FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: FCP - 176556

PRELIMINARY RECITALS

Pursuant to a petition filed on September 3, 2016, under Wis. Admin. Code § DHS 10.55, to review a decision by the Milwaukee Enrollment Services regarding Medical Assistance (MA), a hearing was held on December 6, 2016, by telephone.

The issue for determination is whether the agency properly determined the start date for the Petitioner's enrollment in Family Care.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
Milwaukee Enrollment Services
1220 W Vliet St
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
\sDebra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Milwaukee County. Petitioner has resided in a CBRF at [redacted] since 2013. Petitioner's authorized representative at all times pertinent hereto was her daughter [redacted].

2. On May 20, 2016, the Milwaukee County Department of Aging received an initial referral for options counseling for the Petitioner. On or about May 26, 2016, the Petitioner's representative attempted to apply for healthcare benefits online but was unable to apply. She called and was advised her application was not valid and she was unable to continue the application process.

3. On June 1, 2016, a worker met with the Petitioner and CBRF administrator at the CBRF. A functional screen was completed. The enrollment forms were left at the CBRF for [redacted] to sign. The worker attempted to enter the functional screen information into the agency's system but was unable to do so because another name was attached to the Petitioner's Social Security number.

4. On or about June 14, 2016, the worker contacted [redacted] and informed her that the functional screen was complete and that she would need to sign the paperwork. The worker also informed her that there were technical issues with entering the information in the system due to the problems with the SSN being attached to another individual.

5. On or about June 14, 2016, the agency Help Desk advised the worker to use a "pseudo" SSN to process the Petitioner's functional screen and correct the SSN later. The Petitioner was found to be functionally eligible for Family Care.

6. On June 18, 2016, [redacted] signed a Family Care Enrollment Form. The Form states that the Petitioner resides in a CBRF. She signed a medical/remedial expenses checklist on June 21, 2016.

7. On June 29, 2016, the long-term care packet for the Petitioner was forwarded to the income maintenance agency to determine the Petitioner's financial eligibility. The application stated that the Petitioner was institutionalized. The income maintenance agency did not receive a request for the Family Care program. On June 29, 2016, the agency denied eligibility for the Petitioner for being over the income limit. This was an error. The case was pended because additional information was needed to process the application.

8. On July 6, 2016, the income maintenance agency received the Petitioner's waiver request and began processing it.

9. On July 7, 2016, the agency issued a Notice of Proof Needed to [redacted] requesting for verification of Petitioner's income and assets.

10. On July 12, 2016, [redacted] contacted the worker at Milwaukee County Department of Aging to inquire about the status of the case. The worker informed [redacted] that the income maintenance agency pended the case for verification and was waiting for her to submit verifications. [redacted] informed the worker that she had not received any request for verification.

11. On July 15, 2016, the agency issued request for verification.

12. On July 25, 2016, the agency received the required information to process the application. The Petitioner was found financially eligible for Institutional Medicaid with a backdate to June 1, 2016.

13. On July 26, 2016, the income maintenance agency issued a Notice of Decision to [redacted] informing her that the Petitioner was enrolled in Institutional MA effective June 1, 2016 with a monthly cost share of $516.

14. On August 4, 2016, the worker at Milwaukee County Department of Aging contacted [redacted] to verify that the Petitioner resides in a CBRF. On August 10, 2016, the income maintenance agency was informed the Petitioner was in a CBRF.

15. On August 11, 2016, a Notice of Decision was issued to [redacted] informing her that additional information was needed from the care manager regarding Petitioner's eligibility for Family Care.

16. On August 11, 2016, the income maintenance agency notified the ARDC that the Petitioner was ready to enroll.

17. On August 16, 2016, the ARDC contacted [redacted] and informed her that the Petitioner could be enrolled. An enrollment date of September 1, 2016 was discussed. Petitioner's representative requested additional time to decide on which program.

18. On August 18, 2016, the Petitioner's representative contacted the ARDC with her choice of MyChoice Family Care. The Petitioner's representative raised a concern regarding the start date of September 1, 2016 and was advised to file an appeal if she disagreed.

19. On August 19, 2016, the Petitioner's enrollment into MyChoice Family Care was completed with an enrollment start date of September 1, 2016.

