



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[Redacted]
[Redacted]
[Redacted]

DECISION

MGE/162639

PRELIMINARY RECITALS

Pursuant to a petition filed December 13, 2014, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Door County Department of Social Services in regard to Medical Assistance, a telephone hearing was held on January 06, 2015. The record was not held open post-hearing. However, on January 13, 2015, two faxes were received from the respondent, and on January 21, 2015, a fax was received on behalf of the petitioner. None of the documents submitted post-hearing have been admitted as exhibits due to the fact that neither party was provided an opportunity to review and/or offer testimony regarding the content of said documents.

The issue for determination is whether the respondent correctly denied petitioner's QMB application due to petitioner's alleged failure to verify her income.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[Redacted]
[Redacted]
[Redacted]

Respondent:

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

By: [Redacted]

Door County Department of Social Services
Door County Government Center
421 Nebraska Street
Sturgeon Bay, WI 54235-0670

ADMINISTRATIVE LAW JUDGE:

Peter McCombs
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # Redact) is a resident of Door County.
2. Petitioner applied for Medical Assistance (QMB), but was informed that her application was denied by the respondent.
3. Petitioner provided copies of bank statements to the respondent, but the county worker wanted further information regarding two deposits.

DISCUSSION

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services (CMS) for people over 65 and for certain younger disabled people. Medicare is divided into two types of health coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges. Medicaid Eligibility Handbook (MEH), § 32.1.

As Medicare is an insurance program, it charges premiums. Wisconsin Medicaid pays some or all of their Medicare premiums for those who qualify (Medicare beneficiaries). There are four types of Medicare beneficiaries:

1. Qualified Medicare Beneficiary (QMB),
2. Specified Low-Income Medicare Beneficiary (SLMB),
3. Specified Low-Income Medicare Beneficiary Plus (SLMB+) a/k/a Qualifying Individuals – 1 (QI-1), and
4. Qualified Disabled and Working Individuals (QDWI).

MEH, § 32.1.1. The category of eligibility depends on the recipient's income. Benefits also differ from category to category. MEH, §§ 32.1-.5.

The Medicaid Handbook requires the agency to verify income at application, review, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. MEH §20.7. With regard to income, the handbook requires the agency to average the income over the period between payments if the amount or frequency of regularly received income is known. MEH § 15.2.3.

The respondent presented no exhibits at hearing, relying solely on testimony to establish that it correctly denied petitioner's QMB application. As such, the record does not establish the content of any notices or verification requests. An appeal summary prepared by the respondent was included in the file, but not added as an exhibit, since there was no indication that the summary was provided to the petitioner. The summary contains a timeline of sorts, but nothing was entered into the record to corroborate the information contained therein. The timeline pertaining to petitioner's QMB application contains a confusing litany of notices that were purportedly sent to the petitioner in November and December, 2014. Respondent testified that petitioner was first informed that the denial was due to her eligibility for Medicare Part A or Part B. Subsequently, she was informed that her denial was due to a failure to provide a bank statement, and on another occasion the denial was prefaced on a determination that petitioner's income exceeded program limits and that she failed to provide requested verifications.

At hearing, the respondent focused its denial determination on two deposits, one dated October 20, 2014, in the amount of \$263.41, and a second dated November 10, 2014, in the amount of \$433.41. The respondent testified that because the petitioner did not timely provide adequate verification of these items, her QMB application was denied.

Medical Assistance verification policy states:

Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances. Documentation is a method by which you accomplish verification.

You will ask the questions needed to determine eligibility, but only need to verify mandatory and questionable items.

If the member is applying for other programs of assistance or if you are looking for sources of verification, see the specific verification chapters for those programs in their respective handbooks.

20.1.2 Documentation

Case comments in CARES provide documentation. Your notes report what happened in collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed. There is no requirement to photocopy and file verification items.

20.1.3 Verification Receipt Date

The verification receipt date is the day verification is delivered to the appropriate Income Maintenance agency or the next business day if verification is delivered after the agency's regularly scheduled business hours. Income Maintenance agencies must stamp the receipt date on each piece of verification provided.

...

Income

Verify all sources of non exempt income for EBD Medicaid applicants and recipients. Verify income using the automated data exchanges, when current (the month for which eligibility is being determined) information is available on a specific data exchange. If current income information is not available through a data exchange, the applicant/recipient is required to supply verification/documentation of their earned and unearned income.

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e. checkstubs, award letters, etc.).

The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

Ineligible persons who do not provide an SSN and whose income would be counted in the eligibility determination (Fiscal Test Group member);

Non-citizens without an SSN applying for emergency services. Persons whose employers do not report wages to the Department of Workforce Development (DWD) in Wisconsin, such as Wisconsin residents who work out of state and persons who work for the federal government.

Persons with income from sources that are never available to IM workers through a data exchange, such as self-employment, pensions, retirement income, etc.

The applicant/member is responsible for providing verification of income that is not available through data exchange. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the applicant/member through other sources (i.e. check stubs, award letters, etc.).

Assist the applicant/member in obtaining verification if s/he has difficulty in obtaining it.

Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely when the following two conditions exist:

The applicant/member does not have the power to produce verification, and Information is not obtainable timely even with your assistance.

In this situation, continue to attempt to obtain the verification. Once the verification is received, benefits may need to be adjusted based on the verified information.

MEH, §§ 20.1.1 and 20.3.8.

Based on the record before me, it is difficult to determine whether the respondent has complied with some, or any, of the verification request requirements.

Furthermore, whether or not the the October 20, 2014 and/or November 10, 2014 deposits constitute income for QMB eligibility purposes is unknown, and has not been established by the respondent. The respondent testified that it believes that petitioner is receiving short term disability payments. Nothing in the record corroborates this or otherwise links either or both of the October 20, 2014 and/or November 10, 2014 deposits to payments of short term disability.

Considering the lack of any documentation establishing that the respondent correctly denied petitioner's QMB benefits, I will remand the case to the respondent. The county will be ordered to review and re-determine petitioner's QMB from November, 2014, and going forward, and re-issue a new determination to petitioner.

CONCLUSIONS OF LAW

The respondent failed to establish that it correctly denied petitioner's QMB application.

NOW, THEREFORE, it is **ORDERED**

That the matter be remanded to the county with instructions to re-determine petitioner's QMB eligibility from November, 2014, going forward. The county shall take this action and issue appropriate notice 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 29th day of January, 2015.

\sPeter McCombs
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
Suite 201
5005 University Avenue
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: <http://dha.state.wi.us>

The preceding decision was sent to the following parties on January 29, 2015.

Door County Department of Social Services
Division of Health Care Access and Accountability