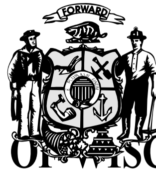


FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

DECISION
Case #: CWA - 210286

PRELIMINARY RECITALS

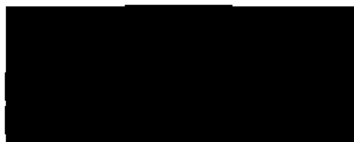
Pursuant to a petition filed on September 14, 2023, under Wis. Admin. Code § HA 3.03, to review a decision by the respondent Bureau of Long-Term Support regarding Medical Assistance (MA), a hearing was held on October 26, 2023, by telephone. Post-hearing, the petitioner's representative (mother) contacted this Administrative Law Judge multiple times, and left multiple voicemail messages. This Administrative Law Judge did not listen to the *ex parte* post-hearing messages, and as such, no information included in those messages was considered as part of the hearing record.

The issue for determination is whether the respondent appropriately denied petitioner's application for the IRIS program.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:



Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Angela Sutherland, Quality Services Specialist for TMG
Bureau of Long-Term Support
PO Box 7851
Madison, WI 53707-7851

ADMINISTRATIVE LAW JUDGE:
Peter McCombs
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a 36 year old disabled resident of Milwaukee County. Petitioner's mother is his primary caregiver.

2. Petitioner was enrolled in the I Respect, I Self-direct (IRIS) waiver program from May 19, 2013, through November 11, 2022.

3. On October 28, 2022, the respondent issued a Notice of Action terminating petitioner's IRIS enrollment. The Notice specified that petitioner was being disenrolled due to the IRIS agency's inability to partner with him and ensure his health and safety. Specifically, the agency indicated that the disenrollment was based upon the following issues:

   - Your IRIS Consultant has not been able to visit you in your home. In-person visits have been made outside of the home. Your IC cannot ensure health and safety in the home without seeing the environment where you reside.
   - Attempts for further contact or even to obtain signatures from you has been very difficult due to the behavior of your parent, ██████████. Several IC changes have occurred in attempts to help mitigate █████ accusations. These accusations range from ICs fraudulently using her signature, remaining parked outside of the home in order to spy on them, and stating IRIS consultants have swapped identities.
   - ████ has yelled at consultants, used foul language, and threatened to press charges for forgery. She does not allow you to sign paperwork required to remain in the IRIS program and encumbers both phone calls and in-person visits from being completed in a satisfactory manner. ICs do not feel safe when attempting to visit you in-person.
   - There is not a robust back up plan in place to help ensure health and safety.
   - APS has been involved previously and a new referral was made recently and the situation is currently being investigated.
   - There were overbilling concerns during the 2019-2020 plan year. Your plan was overspent by more than $9000. DHS authorized your FEA to only pay according to your authorizations because of the severe overspending. Again, TMG was unable to discuss these concerns further due to █████ behavior.

   Exhibit R-B.

4. Petitioner filed an appeal of the disenrollment, and a hearing was subsequently scheduled with the Wisconsin Division of Hearings and Appeals. Petitioner failed to appear for the hearing, and the matter was dismissed as abandoned on January 30, 2023.

5. Petitioner again sought IRIS enrollment via a referral on July 26, 2023.

6. The respondent issued a Notice of Action on August 29, 2023, denying petitioner's reenrollment. The agency specified that, "[b]ecause the issues that led to your disenrollment have not been mitigated, TMG is unable to ensure your health and safety and you are unable to create a safe plan as required by the program, you are being denied enrollment." Exhibit R-B.

7. Petitioner timely appealed the enrollment denial. Exhibit P-1.

DISCUSSION

The IRIS program is a Medical Assistance (MA) home and community-based long term care waiver program authorized under §1915(c) of the Social Security Act. IRIS is an alternative to Family Care,

Partnership, and PACE – all of which are managed care programs. The IRIS program, in contrast, is designed to allow participants to direct their own care and to hire and direct their own workers. The waiver approved by the Centers for Medicare and Medicaid Services (CMS) which proves the program's authority is available at https://www.dhs.wisconsin.gov/iris/hcbw.pdf. State policies governing administration of the IRIS program are included in the IRIS Policy Manual (available at http://www.dhs.wisconsin.gov/publications/P0/P00708.pdf) and IRIS Policy Manual: Work Instructions (available at http://www.dhs.wisconsin.gov/publications/P0/P00708a.pdf).

