FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: FCP - 206397

PRELIMINARY RECITALS

Pursuant to a petition filed on September 27, 2022, under Wis. Admin. Code § DHS 10.55, to review a decision by the Community Care Inc. (CCI) regarding Medical Assistance (MA), specifically the Family Care Program (FCP) a hearing was held on December 8, 2022, by telephone. The appeal was rescheduled one time prior to this date at petitioner's request.

The issue for determination is whether petitioner's request for replacement of carpeting and/or subfloor repair is a covered benefit under the FCP.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Attorney Colleen Olson
Disability Rights Wisconsin
6737 W Washington St
Ste. 3230
Milwaukee, WI 53214

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Jennifer Mathwig
Community Care Inc.
205 Bishops Way
Brookfield, WI 53005

ADMINISTRATIVE LAW JUDGE:
Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Waukesha County and is enrolled in the FCP.

2. Petitioner meets the criteria for both the physical disability and the severe and persistent mental illness target groups in the FCP. Petitioner's outcomes include living independently in her apartment, improving organization, and maintaining her health and safety through the use of supportive home care (SHC) services.

3. On March 30, 2022, petitioner's FCP case manager completed a home visit and noted that the petitioner's apartment was extremely cluttered, there was no clear walking path anywhere in the home, several feet of clutter existed throughout the entire home, all surfaces including the stove, kitchen counters, kitchen sink and flooring were covered in various items, and the home had a distinct foul odor present.

4. Following the home visit, a resource allocation decision (RAD) was completed and SHC was authorized by the FCP for a deep cleaning of petitioner's apartment. The RAD stated, "The core issue relates to the Member's long term-care outcome in the following way(s): Member wants to remain living in her apartment in the community with her assistance animals. Member is at risk of a fire hazard and losing her apartment due to hoarding type behavior and needs assistance to get her apartment back to a safe living environment. Exhibit 2. The FCP contracted with [redacted] to complete the deep cleaning.

5. [redacted] completed a cleanup of petitioner's apartment and reported that 1) the carpeting was soaked in urine, feces, and spoiled food for many years and left untreated; 2) to ensure a safe continued dwelling place, that the carpeting and padding be removed and replaced; 3) they strongly advised the carpet not be washed or vacuumed in such a condition; 4) they were unsure of the condition of the subfloor, which may need to be cleaned, disinfected, and/or sealed and 5) prolonged exposure to any bacteria, viruses or diseases that may be present, could cause serious health risks.

6. On July 27, 2022 petitioner requested the FCP fund the replacement of her carpet with solid flooring and subflooring, if necessary.

7. On August 8, 2022 the FCP denied petitioner's request by way of a Notice of Non-Covered Benefit stating that her request was not covered within her FCP benefit package.

8. On September 2, 2022 petitioner appealed to the Division of Hearings and Appeals.

DISCUSSION

The FCP, which is supervised by the Department of Health Services (DHS), 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 Ch. 10. The first thing that must be decided here is if there is jurisdiction to reach the issue appealed by the petitioner. The petitioner has a right to a hearing under the law as follows:

1. Except as provided in subd. 2., a client may contest any of the following applicable matters by filing, within 45 days of the failure of a resource center or county to act on the contested matter within the time frames specified by rule by the department or within 45 days after receipt of notice of a decision in a contested matter, a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1):

a. Denial of eligibility under s. 46.286 (1).

b. Determination of cost sharing under s. 46.286 (2).

c. Denial of entitlement under s. 46.286 (3).

g. Termination of the family care benefit.

h. Imposition of ineligibility for the family care benefit under s. 46.286 (4).

i. Denial of eligibility or reduction of the amounts of the family care benefit under s. 46.286 (5).

j. Determinations similar to those specified under s. 49.455 (8) (a), made under s. 46.286 (6).

k. Recovery of family care benefit payments.

1m. Except as provided in subd. 2., a client may contest any of the following adverse benefit determinations by filing, within 90 days of the failure of a care management organization to act on a contested adverse benefit determination within the time frames specified by rule by the department or within 90 days after receipt of notice of a decision upholding the adverse benefit determination, a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1):

a. Denial of functional eligibility under s. 46.286 (1) as a result of the care management organization's administration of the long-term care functional screen, including a change from a nursing home level of care to a non-nursing home level of care.

b. Failure to provide timely services and support items that are included in the plan of care.

c. Denial or limited authorization of a requested service, including determinations based on type or level of service, requirements or medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

d. Reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

e. Denial, in whole or in part, of payment for a service.

