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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]
c/o Atty. Andrew G. Falkowski
120 N. Main St. Suite 310
West Bend, WI 53095

DECISION

FCP/153514

PRELIMINARY RECITALS

Pursuant to a petition filed November 18, 2013, under Wis. Admin. Code § DHS 10.55, to review a decision by the Washington County Department of Social Services in regard to Medical Assistance, a hearing was held on December 18, 2013, at West Bend, Wisconsin.

The issue for determination is whether the Washington County Department of Social Services (the agency) correctly denied Petitioner's application for Family Care Medicaid benefits.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]
c/o Atty. Andrew G. Falkowski
120 N. Main St. Suite 310
West Bend, WI 53095

Petitioner's Representative:

Attorney Andrew Falkowski
120 N. Main St. Suite 310
PO Box 87
West Bend, WI 53095

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Ken Benedum, Economic Support Specialist
Washington County Department of Social Services
333 E. Washington Street
Suite 3100
West Bend, WI 53095

ADMINISTRATIVE LAW JUDGE:
Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Washington County.

2. Petitioner resides in Kettle Moraine Gardens, an assisted living facility. He has been doing so since 2012. (Exhibit 3, pg. 2)

3. Petitioner's spouse lives in her own, private home, separately from Petitioner. (Id.)

4. On October 1, 2013, the Washington County Circuit Court issued an order requiring Petitioner's spouse to transfer $1,905.10 of Petitioner's income to herself, each month. (Exhibit 2, pgs. 30-31)

5. On October 29, 2013, Petitioner applied for Family Care Medicaid. (Exhibit 3)

6. On November 13, 2013, the agency sent Petitioner a notice indicating that his application for Family Care benefits was denied because his income was over the program limits. (Exhibit 3, pgs. 2-7)

7. Petitioner's attorney filed a request for Fair Hearing that was received by the Division of Hearings and Appeals on November 18, 2013. (Exhibit 1)

DISCUSSION

The Family Care Program is a subprogram of Wisconsin's Medical Assistance (MA) program and is intended to allow families to arrange for long-term community-based health care and support services for older or impaired family members without resort to institutionalization, *Wis. Stats.* §46.286; *Wis. Admin. Code* §DHS 10.11, *Medicaid Eligibility Handbook (MEH), §29.1.*

In the case at hand, the agency denied Petitioner's application for Family Care Medicaid Benefits, asserting that his income exceeded the program limits. The Petitioner asserts that the agency erred in its calculation of Petitioner's income, because it included Petitioner's spouse in his fiscal test group and because it did not allow for a deduction for a court ordered monthly payment from Petitioner to his spouse.

I. Is Petitioner's Spouse Part of His Fiscal Test Group?

The first issue in dispute is whether Petitioner and his spouse should be counted in the same fiscal test group. In determining Petitioner's eligibility for Family Care, the agency considered Petitioner and his spouse as a single, Fiscal Test Group.

MEH §15.1.1 states that, "An EBD fiscal group includes the individual who is non-financially eligible for Medicaid and anyone who lives with them and who is legally responsible for them. Spouses who live together are in each other's fiscal test group. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses." *Emphasis added.*

Petitioner and his spouse do not live together. Petitioner lives in an assisted living facility, which the Department of Health Services now refers to as Residential Care Apartment Complexes (RCAC). His spouse lives in her own private residence. Because Petitioner and his spouse do not live together, they are not part of the same EBD Fiscal Group.

Further, MEH §28.3, states that, "when one spouse is applying for community waivers, and the other is a community spouse, this is a spousal impoverishment situation. Combine the assets and apply the spousal impoverishment asset test. *The income limit is the same as for institutionalized persons who do not have a community spouse."* Emphasis added.

II. Does the Court Order Requiring a Monthly Transfer of Income to Petitioner's Spouse Constitute Special Exempt Income?

The second issue is whether the court ordered monthly transfer of income from the Petitioner to his spouse may be used as an income deduction. In determining Petitioner's eligibility, the agency did not allow the deduction.

MEH §15.7.2.1 defines support payments as, "payment which a Medicaid member makes to another person outside the Fiscal Test Group for the purposes of supporting and maintaining that person..." MEH §15.7.2.1 further states, "The income deduction for monthly court ordered support expenses is the amount that the member is 'obligated' to pay as stipulated in the court order..."

The court ordered transfer of income from Petitioner to his spouse is a payment made to another person outside Petitioner's Fiscal Test Group, since Petitioner and his spouse do not live together. Thus, the remaining question is whether the payment is made for the purposes of supporting or maintaining Petitioner's spouse.

The court order does not explicitly state the purpose for the transfer of income. However, given that Petitioner's spouse has income totaling $1085.19 (not including the $1905.10 payment that is in question) and has expenses for Insurance, Health Insurance Premiums, Home Owner's Insurance and Property Taxes that totaled $975.18 in October 2013, it is not a stretch to find that the payment was ordered, at least in part, for the support of Petitioner's spouse. (See Exhibit 3, pg. 4) As such, the $1905.10 payment may be used as an income deduction for Petitioner.