20. On August 25, 2016, the income maintenance agency issued a Notice of Decision to [redacted] informing her that effective September 1, 2016, the Petitioner was enrolled in Family Care.

DISCUSSION

The Family Care program, which is supervised by the Department of Health Services, is designed to provide appropriate long-term care services for elderly or disabled adults. It is authorized in the Wisconsin Statutes, §46.286, and is described comprehensively in the Wisconsin Administrative Code, Chapter DHS 10.

Wis. Admin Code, § DHS 10.31(6) Eligibility determination.

> (a) Decision date. Except as provided in par. (b), as soon as practicable, ***but not later than 30 days from the date the agency receives an application*** that includes at least the applicant's name, address, unless the applicant is homeless, and signature, the agency shall determine the applicant's eligibility and cost sharing requirements for the family care benefit, using a functional screening and a financial eligibility and cost-sharing screening prescribed by the department. If the applicant is a family care spouse, the agency shall notify both spouses in accordance with the requirements of s. 49.455 (7), Stats.
>
> (b) Notice. The agency shall notify the applicant in writing of its determination. ***If a delay in processing the application occurs because of a delay in securing necessary information, the agency shall notify the applicant in writing that there is a delay in processing the application, specify the reason for the delay, and inform the applicant of his or her right to appeal the delay by requesting a fair hearing under s. DHS 10.55.***

(emphasis added)

Wis. Admin. Code, §DHS 10.33(2) provides that an FCP applicant must have a functional capacity level of comprehensive or intermediate (also called nursing home and non-nursing home). The process contemplated for an applicant is to test his/her functional eligibility, then his/her financial eligibility, and if s/he meets both standards, to certify him/her as eligible. Then s/he is referred to a Managed Care

Organization (MCO) for enrollment in the MCO. See Wis. Admin. Code, §§DHS 10.33 – 10.41. The MCO then drafts a service plan using MCO selected providers, designing a care system to meet the needs of the person, and the person executes the service plan. At that point the person's services may begin. With regard to the start date, Wis. Admin. Code, §DHS 10.36(1), provides that a person who meets all conditions of eligibility is entitled to enroll in an MCO. §DHS 10.36(2) provides that entitlement to the FC benefit first applies on the effective date of the contract between the MCO and the applicant:

> …
>
> (a) Effective date. Except as provided in pars. (b) and (c), within each county and for each CMO target population, entitlement to the family care benefit first applies on the effective date of a contract under which a CMO accepts a per person per month payment to provide services under the family care benefit to eligible persons in that target population in the county.
>
> …

Wis. Admin Code, §DHS 10.36(2)(a).

DHA explains the process for applying for Family Care as follows:

> 1. There are three steps to determine eligibility and enrollment in a Family Care MCO. The ADRC helps people with each step. The ADRC will visit the person and complete the Long Term Care Functional Screen to assess the person's level of need for services and functional eligibility for the Family Care benefit. Once the individual's particular needs for long-term care are determined, the ADRC will provide advice about the options available to him or her. Options may include enrollment in Family Care, Partnership, IRIS or a different long-term care program. Or the person could choose to receive services through the Medicaid fee-for-service system, or to privately pay for services.
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> 2. If the person is interested in Family Care or another Medicaid program, the ADRC will help the person contact an income maintenance agency to determine financial eligibility.
>
> 3. Once functional and financial eligibility is established, the ADRC contacts the person, either by phone or in person. The ADRC makes sure the person understands what it means to become a member of the MCO, and that he or she understands all the options for long-term care available. If the person decides on Family Care, the resource center finishes the enrollment process and notifies the MCO of the enrollment date.

https://www.dhs.wisconsin.gov/familycare/apply.htm

Strictly applying the regulations concerning the date of Family Care enrollment can and has lead to harsh results. With many entities involved—local agencies, the ADRC, and the CMO—applications sometimes get lost in the shuffle and the chance for error increases. When this happens, the potential recipient, through no fault of his own, does not receive benefits he is entitled to and must find his own financing for things such as nursing care and adult family homes. Because Family Care benefits are not retroactive, stringently applying the regulation that allows benefits only to those actually enrolled in a CMO does not allow the department or the Division of Hearings and Appeals to correct any error that might occur somewhere in the application process by paying for services the applicant has already received and was eligible for. The Division of Hearings and Appeals has issued a number of decisions upholding this type

of result because it lacks equitable powers that would allow it to consider the fairness of the situation. See, e.g., DHA Decision No. FCP/163632.

