FH
[redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

FCP/155113

PRELIMINARY RECITALS

Pursuant to a petition filed January 29, 2014, under Wis. Admin. Code § DHS 10.55, to review a decision by the Community Care Inc. in regard to Medical Assistance, a hearing was held on March 13, 2014, at Kenosha, Wisconsin. The record was held open for 30 days post-hearing to allow the parties to submit additional information. The agency submitted additional information on March 14, 2014. The Petitioner's representative responded in writing on March 28, 2014. The agency submitted an additional reply on April 10, 2014. The record closed on April 10, 2014.

The issues for determination are:
1. Whether certain expenses for supportive home care services incurred by the Petitioner should be allowed as a deduction from her income as remedial expenses for the purpose of determining her cost share liability for the Family Care (FC) program; or, in the alternative,
2. Whether the requested services should be included in the Petitioner's plan of care and paid by FC.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Petitioner's Representative:

Attorney Angela E. Canellos
631 North Mayfair Road
Wauwatosa, WI 53226

Respondent:

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

ADMINISTRATIVE LAW JUDGE:
Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Kenosha County. She lives at home with two sons. One of her sons is disabled due to a stroke and is unable to provide any hands-on care to the Petitioner. The other son travels extensively and is home to provide care approximately two days/week.

2. The Petitioner's FC Member Centered Plan includes supportive home care (SHC) services and personal care services as part of the FC program for 6 hours/day, 7 days/week.

3. The Petitioner's son (who is also her Power of Attorney) arranged for additional supportive home care services so that Petitioner has 24 hour care and supervision. Petitioner requires assistance overnight to ensure that she can safely transfer and toilet when necessary. This additional care has been paid by the Petitioner. The cost is $3000-4500/month.

4. On December 17, 2013, the Inter-Disciplinary Team (IDT) conducted a six month review with the Petitioner. Petitioner's son/POA was present. The assessment included use of the Long Term Care Functional Screen (LTCFS), In-Home assessment tool (IHAT), an RN assessment and a Social Services assessment. Based on these assessments, the agency determined the Petitioner had not experienced any change in condition from her previous review on June 21, 2013. A determination was made that the Petitioner would continue to receive SHC and personal care for 6 hours/day, 7 days/week. Petitioner's son agreed to continue to provide informal natural family supports as needed. It was also noted in the plan that additional supportive home care or personal care would be provided as desired and paid for by the Petitioner.

5. On December 31, 2013, the agency issued a Notice of Decision to the Petitioner informing her that her monthly cost share for the FC program was $910.16/month effective January 1, 2014. This was based on gross monthly income of $2,020 and $105.04 in counted assets.

6. On January 2, 2014, Petitioner's son inquired about additional services for the Petitioner from Visiting Angels.

7. On January 29, 2014, an appeal was filed on behalf of the Petitioner based on the issue of whether "the payments to caregivers are remedial expenses."

8. On February 7, 2014, another home visit was conducted with the Petitioner. On March 3, 2014, the agency completed additional assessments. As a result of the additional assessments, the agency added 1.3 hours/day to the Petitioner's supportive home care services in her plan for a total of 7.3 hours/day that is part of the FC plan.

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 under Wisconsin Statutes, § 46.286, and is described comprehensively in the Wisconsin Administrative Code, Chapter DHS 10. See also, Medicaid Eligibility Handbook at §29.1 et seq., available at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm.

In this case, the Petitioner has been found eligible for FC at the comprehensive level. An eligible person's income is reviewed to determine if the recipient has enough income to be responsible for payment of a monthly "cost share." See, http://www.dhs.wisconsin.gov/mltc/2012/2012Contract.htm (the FCP standard contract), and the MEH, § 29.3. A recipient may request a hearing on the determination of the cost share amount. Wis. Stat. §46.287(2)(a)1b.

