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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

PROPOSED DECISION
ON
COST MOTION
Case #: CMGE - 175523

PRELIMINARY RECITALS

The petitioner requested costs and attorney fees on October 19, 2016, under Wis. Stat. § 227.485, and Wis. Admin. Code § HA 3.11(1), after prevailing in a decision issued on September 27, 2016.

The issue for determination is whether the county agency was substantially justified in denying the petitioner's application for medical assistance because he failed to verify his assets to the agency's satisfaction.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

Petitioner's Representative:

Attorney Peter E. Grosskopf
Grosskopf Law Office LLC
1324 W Clairemont Ave Ste 10
Eau Claire, WI 54701

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By:
Barron County Department of Human Services
Courthouse Room 338
335 E Monroe Ave
Barron, WI 54812

ADMINISTRATIVE LAW JUDGE:
Michael D. O'Brien
Division of Hearings and Appeals

FINDINGS OF FACT

1. The petitioner (CARES #) is a resident of Barron County.
2. The combined income of the petitioner and his spouse has been under $150,000 in each of the last three years.
3. The petitioner applied for institutional medical assistance on January 19, 2016. The county agency denied that application because he allegedly failed to verify his assets. Its main concern was an annuity. The Division of Hearings and Appeals remanded that denial in *DHA Decision No. MGE/172821*, dated May 22, 2016, finding in the Conclusions of Law that the "agency cannot deny ... the application for failing to verify an annuity because the Central Data Processing Unit did not respond to requests that it clarify the information it sought." The end of the Discussion stated that because the "petitioner did provide the needed information once he and his attorney understood what was being asked for ... the agency cannot deny benefits for lack of verification." The decision instructed the department to continue processing the application and allowed the petitioner to file a new appeal if the agency continued to deny the application.
4. The county agency did not appeal *DHA Decision No. MGE/172821* or request a new hearing in the matter.
5. After receiving *DHA Decision No. MGE/172821*, the county agency again denied the petitioner's application because he failed to verify the annuity and because he failed to comply with its additional request that he provide all of his bank statements and other financial information for the five years preceding the request.
6. The petitioner made a reasonable effort to comply with the request, providing hundreds of pages of documentation.
7. The petitioner's attorney spent 12.9 hours prosecuting this case. His legal assistant spent 3.3 hours prosecuting the matter.
8. The consumer price index was 183.9 in July 2003 and 244.5 in February 2017, the latest survey. https://www.bls.gov/cpi/cpid0407.pdf; https://www.bls.gov/cpi/cpid1702.pdf.

DISCUSSION

Those who prevail after a contested hearing are entitled to costs incurred in connection with their case, unless the agency "was substantially justified in its action" or "special circumstances...would make the award unjust." Wis. Stat. § 227.485(3), *referring to* Wis. Stat. § 227.01(3) for the definition of *contested case.* The county agency denied the petitioner's application for medical assistance after determining that he did not verify his assets. He appealed and prevailed. His attorney seeks costs and attorney's fees.

According to Wis. Stat. § 227.485(2)(f), "'Substantially justified' means having a reasonable basis in law and fact." The Wisconsin Supreme Court, in considering the issue of substantial justification in *Sheely v. Wisconsin Department of Health and Social Services*, 442 N.W. 2d 1, 150 Wis. 2d 320 (1988), recited the following language from *Phil Schmidt and Son v. NLRB* 810 F. 2d 638, 642 (7th Cir. 1987):

> To satisfy its burden the government must demonstrate 1) a reasonable basis in truth for the facts alleged; 2) a reasonable basis in fact for the theory propounded; and 3) a reasonable connection between the facts alleged and the legal theory advanced.

The petitioner applied for institutional medical assistance on January 19, 2016. The county agency denied his application after finding that he failed to verify his assets. Its main concern was an annuity. His

attorney had sought clarification of the request numerous times, but he never received any. After he appealed, the Division of Hearings and Appeals overturned the denial because the agency ignored his requests for help and ordered it to continue processing the request. Although the Order section of the decision did not specifically tell the agency that it could not continue to deny the application for failing to verify, other parts of the decision indicated that the Division of Hearings and Appeals had determined he had provided sufficient verification. The Conclusions of Law stated that the "agency cannot deny ... the application for failing to verify an annuity because the Central Data Processing Unit did not respond to requests that it clarify the information it sought." The end of the Discussion section stated that because the "petitioner did provide the needed information once he and his attorney understood what was being asked for ... the agency cannot deny benefits for lack of verification." *DHA Decision No. MGE/172821.* The agency did not appeal this decision or ask for a rehearing.

