FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: FCP - 219433

PRELIMINARY RECITALS

Pursuant to a petition filed on August 1, 2025, under Wis. Admin. Code § DHS 10.55, to review a service authorization denial issued by Inclusa Inc/Community Link, in its capacity as a managed care organization ("MCO") contracted by the Department of Health Services to deliver Family Care Program benefits, a hearing was held on September 18, 2025, by telephone.

The issue for determination is whether Inclusa properly denied Petitioner's request for authorization of a benefits analysis.

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: Tina Schwagel, Care Manager
Inclusa Inc/Community Link
3349 Church St Suite 1
Stevens Point, WI 54481

ADMINISTRATIVE LAW JUDGE:
Teresa A. Perez
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a 36-year old resident of Marathon County who has been enrolled in Family Care, most recently, since 2021. Inclusa is his managed care organization.

2. Petitioner has a corporate guardian of the estate and of the person. Her name is Jamie Pastika.

3. In addition to Family Care, Petitioner receives at least the following public benefits: Social Security Disability Insurance - Disabled Adult Child payments, FoodShare, subsidized housing, and Medical Assistance.

4. In May 2025, [redacted] notified Inclusa that Petitioner was requesting authorization for a benefits analysis.

5. Petitioner has been unemployed since approximately August 2025 but was consistently employed prior to that and is actively looking for a new job.

6. Petitioner has questions regarding how his earnings may affect his benefits.

7. Petitoner's long term care outcomes include having gainful community employment.

8. On June 2, 2025, Inclusa issued a Notice of Adverse Benefit Determination which advised Petitioner that his request for a benefits analysis was denied because "you do not need this service or level of service or support to support your income". The notice included the following additional explanation of the denial:

   Per our conversations regarding your guardian's request for a funded benefits analysis, Your team would like to see due diligence completed by your guardian of finance, ie reviewing SSA info online and contacting SSA directly to gain knowledge related to your income and how earned income may impact your benefits. Your team has contacted SSA to get initial info and relayed this information to you and your guardian. Your guardian may follow up with SSA or confirmation info can be gathered from the SSA by your guardian. If it is found that the SSA is not able to provide the information necessary, your team will review the information provided by the SSA and complete the RAD process again as necessary to continue to support your outcome related to employment and earning income.

9. On June 12, 2025, Petitioner filed a request for an internal appeal and on July 8, 2025, Inclusa upheld the original denial.

10. On August 1, 2025, Petitioner filed a request for fair hearing

DISCUSSION

Family Care (FC) is a Medical Assistance funded waiver program authorized by the Center for Medicare and Medicaid Services (CMS) and is intended to meet the long term care needs of frail elders; individuals age 18 and older who have physical disabilities; and individuals age 18 and older who have

developmental disabilities. See Wis. Stat. §46.286, Wis. Admin. Code ch. DHS 10, Family Care 1915(b) Waiver, and Family Care 1915(c) Home and Community-Based Services Waiver. FC is administered by the Department of Health Services (DHS). DHS contracts with managed care organizations (MCOs) throughout the state to provide case management to FC enrollees. See *Family Care / Partnership Contract* (available online at https://www.dhs.wisconsin.gov/familycare/mcos/fc-fcp-2025-contract.pdf). Case management includes the identification and authorization of allowable and appropriate long term care services and supports for individual FC recipients. Wis. Admin. Code, §DHS 10.44(2)(f).

The Department requires MCOs to utilize a "member-centered planning process" which is referred to as the "Resource Allocation Decision" (RAD) method when determining appropriate long-term care services for a member. See *FC / P Contract*, Article V., Sec. K.; and *Family Care / Partnership / PACE Technical Assistance Series: DHS and MCO Resource Allocation Decision (RAD) and Notice of Adverse Benefit Determination Guidelines*, Issued 06/2013, Revised 02/2024. MCOs may develop service authorization guidelines for use with the RAD but such guidelines must be approved by the department. *FC / P Contract*, Article V., Sec. K.1.a.

The issue in this case is whether the MCO appropriately denied Petitioner's request for a "benefits analysis", also referred to as "Work Incentive Benefits Counseling" (hereafter, WIBC). WIBC is coverable under two Family Care benefit categories: Vocational Futures Planning and Support and Supported employment - individual employment support. *FC/ P Contract*, Addendum VI, Para. 26, Sec e. and Para. 33. ; see also, *Family Care / Partnership / PACE Resource Series: Work Incentives Benefits Counseling and its Role in Employment for Family Care, Family Care Partnership, and PACE members*, Issued 06/26/2013, Revised 11/30/2022.

The Department of Health Services has described the goals of WIBC and the typical steps included in the WIBC process in written guidance made available to MCOs. That guidance provides, in part:

> The aim of WIBC is to provide members with the information they need to make informed decisions about their employment options. Members may be concerned that earnings will affect their eligibility for public benefits, including cash disability benefits and Medicaid. Studies find that the fear of losing disability benefits is a barrier for people with disabilities to pursue [community integrated employment] or career advancement. WIBC has been associated with improved employment outcomes, such as higher earnings and higher employment rates . . .
>
> First, the WIBS obtains a release of information from the member to obtain private health information (PHI). The WIBC service typically involves an individualized benefits analysis to help the member understand the impact of income from employment on their disability benefits, including Medicaid acute and primary care and long-term care benefits. **The benefits analysis is written in summary form and is explained in an in-person meeting with the member**. The member may invite anyone they wish to the meeting. **The MCO should recommend that someone, such as a trusted MCO interdisciplinary team (IDT) staff member, legal decision-maker, family member, or friend accompany the member to this meeting because the information tends to be complex**. This face-to-face meeting is the beginning of an on-going service that follows the member through their employment process. WIBC follow-along service means the WIBS continues to assist the member for up to one year with questions and clarifications along their employment path. The WIBS addresses member, IDT staff, and legal decision-maker questions and clarifies any information about changes in the member's employment status after the initial meeting.