f. The failure of a care management organization to act within the time frames provided in 42 CFR 438.408 (b) (1) and (2) regarding the standard resolution of grievances and appeals.

g. Denial of an enrollee's request to dispute financial liability, including copayments, premiums, deductibles, coinsurance, other cost sharing, and other member financial liabilities.

h. Denial of an enrollee, who is a resident of a rural area with only one care management organization, to obtain services outside the care management organization's network of contracted providers.

i. Development of a plan of care that is unacceptable to the enrollee because the plan of care requires the enrollee to live in a place that is unacceptable to the enrollee; the plan of care does not provide sufficient care, treatment, or support to meet the enrollee's needs and support the enrollee's identified outcomes; or the plan of care requires the enrollee to accept care, treatment, or support that is unnecessarily restrictive or unwanted by the enrollee.

j. Involuntary disenrollment from the care management organization.

2. An applicant for or recipient of medical assistance is not entitled to a hearing concerning the identical dispute or matter under both this section and 42 CFR 431.200 to 431.246.

> **(b)** An enrollee may contest a decision, omission or action of a care management organization other than those specified in par. (a) 1m. by filing a grievance with the care management organization. If the grievance is not resolved to the satisfaction of the enrollee, he or she may request that the department review the decision of the care management organization.
>
> **(c)** Information regarding the availability of advocacy services and notice of adverse actions taken and appeal rights shall be provided to a client by the resource center or care management organization in a form and manner that is prescribed by the department by rule.
>
> Wis. Stat. § 46.287(2)(a)-(c).

Under the Administrative Code it similarly provides:

> RIGHT TO FAIR HEARING. Except as limited in subs. (1m), (2) and (3) and s. DHS 10.62 (4), a client has a right to a fair hearing under s. 46.287, Stats. The contested matter may be a decision or action by the department, a resource center, county agency or CMO, or the failure of the department, a resource center, county agency or CMO to act on the contested matter within timeframes specified in this chapter or in the contract with the department. The following matters may be contested through a fair hearing:
>
> **(a)** Denial of eligibility under s. DHS 10.31 (6) or 10.32 (4).
> **(b)** Determination of cost sharing requirements under s. DHS 10.34.
> **(c)** Determination of entitlement under s. DHS 10.36.
> **(d)** Failure of a CMO to provide timely services and support items that are included in the plan of care.
> **(e)** Reduction of services or support items in the enrollee's individualized service plan, except in accordance with a change agreed to by the enrollee.
> **(f)** An individualized service plan that is unacceptable to the enrollee because any of the following apply:
>
> **1.** The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee.
> **2.** The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified family care outcomes.
> **3.** The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.
> **Note:** The rights guaranteed to persons receiving treatment or services for developmental disability, mental illness or substance abuse under ch. 51, Stats., and ch. DHS 94 are also guaranteed under par. (f), and enrollees may request a fair hearing related to such matters in accordance with this section and ch. HA 3, or may choose the grievance resolution procedure under Subchapter III of ch. DHS 94 to grieve a violation of those rights, and if necessary may choose to appeal a provider or CMO grievance decision to the department of health services as specified in ss. DHS 94.42 and 94.44.
>
> **(g)** Termination of the family care benefit or involuntary disenrollment from a CMO.
> **(h)** Determinations of protection of income and resources of a couple for maintenance of a community spouse under s. DHS 10.35 to the extent a hearing would be available under s. 49.455 (8) (a), Stats.
> **(i)** Recovery of incorrectly paid family care benefit payments as provided under s. DHS 108.03 (3).

(j) Hardship waivers, as provided in s. DHS 108.02 (12) (e), and placement of liens as provided in ch. HA 3.
(k) Determination of temporary ineligibility for the family care benefit resulting from divestment of assets under s. DHS 10.32 (1) (i).

(1m) EXCEPTION TO RIGHT TO FAIR HEARING. An enrollee does not have a right to a fair hearing under sub. (1), if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all enrollees and the enrollee does not dispute that he or she falls within the category of enrollees to be affected by the change.

(2) LIMITED RIGHT TO FAIR HEARING. An enrollee may contest, through fair hearing, any decision, omission or action of a CMO other than those specified under sub. (1) (d) to (f) only if a CMO grievance decision under s. DHS 10.53 (2) (a) or a CMO grievance decision under s. DHS 10.53 (2) (a) or a department review under s. DHS 10.54 has failed to resolve the matter to the satisfaction of the enrollee within the time period approved by the department in s. DHS 10.53 (2) (b) or specified under s. DHS 10.54 (2).

