FH
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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

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

DECISION

MGE/162661

PRELIMINARY RECITALS

Pursuant to a petition filed December 11, 2014, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Eau Claire County Department of Human Services in regard to Medical Assistance, a hearing was held on January 14, 2015, at Eau Claire, Wisconsin.

The issue for determination is whether the petitioner's income is within the Family Care medical assistance limit.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

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

Petitioner's Representative:

Attorney Peter E. Grosskopf
1324 West Clairemont Avenue, Suite 10
Eau Claire, WI 54701

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Sheila Morden
Eau Claire County Department of Human Services
721 Oxford Avenue
PO Box 840
Eau Claire, WI 54702-0840

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

FINDINGS OF FACT

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

2. The petitioner applied for medical assistance on May 27, 2014. The county agency denied her application on July 8, 2014, because she allegedly failed to verify her financial information. The Division of Hearings and Appeals remanded the matter back to the agency on October 28, 2014, with instructions to continue processing the application. *DHA Decision No. MGE/160110.*

3. The county agency sent the petitioner both a positive and a negative notice concerning her eligibility on November 21, 2014. The positive notice stated: "Your application for MA Deduct has been approved, effective [no date provided]. The negative notice stated: "Your application for Medicaid/BadgerCare Plus for the months of August 2014 has been denied because you do not have enough med/remedial expenses to be eligible for Family Care." That notice indicated that her deductible was $2,108.06 per month. Both notices informed her that she must appeal within 45 days if she disagreed with the decision.

4. The petitioner filed an appeal on December 11, 2014.

5. At the hearing, the worker indicated that no actual denial had been made because a decision could not be made until the Aging and Disability Resource Center (ADRC) determined the petitioner's cost of care.

6. The petitioner did not receive any notice that her matter must still be reviewed by the ADRC. The ADRC did not appear at the hearing.

7. The petitioner's monthly income is $2,699.73 per month.

DISCUSSION

The petitioner is a 95-year-old woman who has been seeking medical assistance through the Family Care program since last May. This program provides appropriate long-term care services for elderly or disabled adults. It is supervised by the Department of Health and Family Services, authorized by Wis. Stat. § 46.286, and comprehensively described in Chapter DHS 10 of the Wisconsin Administrative Code. The process contemplated for an applicant is to test functional eligibility, then financial eligibility, and, if both standards are met, to certify eligibility. The applicant is then referred for enrollment in a CMO, which drafts a service plan.

The county agency denied her application in July 2014 because she failed to adequately verify information needed to determine whether she was eligible. The Division of Hearings and Appeals reviewed that decision. It found that the verification was not submitted within the deadline imposed by the agency but granted additional time to do so because of extenuating circumstances. She apparently provided the needed verification. On November 21, 2014, the county agency sent her both a positive and a negative notice concerning her eligibility. The positive notice stated, "Your application for MA Deduct has been approved, effective [no date provided]. The negative notice stated, "Your application for Medicaid/BadgerCare Plus for the month of August 2014 has been denied because you do not have enough med/remedial expenses to be eligible for Family Care." That notice indicated that her deductible was $2,108.06 per month. Both notices informed her that she must appeal within 45 days if she disagreed with the decision. She followed these instructions and filed a timely appeal on December 11, 2014. But at the hearing, the county worker informed her representatives and me that no actual denial had been made because a decision could not be made until the Aging and Disability Resource Center (ADRC) determined her cost of care.

Nothing in the two notices sent on November 21 mentioned the ADRC. Nor did they indicate that a negative action had not yet taken place and the petitioner did not have to appeal; on the contrary, as mentioned, the noticed specifically told the petitioner she had to appeal within 45 days. And the reason she had to appeal was because she had not met her deductible, which was directly related to her cost of

care. (I am aware that the denial notice mentioned only August, but it would be asking a great deal of the petitioner to assume that this means that she can appeal the later months some other time.)

The agency is correct that the ADRC is supposed to be involved in the Family Care process. It is one of the three groups that administer the program. The other two are income maintenance agencies and managed care organizations. The *Medicaid Eligibility Handbook,* § 29.2, summarizes the group's various responsibilities:

1. An Aging and Disability Resource Center (ADRC) serves as a "one-stop" shopping point to provide information and assistance in accessing available support services, housing, costs, and community services. ADRC staff also assess potential clients' functional level of care, which is an eligibility criteria.
2. Income Maintenance Agencies determine and certify Medicaid and Family Care non-financial and financial eligibility, and process Family Care enrollment.
3. Managed Care Organizations (MCOs) complete a comprehensive assessment and develop a plan of care, as well as provide and/or coordinate long term care services for Family Care enrollees. Participants in the Family Care program choose to be enrolled in a MCO.

The interplay of the responsibilities of these groups has created the thicket that must be untangled. The county's income maintenance worker determined that if the petitioner is eligible for Family Care it is under what is known as Group C. This category is for persons whose monthly income exceeds the Community Waivers Special income limit, which is currently $2,163, but who have enough allowable expenses to reduce their income to the medically needy limit, which has been $591.67 for decades. *Medicaid Eligibility Handbook,* §§ 293.1. and 39.4.1. The petitioner's monthly income is $2,699.73. Subtracting $591.67 gives the $2,108.06 deductible the petitioner must meet.

The agency worker could not say why the ADRC had not acted or when it would. In matters such as this, the ADRC is aligned with the county economic support unit as an agency of the department. Together, they have a duty to make a decision on eligibility and present evidence to support their decision at a hearing. Their delay has potentially delayed the petitioner's benefits because she can receive Family Care only after she is enrolled with a CMO. Wis. Admin. Code, § DHS 10.41(1) . I cannot rule against the agency and order it to provide benefits because the petitioner has the burden of proving by the preponderance of the credible evidence that she is eligible, and I simply lack the evidence to make that finding at this point.

But that does not mean she has no remedy. Wisconsin law requires the agency to "determine the applicant's eligibility and cost sharing requirements" within 30 days of receiving a signed application. Wis. Admin. Code, § 10.31(6)(a). Part of the delay here was caused because the petitioner had trouble verifying her information. But after this the agency informed her that it was denying her application, she filed a timely appeal, and she showed up for the hearing, only to be told, in effect, that the department was not ready to proceed because, despite what the notice clearly said, it had not yet determined her eligibility. The earlier DHA decision concerning verification was issued on October 21, 2014. I assume the agency had whatever verification it needed within 10 days of this. It should not profit from its own delays. I am going to order the agency together with the ADRC to make a decision concerning her eligibility and share of her costs within 10 days. If it finds her eligible, it must take whatever steps are necessary to ensure that she gets benefits retroactive to November 1, 2014. If it denies benefits to her and she appeals and prevails, she will be eligible for benefits retroactive to this date.

CONCLUSIONS OF LAW

1. The agency denied the petitioner's application for Family Care medical assistance on November 21, 2014.
2. There is not enough evidence to determine whether the petitioner is eligible for Family Care or what her contribution to her medical costs should be if she is found eligible.
3. The agency has failed to determine the petitioner's eligibility and share of her medical costs within the time set by law.

THEREFORE, it is **ORDERED**

That this matter is remanded to the county agency and the ADRC with instructions that within 10 days of the date of this decision they determine whether the petitioner is eligible for Family Care and, if she is, what her share of her costs are. If the agency finds her eligible, it shall take whatever steps are necessary to ensure that she gets benefits retroactive to November 1, 2014. If it denies benefits, she may file a new appeal.

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 11th day of February, 2015

\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 February 11, 2015.

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