Nevertheless, when the agency reviewed the application after the matter was remanded, it sought additional verification, including all of his financial records for the previous five years. His son-in-law provided hundreds of pages of information, but the agency determined that some of the information was missing. It denied the application because these records were incomplete and because he again failed to verify the annuity to its satisfaction. The petitioner again appealed, and the Division of Hearings and Appeals again remanded the matter, this time simply ordering the agency to find him eligible retroactive to December 1, 2015. That decision pointed out that the intent of the earlier decision was to indicate that the petitioner had submitted enough financial information to determine his eligibility. *DHA Decision No. MGE/175523.*

Applicants must verify their assets. Wis. Admin. Code, § DHS 102.03(3)(h). Verification rules and policies are meant to balance the agency's duty to keep ineligible persons from receiving medical assistance and its duty to ensure that those who cannot afford their medical care receive the benefits. Thus, although applicants must verify financial information, the agency can only deny the applications of those who can actually produce the verification but nevertheless refuse or fail to do so:

> An application for MA shall be denied when the applicant or recipient is able to produce required verifications but refuses or fails to do so .... If the applicant or recipient is not able to produce verifications, or requires assistance to do so, the agency may not deny assistance but shall proceed immediately to verify the data elements.

Wis. Admin. Code, § DHS 102.03(1).

Consistent with this, medical assistance policy requires workers to assist those who have "difficulty in obtaining" verification and not to deny eligibility to those who lack the ability to produce verification. *Medicaid Eligibility Handbook,* §§ 20.1.4. and 20.5.

The county worker testified that she requested five years of data because the state's Help Desk has instructed workers to obtain this much documentation if there is any question concerning a possible divestment. Sometimes this type of request is reasonable, but this depends upon each case's circumstances. And although the county worker presented this five-year verification period as the general rule, as far as I can tell, no such rule is written in any of the various policy manuals such as the *Medicaid Eligibility Handbook.* Thus, it is valid only so far as it is a reasonable extrapolation of policies and regulations that are in writing.

The general tenor of the verification rules is that while those seeking benefits must prove that they are eligible, they should receive the help they need to obtain any verification supporting their eligibility, and, absent evidence that they are hiding something, their application should not be denied if they are making a reasonable effort to obtain verification but cannot do so. The rules are not meant to be a minefield that prevents any person who may possibly fall short of the normal verification requirements from obtaining benefits. Such an interpretation ignores that those seeking nursing home medical assistance are usually

sick and poor and may lack the resources and help they need to comply completely with comprehensive requests.

The question is whether, given the tenor of the verification rules and the earlier remand, the county agency was substantially justified in denying the petitioner's application because he did not adequately verify an annuity or provide five years of financial records. The agency has the burden of proof in this matter: It must prove that its actions were substantially justified; it is not up to the petitioner to prove that the agency's actions were *not* substantially justified. This depends upon whether it meets the three-pronged test found in *Sheely.* The agency never responded to the petitioner's motion for costs, so it is unclear exactly what facts it is alleging, what legal theory it is propounding, and whether there is a reasonable connection between the two. I assume, based on what I heard at the hearing, the factual allegation is that the petitioner failed to verify 100% of his financial information for the five years before he sought benefits. The legal theory seems to be that medical assistance policy requires five years of verification any time there is a potential divestment. And the connection is that unless he provides all of the information requested and proves that there was no divestment he cannot receive medical assistance.

The agency has satisfied only the first prong of this test. As it implicitly alleges, the petitioner failed to provide every piece of financial information he generated in the five years before he sought medical assistance. But nothing in the medical assistance policies and regulations I have seen explicitly requires five years of verification whenever there is a potential divestment. Nor can the agency deny the request when some piece of verification is missing without considering the petitioner's ability to provide the information, assuming he has asked for help gathering it. The petitioner asked for help with the verification, and he provided hundreds of pages of financial information. Neither is consistent with someone trying to hide a divestment. The failure of the agency's agent, the CDPU, to provide help, as it was required to, was why the Division of Hearings and Appeals ruled against the agency in the first decision. That decision also indicated that the agency now had all of the financial verification it needed to determine whether the petitioner was eligible. If the agency believed this was wrong, it could have asked the division reconsider or reverse this decision, but it didn't, so that decision was binding on it. But instead of determining eligibility based on the information it had, it requested more verification and then denied the application after enforcing an unwritten policy.