It should be noted, however, that under MEH §15.4.21, the $1905.10 must be counted as income, when calculating Petitioner's spouse's income, which in turn is used to determine a spousal income allocation. Petitioner should also note that a lower spousal income allocation can result in a higher cost share. *See the discussion under "Other Matters" below.*

III. Other Matters

A person who receives both a Medical Assistance card and Family Care, and is not on "regular MA" because of excess income, is classified as being in Group A, Group B, or Group C.

Group A is, in part, for people who are 18 and over, who meet full benefit Elderly, Blind & Disabled (EBD) Medicaid financial and non-financial requirements and who are also functionally eligible for Family Care at either the nursing home or non-nursing home level of care. *MEH §29.3.1.*

Group B status is available to people 18 and over, who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for Family Care at the nursing home level of care, and whose income is at or below the Community Waivers Special Income Limit, which for a group of 1, is $2,130. *MEH, §§29.3.1 and 39.4.1*

Group C status is for those people 18 and over, who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for Family Care at the nursing home level of care, whose income is above the Community Waivers Special Income Limit ($2,130 for a group of 1) and whose allowable monthly expenses are sufficient to reduce their income to the medically needing income limit. *MEH, §§29.3.1 and 39.4.1*

It is undisputed that Petitioner falls into Group C status.

In order to be eligible for family care, a person in Group C status must expend income that exceeds the monthly medically needy income limit of $591.67. *MEH, §29.3.1.* This amount is known as a spend down amount:

The spend down obligation is the amount a Group C waivers participant must incur monthly in medical/remedial expenses and/or Medicaid card services to lower countable income to the Medically Needy Income limit (See 39.4 EBD Assets and Income Tables) The care manager monitors and documents that this occurs monthly.

A single Group C waivers participant must:

1. Incur, **and**
2. Be held financially responsible for the spend down amount on a monthly basis.

A married Group C waivers participant must:

1. Incur the spend down amount, **and**
2. Pay the cost share monthly, if applicable.

MEH §28.5.2

The spend down amount is calculated by subtracting the Medically needy income limit from an applicant's countable income. *See worksheet F-20919; MEH§28.8.1.* Countable income is determined using the following formula:

Gross Earned Income
-$65 and ½ earned income disregard
+ Total Unearned Income
-$20 disregard
-Special Exempt Income
-Health Insurance Premiums
-Excess Self Employment Expenses

Countable Income *Id.*

As such, in determining Petitioner's eligibility for Family Care, the agency will have to determine his countable income and subtract from that $591.67 to determine Petitioner's Spend Down amount.

Once the Spend Down amount is calculated, the agency will have to see if Petitioner's medical/remedial expenses meet the Spend Down amount.

The spend down amount should not be confused with the cost share, which is the amount a Family Care participant must pay to the State, via the managed care organization, to partially offset the cost of his Medicaid services. *MEH §27.7.1; 28.8.3.6*

According to §27.7.1 of the *Medicaid Eligibility Handbook,* for a community waivers member, with or without a community spouse, the cost share is calculated following the directions in MEH §28.5.1, which states to follow directions in §28.7.3.1. That section states that a Personal Maintenance Allowance is used in determining the cost share calculation of a Group C waiver member, when completing section C of the Spousal Impoverishment Income Allocation Worksheet (worksheet 7) per §18.6.4, which provides directions to complete section C of worksheet 7 as follows:

1. Enter the institutionalized person's gross monthly income on Line 1. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.
2. Enter his/her personal allowance on Line 2:
    a. Personal Needs Allowance (39.4.2 EBD Deductions and Allowances) for a person in a medical institution, **or**

b. Personal Maintenance Allowance for a person in community waivers. This is the Community Waivers Basic Needs Allowance (39.4.2 EBD Deductions and Allowances) plus other applicable deductions (28.8.3.1 Personal Maintenance Allowance) up to the EBD Maximum Personal Maintenance Allowance amount (39.4.2 EBD Deductions and Allowances).

3. Enter on Line 4 the income allocation amount (Section A, Line 3) that is actually allocated to the community spouse.
4. Enter on Line 6 the dependent family member allowance from Section B, Line 4.
5. Enter on Line 8 any court-ordered guardian or attorney fees (27.6.6 Fees to Guardians or Attorneys).
6. Enter on Line 10 the institutionalized person's medical/remedial expenses and the cost of his/her health insurance premiums.
7. Do the math from Line 1 through Line 11. The result on Line 11 is the amount the institutionalized spouse must pay toward cost of care.

CONCLUSIONS OF LAW

The agency did not correctly deny Petitioner's application for Family Care Medicaid benefits.

THEREFORE, it is **ORDERED**

That the agency re-determine the Petitioner's eligibility for Family Care, treating Petitioner as a Fiscal Test Group of one and allowing a deduction for special exempt income in the amount of $1905.10 for the court ordered monthly payment to Petitioner's spouse.

The agency shall take all administrative steps necessary to complete these tasks within 10-days of this decision.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found 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 served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that

Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee, Wisconsin, this 31st day of January, 2014.

\sMayumi M. Ishii
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 31, 2014.

Washington County Department of Social Services
Office of Family Care Expansion
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