



STATE OF WISCONSIN

In the Matter of

(petitioner)

DECISION

MDD-58/80227

The proposed decision of the hearing examiner dated March 20, 2007 is hereby adopted as the final order of the Department.

REQUEST FOR A REHEARING

This is a final fair hearing 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. To ask for a new hearing, 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 as "PARTIES IN INTEREST" in the proposed decision. Your request must explain what mistake the examiner 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.

Your request for a new hearing must be received no later than 20 days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in Wisconsin Statutes § 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 filed 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 Wisconsin Department of Health and Family Services. Appeals must be served on the Office of the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 650, P.O. Box 7850, Madison, WI 53707-7850.

The appeal must also be served on the other "PARTIES IN INTEREST" named in the proposed decision. The process for Court appeals is in Wisconsin Statutes §§ 227.52 and 227.53.

Given under my hand at the City of Madison,
Wisconsin, this 16th day of April, 2007.

/s

Reginald Bicha, Deputy Secretary
Department of Health and Family Services



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

(petitioner)

PROPOSED
DECISION

MDD-58/80227

PRELIMINARY RECITALS

Pursuant to a petition filed September 6, 2006, under Wis. Stat. §49.45(5) and Wis. Adm. Code §HA 3.03(1), to review a decision by the Shawano County Dept. of Social Services in regard to Medical Assistance (MA), a hearing was held on February 21, 2007, at Shawano, Wisconsin. Hearings set for November 20 and December 20, 2006 and January 24, 2007, were rescheduled at the petitioner's request. At the request of the petitioner, the record was held open for 15 days to submit additional documentation.

The issue for determination is whether petitioner is eligible for MA as a disabled person.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

(petitioner)

Represented by:

Steven L. Toney
Toney Law Offices
PO Box 265
New London, WI 54961

Respondent:

Wisconsin Department of Health and Family Services
Disability Determination Bureau (Bureau)
722 Williamson Street
P.O. Box 7886
Madison, WI 53707-7886

By: No Appearance

ADMINISTRATIVE LAW JUDGE:

Joseph A. Nowick
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Shawano County, 53 years old, and has no minor children at home.
2. Petitioner applied for Medicaid/MA on May 16, 2006. By letter dated July 27, 2006, the Disability Determination Bureau (Bureau) found that petitioner was not disabled. Petitioner sought reconsideration, but the Bureau affirmed its determination on October 19, 2006.

3. Prior to or concurrently with the MA application, petitioner also applied for Social Security disability benefits and Supplemental Security Income (SSI). Those benefits were denied on October 18, 2006, with findings of no disability.
4. The petitioner alleged several new medical impairments that were not considered in either the Social Security decision or the Medicaid application. The petitioner also alleged the worsening of most of the impairments considered in the Social Security decision.

DISCUSSION

In Wisconsin, a person between ages 18 and 65, with no minor children, must be blind or disabled to be eligible for MA. A finding of disability must be in accordance with federal Social Security/SSI standards.

SSI is a federal cash assistance program for individuals who are aged, blind, or disabled and who also have limited incomes and resources. Medicaid is a cooperative federal-state program that helps the poor pay for medical care. Medicaid incorporates the disability standard contained in SSI. Under Medicaid, participating states such as Wisconsin must provide benefits to disabled individuals who actually receive SSI benefits. At their option, participating states also may extend Medicaid benefits to individuals who are not receiving SSI benefits, but who are eligible for those benefits based on the same disability standards as is used by the SSI program. See Wis. Stat. § 49.47(4)(a)4.

Because the standards are the same, there are issues as to when a determination for Social Security/SSI is binding on the state Medicaid agencies. As a general rule, a finding of no disability for Social Security/SSI purposes made within 12 months of the MA application is binding on a State Medicaid (MA) agency. Exceptions may occur only if certain conditions exist such as allegations of a different disabling condition or changes in the previously considered conditions. This process is addressed in the following from 42 C.F.R. § 435.541(a):

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Sec. 435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under Sec. 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section--

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and--

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and--

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

(d) Basis for determinations. The agency must make a determination of disability as provided in paragraph (c) of this section--

(1) On the basis of the evidence required under paragraph (e) of this section; and

(2) In accordance with the requirements for evaluating that evidence under the SSI program specified in 20 CFR 416.901 through 416.998.

It is clear from the above regulation that after excluding the exceptions enumerated in the above regulation, SSA determinations are binding on the state Medicaid agency in terms of making a disability determination. ((b)(1), supra) Also, for Wisconsin, those exceptions are found in (c)(4). The question is at what stage of the Medicaid application process must the individual allege that at least one of those exceptions applies. In the case at hand, the pertinent exception is in (c)(4)(i). That part of the regulation states that a SSA determination is not binding when “[t]he individual applies...and (i) [a]lleges a disabling condition different from, or in addition to, that considered by SSA in making its determination...” I submit that any such disabling condition must be alleged at the time of application for Medicaid, not after the application is denied and the individual is waiting for a state administrative hearing.

When 42 C.F.R. § 435.541 was amended, the Department of Health and Human Services (DHHS) published the final rule and its public comments in the federal register at 54 FR 50755 (December, 1989), in which the following appeared:

Consideration of New and Material Evidence

Since SSA determinations are controlling, HCFA has determined that new and material evidence or allegations by individuals regarding previous SSA determinations of disability must be presented to SSA for reconsideration in accordance with SSA's rules. SSA is in the best position to reconsider or reopen its prior determinations. SSA has an ongoing process for making disability determinations and has a high level of expertise in this area. It is not in the interest of program efficiency or in the best interests of recipients for States to perform duplicate tasks which might arrive at different or conflicting determinations of eligibility. To do so would be wasteful of Federal tax dollars and would subject recipients unnecessarily to application of two separate processes.