I understand why the agency seeks to gather information that would prevent those who gave away their assets from improperly becoming eligible. But it is not enough for it to provide a plausible reason for its action. Because it lost twice on the same issue, it has the burden of proving that its denial was substantially justified. It had 15 days to respond to the petitioner's claim for costs but never did so. See Wis. Stat. § 227.485(5). Nor, as discussed throughout this decision, does the record provide a substantial justification for its decision. Therefore, he is entitled to reimbursement for the legal costs he incurred prosecuting this matter.

Administrative law judges must use the criteria in Wis. Stat. § 814.245 to determine costs for successful petitioners. Wis. Stat. § 227.485(5). Costs include "reasonable" attorney fees up to $150 per hour "unless the court determines that an increase in the cost of living ... justifies a higher fee. Wis. Stat. § 814.245(5)(a)2. In *Stern v. DHFS,* 222 Wis. 2d 521 (Ct. App. 1998), the court held that the previous limit, $75 per hour, could be increased by the percentage increase in the cost of living that occurred between November 1985, when that statute took effect, and the date of the most recent month for which the index was published. The statutory amount of the fees was raised to $150 per hour as of July 1, 2003, by 2003 Wisconsin Act 145. The consumer price index has increased from 183.9 in July 2003 to 244.5 in February 2017, the most recent month available. *http://data.bls.gov/cgi-bin/surveymost.* This represents a 33% rise in the index. A 33% rise in the $150 statutory rate brings the maximum current rate under the *Stern* analysis to $199.50.

The petitioner's attorney submitted a statement indicating that he worked 12.9 hours on this matter and that his paralegal worked another 3.3 hours. He seeks the regular rate for himself and half of his rate for

his paralegal. Section 814.245 does not specifically allow reimbursement for paralegals, but it does allow reimbursement for "agents," who also are not attorneys. I find reimbursement for a paralegal reasonable because it encourages attorneys to provide less expensive services. If the paralegal had not performed these tasks, the petitioner's attorney would have to have done them at twice the cost. Given that this matter stretched for several months and involved two appeals, I find the 12.9 hours the attorney and the 3.3 hours the paralegal requested to be reimbursed are reasonable. Multiplying $199.50 per hour by the 12.9 hours the petitioner's attorney worked on the matter gives reasonable fees of $2,573.55. Multiplying half of that, $99.75, by the 3.3 hours his paralegal spent on the case gives $329.18. The total reasonable costs the petitioner incurred in prosecuting this matter is $2,902.73.

CONCLUSIONS OF LAW

The petitioner is entitled to $2,902.73 in legal costs related to his medical assistance appeals because he prevailed in those actions and the county agency was not substantially justified in denying his application.

THEREFORE, it is **ORDERED**

That if the Department adopts this as its final decision, this matter is remanded to the county agency with instructions that within 10 days of the date of the final decision it take all steps necessary to ensure that the petitioner is reimbursed $2,902.73 for legal costs he incurred in this matter.

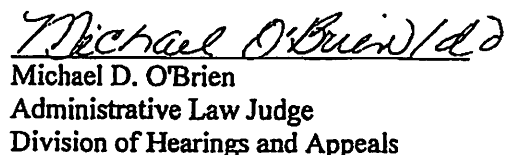
NOTICE TO RECIPIENTS OF THIS DECISION:

This is a Proposed Decision of the Division of Hearings and Appeals. IT IS NOT A FINAL DECISION AND SHOULD NOT BE IMPLEMENTED AS SUCH. If you wish to comment or object to this Proposed Decision, you may do so in writing. It is requested that you briefly state the reasons and authorities for each objection together with any argument you would like to make. Send your comments and objections to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy to the other parties named in the original decision as 'PARTIES IN INTEREST.'

All comments and objections must be received no later than 15 days after the date of this decision. Following completion of the 15-day comment period, the entire hearing record together with the Proposed Decision and the parties' objections and argument will be referred to the Secretary of the Department of Health Services for final decision-making.

The process relating to Proposed Decision is described in Wis. Stat. § 227.46(2).

Given under my hand at the City of Madison,
Wisconsin, this 29 day of March, 2017



Michael D. O'Brien
Administrative Law Judge
Division of Hearings and Appeals