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 for person who receives SSI or certain other benefits that are not relevant here. The petitioner does not fit within Group A. Group B status is available to a person who has gross income below the Community Waivers MA income limit of $2,163. MEH, § 39.4.1. A Group B recipient may have health insurance premiums, certain medical/remedial expenses and a Personal Maintenance Allowance (possibly including housing expenses) subtracted from her income before a cost share is computed. 42 C.F.R. §435.726; Wis. Admin. Code §DHS 103.07(1)(d). The Petitioner's gross income of $2,020 places her under the income limit for Group B status. Therefore, she is entitled to have health insurance premiums, certain medical/remedial expenses and a personal maintenance allowance subtracted from income to compute the cost share. Remedial expenses are defined in the Medicaid Eligibility Handbook:

> Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.
>
> Some examples of remedial expenses are:
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> 1.Case management.
>
> 2.Day care.
>
> 3.Housing modifications for accessibility.
>
> 4.Respite care.
>
> 5.Supportive home care.
>
> 6.Transportation.
>
> 7.Services recognized under s.46.27, Wis. Stats.
>
> 8.Community Options Program, that are included in the person's service plan.

Medicaid Eligibility Handbook (MEH), § 15.7.3.

The issue is whether the additional services the Petitioner pays for overnight supervision and assistance meet the definition of a remedial expense, specifically whether these services are "reimbursable by any other source, such as Medicaid, private insurance, or employer."

The agency asserts that the services at issue are SHC services. The FC benefit package includes SHC services as a covered benefit. The agency has determined that the Petitioner needs 7.3 hours/day of SHC and has included that number of hours as part of her FC plan. Therefore, the agency reasons, because SHC services is a covered benefit in the FC package, any SHC services not included in the Petitioner's plan that are paid by the Petitioner cannot be used as a remedial expense.

In determining that the cost of the additional supervision is not a remedial expense, the agency relies on a Department of Health Services Memo, DLTC Numbered Memo 2010-05 in denying the additional SHC expense as a medical/remedial expense in determining the cost share. Specifically, that Memo indicates that a medical/remedial expense is defined on pages 2 and 3 as follows:

> An item can be counted as a medical or remedial expense for the purposes of determining Medicaid eligibility and cost share amount for individuals when:
>
> 1. The person pays for the item out-of-pocket; and
> 2. The item or support is effective in diagnosis, cure, treatment, or prevention of disease (medical expense) or in relieving, remedying, or reducing a medical or health condition (remedial expense); and
> 3. The expense of the item is the responsibility of the person and cannot be reimbursed by any other source available to the person, such as Medicaid, Family Care, IRIS, or private insurance.

The Memo goes on to state at page 3:

> . . .
>
> Any item included in the Family Care, Family Care Partnership, PACE or IRIS benefit packages cannot be considered a medical or remedial expense.
>
> Aging and Disability Resource Centers, Managed Care Organizations, and IRIS Consultants will begin using the criteria listed above when providing local Economic Support/Income Maintenance Units with the dollar amount of medical and remedial expenses for the purposes of determining Medicaid eligibility and cost share amounts.
> . . .
>
> In order for a program to provide an item/service to a participant that is included in the program's benefit package, that item must be included in the care plan developed with the program participant. *Any item/service that is included in a benefit package, but is not included in an individual's care plan, will not be provided by the program and may not be counted as a medical or remedial expense should the individual choose to buy the item out-of-pocket.*
>
> In managed care, the care team, which includes the member, determines supports, supplies and items, including any over the counter supplies and medications that will support the member's desired outcomes. Supports/services that are determined to be the most effective and cost-effective way to support outcomes will be included in the care plan. Any supports or services that do not meet those standards will not be included in the plan and also cannot be counted as medical or remedial expenses. Any denial, reduction or termination of a good or service, including decisions regarding inclusion or exclusion of a good or service in a care plan, are subject to appeal and consumers will receive appropriate notice.

Wisconsin Department of Health Services Memo, DLTC Numbered Memo 2010-05. (Emphasis added).