In the last year, the Department of Health Services has issued some final decisions that mitigate the harshness of this interpretation. Although the department's final decisions are not binding on the Division of Hearings and Appeals, the division generally gives them significant weight and deference. Recently, the Department issued Final Decision No. FCP/173457. In that matter, the agency incorrectly calculated the applicant's assets, which led to an incorrect denial of Family Care benefits. The final decision reversed the denial and found the applicant eligible back to the date of his second application. In doing so, it held: "Although there is no retroactive enrollment in the Family Care program, enrollment as of the date established in correction of an agency error is necessary and appropriate."

Another final decision, this one modifying a decision the Division of Hearings and Appeals issued last October, found that enrollment in a CMO can begin "effective the actual date on which an individual completed an enrollment form and meets all eligibility and entitlement criteria, even if that date is earlier than the date on which the agency completes all its calculations/verifications and verifies the individual has met all financial and non-financial eligibility criteria." Final Decision No. FCP167655. As an example, it noted that if a "person was determined to be functionally eligible on January 1st and also completed the MA application and the Family Care Enrollment form on January 1st, but the agency finishes its eligibility determination on February 5, 2015, and verifies the person met all financial, non-financial eligibility criteria as of January 1st, there is nothing that precludes enrolling the person effective January 1st."

There are three points to take from this decision. First, enrollment can begin before the date the CMO actually accepts the person into the program. The department noted that in these instances, the CMO could receive capitation payments to cover the cost of the service it provided before the person was formally accepted into the program. Of course, if the applicant loses his appeal, he may be responsible for those costs. The second point is that financial eligibility does not depend upon the date the applicant proves that he is financially eligible but rather on the date he actually met the financial requirements. Third, functional eligibility begins on the date a functional screen establishes that the person is functionally eligible. This is established by the language in Final Decision No. FCP167655 that makes eligibility dependent on the date the person was determined to be functionally eligible." This refers to the date that the determination was made. If the department had meant for functional determinations to consider the person's functional ability before it was determined, the language would clearly state this as it did when referring to financial eligibility.

In this case, the Petitioner's functional eligibility was determined as of June 14, 2016. With regard to financial eligibility, the income maintenance agency determined the Petitioner was financially eligible for MA as of June 1, 2016. I conclude the numerous errors and delays in processing the Petitioner's application and eligibility delayed her enrollment in Family Care. Some of the delays were explained by the technical issues in processing the application and some were based on agency delay due to agency error or other delays that did not have an adequate explanation. Specifically, there was a delay of several weeks in June, 2016 while the agency tried to determine how to process the Petitioner's application due to her Social Security number being incorrectly assigned to another individual. In addition, though the Petitioner's functional eligibility was determined as of June 14, 2016 and the necessary enrollment forms were signed on June 18, 2016, the enrollment forms were not sent to the income maintenance agency until June 29, 2016. There was no explanation provided at the hearing for that delay in forwarding the enrollment forms to income maintenance. Further delays were caused when the Department of Aging erred with regard to her residence in a CBRF and when the income maintenance agency improperly processed the application as a result of that error.

The Petitioner's enrollment into the Family Care program took more than 90 days from the date the Petitioner started the process. None of this delay was caused by the Petitioner. Thus, I conclude that this is a case in which the holding from the Department of Health Services' final decision of FCP/173457 noted above is appropriate: "Although there is no retroactive enrollment in the Family Care program, enrollment as of the date established in correction of an agency error is necessary and appropriate." In this case, the Petitioner was functionally and financially eligible for Family Care as of July 1, 2016 and should have been enrolled effective July 1, 2016.

CONCLUSIONS OF LAW

The Petitioner was functionally and financially eligible for Family Care as of July 1, 2016 and should have been enrolled in Family Care effective July 1, 2016.

THEREFORE, it is ORDERED

That this matter is remanded to the agency to take all administrative steps necessary to revise its records to show Petitioner's effective date of enrollment in the Family Care program is July 1, 2016. These actions shall be completed within 10 days of the date 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, **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 Milwaukee,
Wisconsin, this 28th day of December, 2016

\s_____
\sDebra Bursinger
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 January 12, 2017.

Milwaukee Enrollment Services
[redacted]