(3) REQUESTING A FAIR HEARING. A client shall request a fair hearing within 45 days after receipt of notice of a decision in a contested matter, or after a resource center or CMO has failed to respond within timeframes specified by this chapter or the department. Receipt of notice is presumed within 5 days of the date the notice was mailed. A client shall file his or her request for a fair hearing in writing with the division of hearings and appeals in the department of administration. A hearing request shall be considered filed on the date of actual receipt by the division of hearings and appeals, or the date of the postmark, whichever is earlier. A request filed by facsimile is complete upon transmission. If the request is filed by facsimile transmission and such transmission is completed between 5 p.m. and midnight, one day shall be added to the prescribed period. If a client asks the department, a county agency, a resource center or CMO for assistance in writing a fair hearing request, the department, resource center or CMO shall provide that assistance.

Wis. Adm. Code § DHS 10.55(1)-(3).

There is also the "catch all" at Wis. Adm. Code § HA 3.03(4). which provides that an "applicant, recipient or former recipient may appeal any other adverse action or decision by an agency or department which affects their public assistance or social services benefits where a hearing is required by state or federal law or department policy."

Under CCI's contract with the State of Wisconsin ("Contract", available online at https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2022-generic-final.pdf) there are also provisions about what issues members can appeal. Members are only permitted to appeal actions that constitute an "adverse benefit determination" as defined by the Contract. That document provides:

1. *Adverse benefit determination*
  a. An "adverse benefit determination" is any of the following:
    i. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the MCO's administration of the LTCFS, including a change from nursing home level of care to non-nursing home level of care.
    ii. The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VI, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.

iii. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has been completed.
iv. The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VI. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" under 42 CFR § 447.45(b) is not an adverse benefit determination.
v. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
vi. The denial of a member's request to obtain services outside the MCO's network when the member is a resident of a rural area with only one managed care entity.
vii. The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department.
viii. The development of a member-centered plan that is unacceptable to the member because any of the following apply.
a) The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member.
b) The plan does not provide sufficient care, treatment, or support to meet the member's needs and support the member's identified outcomes.
c) The plan requires the member to accept care, treatment, or support items that are unnecessarily restrictive or unwanted by the member.
ix. The involuntary disenrollment of the member from the MCO at the MCO's request.
x. The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals.

b. An "adverse benefit determination" is not:
i. A change in non-residential provider;
ii. A change in the rate the MCO pays a provider;
iii. A termination of a service that was authorized for a limited number of units of service or duration of a service as defined in Article V.K.3.a. and b.; or
iv. An adverse benefit determination that is the result of a change in state or federal law; however, a member does have the right to a State Fair Hearing in regard to whether he/she is a member of the group impacted by the change.
v. The denial of authorization or payment for a service or item that is not inside of the benefit package specified in Addendum VI.
vi. The denial of authorization for remote delivery of a waiver service or a state plan service delivered via interactive telehealth.
vii. The denial of a member's request to self-direct a service or the limitation of a member's existing level of self-direction.

2. Appeal An "appeal" is a request for MCO review of an "adverse benefit determination." If a member is dissatisfied with the MCO's appeal decision, the member can request a State Fair Hearing.

3. Grievance "Grievance" is an expression of a member's dissatisfaction about any matter other than an "adverse benefit determination." If a member is dissatisfied with the MCO's grievance decision, the member can request DHS Review of the decision. When a member expresses dissatisfaction about any matter other than an adverse benefit determination, the member is expressing a grievance. As indicated under

> section F, the IDT staff will first attempt to resolve this grievance informally unless the member objects. If the IDT staff is unable to resolve the issue to the member's satisfaction (or if the member objects) then IDT staff will refer the member to the Member Rights Specialist. The Member Rights Specialist will then assist the member in filing a formal grievance while simultaneously attempting to resolve the issue informally unless the member objects.

Contract, pp. 184-186.

In this case, the petitioner has requested that the FCP fund the replacement of carpeting and/or subfloor in her apartment. She has requested a solid flooring replacement (no specific type specified) and the extent of any need for subfloor replacement is unknown as the carpet has not yet been removed to determine the extent of damage. The FCP denied her request and determined that her request was for a service not inside the benefit package under the Contract. Then, according to the Contract, the agency issued her a notice of denial. Under the Contract, CCI is required to inform members in writing when a request for a service outside the benefit package is denied and must utilize DHS' Notification of Non Covered Benefit template (available online at https://www.dhs.wisconsin.gov/library/f-01283.htm). Notably, this notice does not provide petitioner with appeal rights, and it is not required to under the Contract. There is no evidence that petitioner filed a formal grievance with the MCO. The FCP program thus requested the matter be dismissed on jurisdictional grounds because it was not an appealable issue to the Division of Hearings and Appeals.