The Petitioner argues that the additional supervision and assistance expense that is paid by the Petitioner meets the definition of a remedial expense and should be considered as such in determining the Petitioner's cost share. The Petitioner asserts that the agency's action in not including a service in the plan makes that service one that is not covered by the FC program and thus meets the definition of a remedial expense when the Petitioner pays privately for that service. The Petitioner argues that the agency interprets the definition of "remedial expense" too expansively, noting that the FC benefit package is so broad that virtually any medical or remedial service is a service that may be reimbursed under the FC program. Thus, any medical or remedial service that the agency decides not to include in the FC plan

and the individual decides to pay for privately may not be used as a medical or remedial expense under the agency's interpretation even if it is a service that reduces or alleviates a health or medical condition.

In this case, the agency does not dispute that the Petitioner is a fall risk and that she needs assistance with transfers and toileting to ensure she can complete the task safely. The agency does not dispute that the Petitioner needs such assistance at night if she needs to use the toilet. However, the agency argues that the Petitioner's current 7.3 hours/day of care is sufficient to cover the time at night when she would need direct assistance with transfers and toileting. The agency notes that inactive supervision is not a service that the FC program covers and that it doesn't pay for a caregiver "in case" assistance is needed. The Petitioner's son testified that the Petitioner requires such assistance at least two times each night. However, the schedule and frequency is unpredictable. Therefore, the Petitioner's son argues that she needs a caregiver present 24/7 to ensure that she can get the assistance when she needs it.

The 2014 Family Care Programs Contract defines "supportive home care" as follows:

> Supportive home care (SHC) is the provision of services to directly assist persons with daily activities and personal needs to meet their daily living needs and to insure adequate functioning in their home. Services include:
>
> a. Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, toileting, assistance with ambulation (including the use of a walker, cane, etc.), care of hair and care of teeth or dentures.
> . . .

2014 Family Care Programs Contract, Addendum X, Section A20.

The agency asserts that the expense for overnight supervision for the Petitioner is SHC which is a covered service under the FC benefit package. Because it is a covered benefit that is not included in the Petitioner's FC plan, it cannot be considered a remedial expense. At the same time, the agency also asserts that FC does not cover inactive or indirect supervision or supervision of the Petitioner "in case" she needs assistance and that it only covers hands-on assistance.

I conclude that the evidence demonstrates that the Petitioner's health condition makes it important for her to have overnight supervision and a caregiver to assist her with transfers and toileting when it is necessary. The portion of caregiver expense that the Petitioner incurs for inactive supervision at night is not a covered benefit of the FC program. Therefore, it meets the definition of a remedial expense and must be considered as such in determining the Petitioner's cost share.

With regard to the Petitioner's argument that the services should be included in the Petitioner's FC plan, the evidence is not sufficient to determine whether the Petitioner's son requested 24/7 SHC services. The evidence demonstrates that there was some discussion between the Petitioner's son and the agency about increasing the SHC hours in or about February, 2014. The agency did increase the hours based on additional assessments. Therefore, it is not clear that there was any agency action to deny requested services. No Notice of Action was issued denying services. Therefore, I conclude that there is insufficient evidence to demonstrate that there has been any action by the agency to deny inclusion of a service in the Petitioner's FC plan for which there is an appeal right at this time.

CONCLUSIONS OF LAW

1. The Petitioner's out-of-pocket expenses for indirect or inactive supervision from Visiting Angels to assist the Petitioner meet the definition of remedial expenses that must be considered in determining the Petitioner's cost share.

2. There is insufficient evidence to conclude that the agency denied any requested services to be included in the Petitioner's FC plan. Therefore, there is no right of appeal at this time on that issue.

THEREFORE, it is **ORDERED**

That this matter is remanded to the agency to take all administrative steps necessary to re-calculate and re-determine the Petitioner's cost share considering the Petitioner's out-of-pocket expense for indirect and inactive supervision from Visiting Angels as a remedial expense. This action shall be taken within 10 days of the date 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 14th day of May, 2014

\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 May 14, 2014.

Community Care Inc.
Office of Family Care Expansion
Attorney Angela Canellos