FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MGE - 213476

PRELIMINARY RECITALS

Pursuant to a petition filed on May 7, 2024, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Milwaukee Enrollment Services regarding Medical Assistance (MA), a hearing was held on June 26, 2024, by telephone.

The issue for determination is whether the Department has correctly denied the petitioner's application for Medical Assistance/Nursing Home – Long Term 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: Lyesha Griffin, Income Maintenance Worker
Milwaukee Enrollment Services
1220 W Vliet Street
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:
Kenneth D. Duren
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is currently residing in a nursing home in Milwaukee County. On or about February 29, 2024, he filed an application for Medical Assistance, i.e., Nursing Home - Long Term Care. He has a spouse, [redacted], living in the community.

2. On March 1, 2024, the agency issued a letter to the petitioner informing him that he needed to provide verification items to the agency by March 25, 2024, i.e., the cash surrender values applicable to: two whole life insurance policies with [redacted] company; one term life insurance policy with [redacted]; and one whole life policy with [redacted] company; as well as verification of two streams of pension or retirement income he has. The letter also noted that the agency would be trying to obtain income information directly from the petitioner's wife's bank about savings, checking or money market accounts.

3. On March 11, 2024, the agency again issued a letter to the petitioner informing him that he needed to provide verification items to the agency by March 25, 2024, i.e., the cash surrender values applicable to: two whole life insurance policies with [redacted] company; one term life insurance policy with [redacted]; and one whole life policy with [redacted] company; as well as verification of two streams of pension or retirement income he has. The letter also noted that the agency would be trying to obtain income information directly from the petitioner's wife's bank about savings, checking or money market accounts.

4. On March 12, 2024, the agency issued a Notice of Decision to the petitioner informing him that his application had been denied because his income was found to be in excess of program limits. His gross income was found to be $3,633.84, and the gross income limit for nursing home long term care was found to be $2,829 per month.

5. On March 12, 2024, the agency issued a Notice of Decision to the petitioner informing him that he needed to provide verification to the agency by March 25, 2024, i.e., the cash surrender values applicable to two whole life insurance policies with [redacted] company and one term life insurance policy with [redacted].

6. On March 26, 2024, the agency worker noted in Case Comments on that date that the bank asset has still not been verified.

7. On March 26, 2024, the agency issued a Notice of Decision to the petitioner informing him that his application for Nursing Home – Long Term Care had been denied because he had failed to verify the term life and two whole life policies with [redacted]. No reference was made to any [redacted] insurance policy.

8. On May 7, 2024, the petitioner filed an appeal contesting the agency's denial of Nursing Home – Long Term Care benefits.

9. The agency submitted a summary letter dated May 21, 2024, that states that the denial was because the petitioner did not verify one [redacted] whole life insurance policy ([redacted]) held by wife [redacted] and a [redacted] account. The agency admitted in the summary and at the hearing that the [redacted] had closed and there was no such account anymore.

10. The record was held open for the petitioner's wife to obtain insurance cash value information for the [redacted] whole life policy. On July 3, 2024, [redacted] of the business office at the petitioner's nursing home faxed to the Division a copy of documents from [redacted] stating that [redacted] owns a whole life policy ([redacted]) with a face amount of $10,000 and a cash value less loan balance due of $1,360.70; and a second whole life policy ([redacted]) with a face amount of $10,000 and a cash value less loan balance due of $1,511.40.

DISCUSSION

The *Medicaid Eligibility Handbook*, at §20.4.1, provides in the parts relevant here:

> The applicant or member has primary responsibility for providing verification and resolving questionable information. However, the IM worker must use all available data exchanges to verify information rather than requiring the applicant to provide it, unless the information from the data source is not reasonably compatible with what the applicant or member has reported (see SECTION 20.3.8.1 REASONABLE COMPATIBILITY FOR INCOME FOR HEALTH CARE and SECTION 20.3.5.2 REASONABLE COMPATIBILITY FOR ASSETS).
>
> IM agencies must assist the applicant or member in obtaining verification if they request help or have difficulty in obtaining it.
>
> The best information available should be used to process the application or change within the time limit when both of the following conditions exist:
>
> 1. The applicant or member does not have the power to produce verification.
> 2. Information is not obtainable timely even with the IM worker's assistance.
>
> Applicants meeting the health care program eligibility criteria based on this best available information are eligible for benefits. Even after the application or change is processed using best available information, the IM agency is required to continue in their attempts to obtain verification. When the verification is received, benefits may need to be adjusted based on the new information. The agency must explain this to the applicant or member when requesting verification.

This is a close case. The agency was correctly seeking verification of necessary items, but the requests became numerous and internally inconsistent. I am convinced by the pattern of verification attempts here that the petitioner and his wife were confused as to what was left to verify and how to do so. In addition, the petitioner went into a nursing home and has had multiple serious medical conditions pressing on him and his family. Under these circumstances, it appears to me that they were trying to cooperate with verification and that the agency was either over-verifying some items (the [redacted] did not exist for example so no account could be accessed) or unclear about exactly what items were remaining due and necessary (there were *two* [redacted] insurance policies not one, and they were owned by the spouse not the applicant. And there was no more mention of the [redacted] insurance policies in the hearing.)

I explained to the petitioner and his wife the nature of means-testing in public assistance programs like Medical Assistance, and the need for timely and complete verification when sought. In good faith, they responded by getting a nursing home financial agent to assist them in obtaining life insurance verification. [redacted] succeeded in promptly contacting the insurance company and getting the missing information during the open records period provided.

I am satisfied that the petitioner was having difficulty obtaining the life insurance verification from [redacted] due to not understanding what and why it was necessary; and due to the confusing nature of the [redacted] information request. The agency representative reported at hearing and in the summary that only the [redacted] information was and is lacking.

I am going to remand Exhibit #3, the post hearing verification received about the *two* extant [redacted] whole life policies, to the agency and direct it to review and re-determine the petitioner's

eligibility for Nursing Home – LTC to the first date of eligibility possible under the application of February 29, 2024, using this [redacted] verification information as if it were received on March 25, 2024, when it should have been provided. **As a sidenote to the parties, directing this be performed by no means guarantees that the petitioner is eligible for MA or Nursing Home – LTC.** Rather, I reverse the denial and direct review and re-determination using the [redacted] information as if timely received, and a written re-determination. If the petitioner is again aggrieved by the re-determination result, he must file a *new* appeal at that time.

CONCLUSIONS OF LAW

That the agency failed to follow verification procedures and the verification requests were confusing and misleading, causing the petitioner to be unable to timely provide verification of two [redacted] whole life insurance policies that have now been received; the verification has now been received and is to be re-processed as if timely submitted.

THEREFORE, it is ORDERED

That the matter is remanded to the Department and its agents with instructions to: accept a copy of Exhibit #3 (as transmitted by email from the Division) and accept it as if it was submitted on March 25, 2024; review and re-determine the petitioner's eligibility for Nursing Home – Long Term Care retroactive to the earliest date possible under the application of February 29, 2024; and certify him for any and all Nursing Home-Long-Term Care coverage to which he was otherwise entitled, with written notice. 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, 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 8th day of July, 2024

\s_____
Kenneth D. Duren
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 July 8, 2024.

Milwaukee Enrollment Services
Division of Health Care Access and Accountability