FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]
c/o [redacted]
[redacted]

DECISION

MGE/157892

PRELIMINARY RECITALS

Pursuant to a petition filed May 21, 2014, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Chippewa County Department of Human Services in regard to Medical Assistance, a hearing was held on July 15, 2014, at Chippewa Falls, Wisconsin.

The issue for determination is whether the county agency correctly denied the petitioner's application for institutional medical assistance because she allegedly failed to adequately verify her assets.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Jessica Hughes
Chippewa County Department of Human Services
711 N. Bridge Street
Chippewa Falls, WI 54729-1877

ADMINISTRATIVE LAW JUDGE:
Michael D. O'Brien
Division of Hearings and Appeals

FINDINGS OF FACT

1. The petitioner (CARES # [redacted]) is a resident of Chippewa County.

2. On April 23, 2014, the Centralized Document Processing Unit requested that the petitioner verify the value of a trust with her family name dated January 3, 1997, and her ability to obtain funds within 30 days from a WisPact trust.

3. The petitioner provided verification of the WisPact Trust to the county agency in November 2011.

4. The petitioner's attorney informed the county agency in November 2011 that she had depleted the trust with her family name and that the family was unable to find any documentation concerning it. On April 11, 2014, the petitioner indicated that the only asset in the trust was a bank account at the People's State Bank. The petitioner verified this asset.

5. Any assets that the petitioner has other than those in the WisPact Trust are under $2.000.

DISCUSSION

The petitioner is a nursing home resident whose institutional medical assistance benefits ended on October 31, 2013, when the county agency determined she did not adequately verify her assets. She reapplied at least twice, but the only relevant application for this hearing is one filed on March 31, 2014, because the earlier applications were denied more than 45 days before any appeal was filed. Wisconsin law requires recipients and applicants to appeal negative agency actions within 45 days. Wis. Admin. Code § HA 3.05(3). If the appeal is filed late, the Division of Hearings and Appeals has no legal authority to consider it. When the petitioner filed her latest application, she requested benefits retroactive to when they ended on October 31, 2013. However, medical assistance rules allow retroactive eligibility only back to "the first day of the month 3 months prior to the month of application." Wis. Admin. Code § DHS 103.08(1). Thus, her eligibility cannot begin before December 1, 2013.

Medicaid rules require recipients to verify relevant information, including assets. Wis. Admin. Code, § DHS 102.03(3)(h). Agencies must allow at least 30 days from the date of application, or 10 days from the date of the request, whichever is later, to verify the information. *Medicaid Eligibility Handbook,* § 20.7.1.1. *see also* Wis. Admin. Code § DHS 102.03(1). At different times, the county agency requested that the petitioner verify different information and ultimately denied her application when it considered her response insufficient. Although the agency requested a number of different items, it is difficult to determine which allegedly missing items provide the basis of its denial because it did not include its denial letter in the documents it provided to the Division of Hearings and Appeals. I will assume, based upon the documentation I have and the testimony at the hearing, that the agency denied the application because it determined that the petitioner failed to verify a trust established in 1997 and a more recent WisPact Trust.

Medical assistance is meant to provide medical care to those who cannot afford it. Verification rules are meant to limit medical assistance to those who actually need it. There is some tension between the goal of ensuring that the indigent receive benefits and that the state spends money only on those who qualify. Imposing strict verification procedures will lead to some who need benefits not getting them because a person may have lost access to the documents needed to complete the verification or lack the physical or mental ability to comply with the request. Conversely, imposing lenient procedures will allow some who should be ineligible for benefits to receive them.

The Verification rules in effect put the burden on those seeking benefits to prove that they are eligible but provide them with extensive flexibility in doing so. Workers are instructed not to "over verify," which occurs when the agency requires "excessive pieces of evidence for any one item." Workers are also instructed not to "exclusively require a particular type of verification when various types are possible" or to "verify information already verified unless [they] believe the information is fraudulent or differs from more recent information." And they are instructed to "[o]nly verify items necessary to determine eligibility for Medicaid." *Medicaid Eligibility Handbook,* § 20.2. Applicants and recipients must resolve questionable information, but workers must assist those who have "difficulty in obtaining" verification.