> The WIBS verifies the member's benefits with the agency that provides the benefit and explains the potential impact of employment related to each disability benefit the member receives. For example, the WIBS explains to the member the effect of employment on Social Security payments, Medicaid, and other publicly funded benefits. For some members, accurate information regarding work incentives will be essential to them obtaining and retaining a job.
>
> Information provided in WIBC services includes:
>
> - The member's current benefits
> - Benefits that may change as the result of increased work earnings
> - Options and costs for health and long-term care benefits (for example, cost share vs. Medicaid Purchase Plan Premium that may result from employment earnings)
> - The availability of Social Security Work Incentives for a working member
> - Foreseeable points of benefit changes
> - Contact information for agencies to which the member will need to report earnings
> - Training or other resources to start employment

[Emphasis added.] *Family Care / Partnership / PACE Resource Series: Work Incentives Benefits Counseling and its Role in Employment for Family Care, Family Care Partnership, and PACE members*, Issued 06/26/2013, Revised 11/30/2022; see also, *Vocational Futures Planning and Support: Scope of Service*, Sec. 2.5 (Resp.'s Ex. 8).

The MCO here denied Petitioner's request, in part, because a member of his care management team was able to contact the Social Security Administration and obtain basic, non-individualized information regarding trial work periods, which is one of several work incentive programs set forth in Social Security law, regulation, and policy. The MCO noted that Petitioner is not working now and indicated that he therefore does not need a benefits analysis right now. The MCO also opined that Petitioner's guardian is not doing her due diligence to advise Petitioner on how work may affect his benefits.

As someone who has worked in the field of public benefits for 25 years, I disagree with the MCO. Petitioner receives not only Social Security - Disabled Adult Child Benefits but also Medicaid, FoodShare and subsidized housing. Each of these programs is administered by different governmental entities and operates under different sets of laws. Earned income and work activity have different impacts, or potential impacts, on each program. Sometimes, there is complex interplay between the programs.

As just one example of the inherent complexity of maintaining public benefit eligibility for a person with a disability, of the potential interplay between benefits, and of the knowledge and type of analysis needed to understand one's own circumstances (as opposed to understanding a single, general rule), I offer the following. Petitioner receives Social Security as a disabled adult child ("DAC"). At hearing, there was testimony that he previously received SSI benefits. Section 1634(c) of the Social Security Act requires states to consider disabled adult children who lose SSI eligibility as if they were still SSI recipients for Medicaid purposes *so long as they would have remained otherwise eligible for SSI benefits but for their entitlement to (or increase in) Social Security - DAC benefits*. This means that Petitioner's countable earnings plus any other countable income he receives must stay under the SSI Federal Benefit Rate, an amount that changes annually, to continue receiving Medicaid related to his Social Security. By virtue of Petitioner's DAC-related Medicaid eligibility, he should have no Family Care cost share right now. If,

however, he begins working, his wages could change that. As a result, he could end up owing a cost share. And, it is important for Petitioner and his legal guardian to understand that in greater detail.

The legal guardian, who appeared at hearing with Petitioner, explained that Petitioner received a written report following a benefits analysis several years ago and that she serves other wards who have also received such reports. She indicated that she has found WIBC reports to be indispensable and that she does not feel capable of doing the type of analysis that she has seen in those reports. I do not think that the guardian is saying so to duck responsibility. Public benefits law rivals the tax code in terms of complexity. The guardian rightly recognizes the importance of making sure vulnerable people, including Petitioner, receive accurate information when making work-related decisions that could adversely impact not only their income but also their health coverage, shelter costs, and nutrition assistance. Moreover, she persuasively argued that the time to begin that analysis is before and not after obtaining work because the goal is to help inform Petitioner's work-related decisions and, in turn, to hopefully ensure that Petitioner is able to maximize his employment potential while safeguarding his access to affordable health care.

Not every Family Care member with a job requires a personalized, in-depth benefits analysis. However, the evidence in the record demonstrated that such an analysis is appropriate for Petitioner based on his complicated circumstances (i.e., as an individual who relies on multiple public benefit programs, as an individual with DAC status, and as someone who has a lengthy history of work and desire to return a work).

CONCLUSIONS OF LAW

(1) An individualized benefits analysis will assist Petitioner in meeting his employment-related long term care outcome by providing information that he needs to maximize employment in the community and to increase his income while also ensuring that he does not inadvertently jeopardize his access to affordable health care and shelter.
(2) The MCO did not demonstrate a more cost-effective or effective means of meeting Petitioner's employment-related long term care outcome.

THEREFORE, it is ORDERED

That the matter is remanded to Inclusa to rescind the Adverse Benefit Determination, to authorize the requested benefits analysis, and to notify Petitioner and his guardian of the authorization. Inclusa shall comply with these instructions within ten 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, 4822 Madison Yards Way, 5th Floor North, 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 Madison,
Wisconsin, this 16th day of October, 2025

\s_____
Teresa A. Perez
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 October 16, 2025.

Inclusa Inc/Community Link
Office of Family Care Expansion
Health Care Access and Accountability