The Department has the right to deny an application for the IRIS program during the referral stage for the following reasons: cost share in arrears, substantiated fraud during a previous enrollment in IRIS or another long term care program, living in an ineligible residential setting, or inability or unwillingness to develop an Individual Support and Service Plan (ISSP) that ensures the participant's health and safety. IRIS Policy Manual: Work Instructions, 3.3A.1. The latter ground for denial refers to "…situations wherein the participant is unwilling or unable to address the identified health and safety concerns resulting in the IRIS Consulting Agency (ICA) being unable to ensure the health and welfare of the participant as required by the 1915(c) Home and Community-Based Services (HCBS) Waiver…." Id.

The IRIS Policy Manual, quoting the waiver application, provides the following additional language regarding the ICA's obligations to ensure health and safety:

> Participation in a self-directed waiver provides participants with new opportunities, responsibilities, and risks. Finding the right balance between the participants' right to make choices with OIM's (Office of IRIS Management) obligation to ensure participant safety requires special consideration and careful planning.
>
> ICAs are required to collaborate with participants to identify potential risks and to help identify and implement strategies to mitigate identified risks. ICAs [IRIS consultant agencies] are able to define their own practices for assessing risks to participants during the ISSP [Individual Support and Service Plan] development process.
>
> OIM monitors the health and safety of participants through the record review process, which has indicators in place that ensure the ICA addressed all health and safety risks. Health and safety issues must be addressed in the ISSP based on the participant's needs and preferences.
>
> As part of risk mitigation, participants are required to have comprehensive emergency backup plans in the event that needed services are for any reason not accessible. Emergency backup plans must contain the following components:
> - Medical needs
> - Behavior needs
> - Medication and medical equipment needs
> - General overview of the participant's daily schedule
> - Contact information for emergency backup providers
> - Contact information for service providers including medical providers and the IRIS consultant
>
> Other pertinent participant-specific information ICAs may implement their own emergency backup plan format approved by OIM. All formats must provide sufficient information to ensure a backup caregiver can provide the participant

> with needed care to ensure the participant's health and safety in the absence of the participant's primary caregiver.
>
> The participant and IRIS consultant collaborate to develop the emergency backup plan as part of the ISSP development process. The participant and the IRIS consultant review the accuracy and effectiveness of the emergency backup plan during every face-to-face visit and every phone contact. The participant is responsible for notifying the IRIS Consultant of any changes to their emergency backup plan.

IRIS Policy Manual, § 4.1.

It is a well-established principle that a moving party generally has the burden of proof, especially in administrative proceedings. *State v. Hanson*, 295 N.W.2d 209, 98 Wis. 2d 80 (Wis. App. 1980). The court in *Hanson* stated that the policy behind this principle is to assign the burden to the party seeking to change a present state of affairs. As this case involves the denial of an application for the IRIS program, the petitioner is the moving party and must prove by a preponderance of evidence that the denial was not justified.

When reviewing a discretionary determination, a reviewing decision maker must determine if the agency erroneously exercised its discretion. *Brookfield v. Milwaukee Sewerage Dist.,* 171 Wis. 2d 400, 423 (1992). This term replaced the prior term "abuse of discretion" in Wisconsin law. The standard of review, however, remains the same. An erroneous exercise of discretion is when a decision maker fails to apply the appropriate legal standard to the relevant facts. *Hedtcke v. Sentry Ins. Co.,* 109 Wis. 2d 461, 471, (1982). "The exercise of discretion must depend on facts that are of record or that are reasonably derived by inference from the record and the basis of the exercise of discretion should be set forth." *Howard v. Duersten,* 81 Wis. 2d 30, 305 (1977). Thus, if a discretionary action has a rational basis, it is not an erroneous use of discretion.