See 54 FR at 50757. The DHHS comments also support the conclusion that the allegations of a new condition must be made at the time of the application so the Bureau can consider it.

However, HCFA believes that a separate State Medicaid agency decision is warranted *where the individual applies for Medicaid as a noncash recipient and alleges changed circumstances from those present at the time of the SSI determination* which would make it unreasonable to consider the SSI determination controlling. This would occur, for example, if the applicant alleges (1) a new and different disabling condition, or (2) a deterioration of his or her condition since SSA made its original determination, occurring at least 12 months after the date of the most recent final SSA determination, and the applicant has not applied for SSI with respect to these allegations. (Emphasis added.)

See 54 FR at 50757-58. As stated above, the DHHS policy is that the SSA determination is binding because it has the ongoing expertise to make disability determinations and is also fiscally prudent not to have two separate determination processes. Just as importantly, the DHHS also states that if the *applicant* alleges a new and different disabling condition, then the state Medicaid agency may make a new determination. This also supports the conclusion that the individual must allege the new conditions when he or she is applying for Medicaid eligibility based on a disability.

In addition, courts dealing with this issue have supported the policy underlying the expectation that the SSA determination is binding. One example is *Armstrong v. Palmer*, 879 F.2d 437 (8th Cir.1989), which states:

We also note that the Secretary's interpretation furthers Congress's desire to avoid spending limited benefit funds "to duplicate * * * the eligibility work already being carried on by the [f]ederal agency." H.R.Rep. No. 231, 92d Cong., 1st Sess. 196 (1971), *reprinted in* 1972 U.S.Code Cong. & Admin.News 4989, 5182. Additionally, as the state agency correctly points out, federal law provides numerous opportunities for individuals to seek administrative and judicial review of the SSA's nondisability determination under SSI. *See* 42 U.S.C. § 405 (1982 & Supp. IV 1986); 20 C.F.R. § § 416.1400 to .1494 (1987). Furthermore, if an SSI nondisability determination is reversed, the Iowa state agency retroactively awards Medicaid benefits. *See* Iowa Admin.Code r. 441-75.8 (1988).

See *Armstrong*, 879 F.2d at 440.

There is a reason why SSA requires that its determination decision be binding for 12 months. During the first 12 months after SSA has made a decision denying disability, an applicant may seek reconsideration or reopening of that decision from SSA. See 20 CFR §404.988. Whether SSA will reopen its disability determination depends on a number of factors; for example, whether the applicant submits new evidence, or whether the applicant alleges a new onset date. It is during the 12 month period that an individual may seek a new determination from SSA if a new condition should arise after there has been a denial of an application for MA.

There is also the matter of the role of a state fair hearing. That role is to review the decision to deny Medicaid made by the Disability Determination Bureau. By considering impairments that were not alleged at the time of the Medicaid application, the Administrative Law Judge will not be reviewing the Bureau's decision but instead making a determination "de novo". That certainly is not what DHHS had in mind when it refers to the "expertise" of the SSA to make such determinations.

This inconsistency is even more evident when the new alleged impairment could result in the finding of a period of disability that is different from what was requested in either the Social Security or Medicaid applications. If the ALJ finds that the Bureau was correct in its denial but that the individual is disabled at a later date due to a new condition, that decision would be made without the Bureau having an opportunity to evaluate the individual's impairments. Even if the Bureau would have found that the individual's new impairments in addition to the ones previously alleged would result in an allowance, there is the matter of finding the correct onset date.

This does not mean that a denial by SSA always prevents this office from making a determination of an individual's eligibility for Medicaid for 12 months after that denial under (c)(4)(i), supra. As an example, an individual applies for Medicaid 9 months after the SSA denial and alleges a new impairment at that time. The Bureau would then have the opportunity to make a determination that considers that alleged impairment. If the Bureau does not find the individual disabled, an ALJ can review the denial on the merits as the impairment would not have been considered by SSA but was considered under the Medicaid program. In terms of the case at hand, the Bureau denied a reconsideration of the petitioner's application for Social Security disability benefits and/or Supplemental Security Income (SSI) on October 18, 2006. This is one day prior to the Bureau's denial of the petitioner's Medicaid application. There is no way that the petitioner had alleged an impairment in the Medicaid application that was not considered in the contemporaneous Social Security decision.

Thus, because petitioner has been denied Social Security/SSI following a finding of no disability, I must conclude that petitioner is not eligible for MA. If the petitioner should win her SSA decision, she would be eligible for MA from the date of onset for SSI, assuming she meets all other requirements.

CONCLUSIONS OF LAW

The ALJ has no authority to find the petitioner disabled as that term is used for MA purposes pursuant to Wis. Stat. § 49.47(4).

NOW, THEREFORE, it is **ORDERED**

That the petition for review herein be and the same is hereby dismissed.

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 & Family Services for final decision-making.

The process relating to Proposed Decisions is described in WI Stat. § 227.46(2).

Given under my hand at the City of Madison,
Wisconsin, this 20th day of March, 2007

/s/sJoseph A. Nowick
Administrative Law Judge
Division of Hearings and Appeals
727/JAN