In order to determine if there is jurisdiction to hear the case, one must determine whether the requested service is/is not inside of the benefit package under the Contract. Accordingly, testimony was taken and legal arguments were made at the hearing. There is no list or set of definitions of what "is not" inside the benefit package. There is only the list of covered services at Addendum VI, Benefit Package Service Definitions in the Contract.

The petitioner's attorney argues that the requested flooring replacement is a FCP benefit under the Contract as either a "environmental accessibility adaption (home modification)" and/or "supportive home care." The Contract states:

> **Environmental accessibility adaptations (home modifications)** are the provision of services and items to assess the need for, arrange for, and provide modifications and or improvements to a member's living quarters in order to increase accessibility or safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, enable members to increase their abilities to perform ADLs or IADLs, and decrease reliance on paid providers. Home modifications may include materials and services such as ramps, stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen and/or bathroom modifications; specialized accessibility/safety adaptations; and voice-activated, light-activated, motion-activated, and other electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety, or independence of the person; prevent institutionalization; and are the most cost-effective means of meeting the accessibility or safety need. Contractors must comply with local and/or state housing and building codes.

Contract, p. 352, par. 9.

This language and the preponderance of the evidence does not persuade me to find that the requested service meets the definition of an environmental accessibility adaption (home modification). As explained by the FCP's main witness, this service is generally meant for one-time projects that provide safe accessibility in, out, or within the home. Much like a leaking roof would not be covered under this service category, the requested flooring replacement is not about accessibility – even if it might improve her health or safety. Even if the flooring needed replacement because a pipe burst and left the floor in disrepair, the replacement would not be to provide the safe access, or safety generally, as described under this category. The examples clearly are about increasing the ability to live independently and are limited enough in scope. Accordingly, I do not find the requested service to be a covered benefit under this service category.

The Contract also states:

> **Supportive home care (SHC)** is the provision of services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include the following: Hands-on assistance with activities of daily living such as dressing/undressing; bathing; feeding; managing medications and treatments that are normally self-administered; toileting; assistance with ambulation (including the use of a walker, cane, etc.); carrying out professional therapeutic treatment plans; and grooming, such as care of hair, teeth or dentures. This may also include preparation and cleaning of areas that are used during provision of personal assistance such as the bathroom and kitchen. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member, to ensure that the member safely and appropriately completes activities of daily living and instrumental activities of daily living. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, and arrangement and use of transportation and personal assistance at a job site and in non-employment related community activities. Routine housekeeping and cleaning activities performed for a member, consisting of tasks that take place on a daily, weekly, or other regular basis. These tasks may include: washing dishes, doing laundry, dusting, vacuuming, cooking, shopping, and similar activities that do not involve hands-on care of the member. <u>Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the member's continued community living. These tasks may include outdoor activities, such as yard work and snow removal; indoor activities, such as window washing; cleaning of attics and basements; cleaning of carpets, rugs, and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs and other adaptive equipment; bed bug inspection and extermination; and home modifications such as ramps.</u> This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

Contract, pp. 370-371, par.24 (<u>emphasis added</u>).

The petitioner's attorney argues that the language emphasized above should also qualify the requested flooring replacement as a covered benefit. For the same reasons as stated above regarding environmental accessibility adaptions, this is not a home modification. It is also not an intermittent major household task. Petitioner was allowed the SHC service for the deep cleaning. That was clearly a major household task. What that deep cleaning revealed was a carpet that could not be safely salvaged. Had that cleaning instead revealed a broken refrigerator, that also would not be a covered SHC service as defined here even though that would also relate to her health and safety.

Accordingly, I find petitioner's request for replacement of carpeting and/or subfloor repair is not a covered benefit under the FCP, and the Division of Hearings and Appeals does not have jurisdiction to address the denial of a noncovered benefit.

CONCLUSIONS OF LAW

1. Petitioner's request for replacement of carpeting and/or subfloor repair is not a covered benefit under the FCP.

2. The Division of Hearings and Appeals does not have jurisdiction to address the denial of a noncovered benefit.

THEREFORE, it is ORDERED

The petition for review is dismissed.

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, 4822 Madison Yards Way 5th Floor, 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 ~~_______ day of January, 2023~~17th day of January, 2023

\s_________________________________
Kelly Cochrane
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 17, 2023.

Community Care Inc.
Office of Family Care Expansion
Health Care Access and Accountability
Attorney Mary Olson