to end the petitioner's enrollment due to her failure to pay her spend down obligations. Simply put, the petitioner has clearly established that she was never notified of her spend down obligations prior to November 20, 2013. Petitioner's Orientation Consultant corroborated this in oral testimony at hearing, noting that he recalled telling petitioner's daughter that she would not have to write a check for the spend down. I find the June, 2013, notice to be worryingly vague referring to petitioner's "monthly cost," and her "spend down" in the same section. Is her monthly cost the same thing as her spend down? It would appear to be the case, but I can hardly impose my assumption on the petitioner in such an instance. In any event, the fact that petitioner's Orientation Consultant admittedly advised her not to pay the spend down eviscerates any argument by the respondent to the contrary. I found the Orientation Consultant's testimony to be very credible on this point.

2. Spend Down Obligations constitute an Overpayment?

The petitioner argues that the past-due spend down amount constitutes a non-recoverable overpayment. I am not aware of any determination of overpayment made by the respondent, and therefore do not find this argument ripe for adjudication at this time. Petitioner was notified via a Monthly Cost Share Report of an arrearage, but there has been no claim of an overpayment. In the event that the respondent determines to assert an overpayment, petitioner may appeal that issue at that time.

3. Spend Down Obligation December, 2013 to present.

Petitioner correctly notes that she does not have a cost share for the IRIS program, and she concedes that she does have a spend down obligation. Petitioner has entered into a personal care contract with her daughter, which results in payments for personal care services that equal her monthly spend down obligation. The respondent asserted at hearing that this constitutes a divestment of income, and that petitioner must expense Medicaid services to meet her monthly spend down.

Petitioner successfully addressed these arguments in her March 6, 2014 Memorandum of Law in Support of [REDACTED]. She correctly notes that a spend down can be met for an individual person by incurring and being held financially responsible for medical/remedial expenses or Medicaid card services. She further comments that MEH § 15.7.3 includes supportive home care as a remedial expense. As such, I find it reasonable to conclude that petitioner's personal care contract qualifies as a remedial expense that is properly the subject of petitioner's monthly spend down.

Respondent additionally argues that the supportive home care is actually a divestment, since petitioner already receives personal care services 13 hours each day. Since she is able to sleep for 6 hours uninterrupted, respondent reasons that there is no need for additional personal care services. The petitioner successfully rebuts this argument noting that petitioner's doctor commented that:

[Petitioner] has end-stage Parkinson's with an element of dementia. She is a fall risk and requires 24 hour care and assistance with transfers, toileting, bathing, and medication management.

Petitioner's Memorandum of Law in Support of [REDACTED], Exhibit 4. The respondent has not established that petitioner's personal care contract constitutes a divestment of income. Petitioner has established that the personal care contract is necessary for petitioner's care.

CONCLUSIONS OF LAW

1. The agency did not correctly terminate petitioner's IRIS enrollment for failure to pay her assessed spend down.
2. The agency has not asserted an overpayment nor sought recovery of overpaid benefits.
3. Petitioner's personal care contract qualifies as a remedial expense that is properly the subject of petitioner's monthly spend down.

THEREFORE, it is

ORDERED

That the agency rescind its termination of petitioner's IRIS enrollment and qualify petitioner's personal care contract as a remedial expense that is properly the subject of petitioner's monthly spend down.

The agency shall take all administrative steps necessary to complete these tasks within 10-days 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, Wisconsin 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 (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 4th day of April, 2014

\sPeter 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 April 4, 2014.

Bureau of Long-Term Support
Attorney Heather Poster