Workers cannot deny eligibility to those who lack the ability to produce verification. *Id.,* 20.5. These instructions are consistent with medical assistance regulations. According to Wis. Admin. Code, § DHS 102.03(1):

> An application for MA shall be denied when the applicant or recipient is able to produce required verifications but refuses or fails to do so….If the applicant or recipient is not able to produce verifications, or requires assistance to do so, the agency may not deny assistance but shall proceed immediately to verify the data elements.

The county agency had previously requested information about the trust set up in 1997 late in 2011. The petitioner's attorney informed the county agency in a November 18, 2011, letter that the trust's only asset had been her house, which she had sold. Money from the sale was then placed in a bank account. Her attorney also indicated that the family was unable to find any documentation concerning it. On April 11, 2014, the petitioner indicated that the only asset in the trust was a bank account at the People's State Bank that was reported separately. On May 22, 2014, her attorney pointed out that the petitioner was disabled and could not obtain this information herself. He requested that pursuant to *Medicaid Eligibility Handbook,* § 20.5, the agency seek any verification it required on its own.

A WisPact Trust allows disabled persons to place certain assets in a pooled trust. Because funds in these trusts are exempt from the medical assistance asset limit, the *Medicaid Eligibility Handbook,* § 16.6.6 **,** instructs workers to "[d]isregard pooled trusts for disabled persons managed by … WisPACT Trust I." As an exempt asset, it cannot affect eligibility, and there is no need to verify it other than to confirm its existence. The county agency had already done this, so there was no need to do so again. The petitioner's attorney indicated in an April 28, 2014, letter to the county agency both that he had already provided documentation of the trust to it and that the trust was exempt. He went on to say that he believed that the agency had everything it needed but that it should let him know if it did not. It never responded to this letter. His statement that the petitioner had already provided the agency with a copy of the trust is corroborated by his November 18, 2011, letter, which indicates that a copy of the trust was included.

The medical assistance application process is not supposed to be a minefield that can be navigated only by the most vigilant and lucky, but that is what appeared to be the case here. There was unnecessary. The evidence clearly shows that the agency was already aware that the petitioner's family trust had previously been substantially depleted and that the petitioner's representatives could not find documentation of it. It must have accepted these assurances because the petitioner was eligible for medical assistance for two years after the assurance were made. The petitioner's son testified believably that he had provided bank statements to the agency every month, so there was no reason to believe that it was hiding information or that anything about the trust had changed. When the petitioner's attorney reasserted these facts this spring, the agency should either have accepted his statements or attempted to obtain the information itself. As for the WisPact Trust, the worker who requested it did not testify, and the worker who testify could not provide any such reason. I am unaware of any reason for this request either. The petitioner had already provided a copy of the trust to the agency, so it was aware of its existence. Because the trust is exempt, it does not matter how much money the petitioner had in it

Based upon this, I find no basis for the finding that the petitioner failed to verify necessary information. Therefore, this cannot provide a basis for denying her application. The agency provided no other basis for denying the application. Nor did it provide any evidence that her financial situation has changed since last December. As a result, I find that she is eligible for medical assistance retroactive to December 1, 2014.

CONCLUSIONS OF LAW

The petitioner verified all of the information she is required to verify to be found eligible for medical assistance.

THEREFORE, it is **ORDERED**

That this matter is remanded to the county agency with instructions that within 10 days of the date of this decision it take all steps necessary to ensure that the petitioner is eligible for medical assistance retroactive to December 1, 2013.

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 30th day of July, 2014

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\sMichael D. O'Brien
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 July 30, 2014.

Chippewa County Department of Human Services
Division of Health Care Access and Accountability
Attorney Peter Grosskopf