The question here is whether the petitioner has demonstrated, by a preponderance of the credible evidence, that the respondent erroneously exercised its discretion when it denied the petitioner's IRIS application.

Notwithstanding the respondent's denial of his IRIS application based upon safety concerns, an inability to collaborate with his mother/caregiver/guardian, and issues concerning overbilling, petitioner is otherwise arguably eligible for IRIS enrollment.

IRIS policy requirements provide:

> The Centers for Medicare and Medicaid Services (CMS) require an assessment of IRIS participants' needs and preferences. CMS further requires IRIS participants' Individual Support and Service Plans (ISSPs) to address all needs and preferences identified in the assessment. CMS requires a person-centered approach during ISSP development.
>
> The approved 1915 (c) Medicaid Home and Community Based Services (HCBS) waiver states in Appendix E (E-1):
>
> "Using the person-centered approach, the Individual Support and Service Plan revolves around the individual participant and reflects his or her chosen lifestyle and culture. Planning occurs where, when and with whom the participant chooses. The participant directs development of the Plan, which serves as the foundation for participation in this waiver."

> The approved 1915 (c) Medicaid HCBS waiver describes the aforementioned assessment process in Appendix D (D-1):
>
> "Person-centered planning includes a discovery process, e.g., assessment process. There are tools, resources, and information available to help participants express their needs and the IRIS Consultant will assist the participant in using a risk assessment to identify strengths and weaknesses that may impact the participant's health and welfare. In addition to the discovery process, participants and IRIS Consultants may have access to information from the LTC FS assessment and content area experts. All ICAs will have initial conversations with participants to explore the following areas:
>
> 1. Long-term care outcomes
> 2. Strengths and capacities, including the areas of strength for the participant and the natural supports and other resources available
> 3. Accomplishments, e.g., areas of skill
> 4. Personal relationships with family and friends
> 5. Community life, memberships, associations, and faith communities
> 6. Work, school or other daily activities
> 7. Health status and service needs
> 8. Risk factors
>
> As authorized by CMS through the approved 1915 (c) HCBS waiver, the Department of Health Services (DHS) requires each IRIS participant to maintain a current ISSP with achievable outcomes, including a back-up plan. DHS requires the ISSP to contain the type, scope, amount, duration, and frequency of authorized services. IRIS Consultants (ICs) update the IRIS participants' ISSP at least annually or when the needs of the IRIS participant change.

IRIS Policy Manual, §5.0.

Appendix D to the approved IRIS Waiver application further states that:

> b) Information used in level of care assessments for new enrollees using the state's automated Long-Term Care Functional Screen (LCTFS) is gathered by Aging and Disability Resource Cerner (ADRC) screeners during a face-to-face meeting with the participant. …
>
> **To create the participant's initial ISSP, the IC uses the results of the LTCFS**, … to comprehensively assess and identify the participant's needs and long-term care outcomes…

Application for a §1915(c) Home and Community-Based Services (HCBS) Waiver (viewed at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83621) (emphasis added).

The respondent has presented testimony and documentary evidence demonstrating multiple instances which have caused the agency to believe that in a self-directed program, in which petitioner and his representatives are making critical choices, the agency will be unable to collaborate to ensure the creation of an appropriate ISSP and/or a robust back up plan. The agency questioned the judgment and decision making of petitioner or his representative. The agency also cites a history of animosity and a lack of

cooperation by petitioner and his representative with the IRIS agency. The petitioner did not substantively rebut any of the agency's assertions.

At hearing, petitioner was represented by his mother. Petitioner's mother testified that she does not want her son enrolled in IRIS, which she accused of fraud and theft. Petitioner was informed that, as an administrative tribunal, this Administrative Law Judge lacks any authority to address such allegations, and is solely disposed to adjudicating whether or not the agency correctly denied petitioner's enrollment in the IRIS program. Petitioner is encouraged to seek legal counsel or the assistance of her elected representatives to address concerns of fraud or theft in the IRIS program.

There is no entitlement to become enrolled in IRIS. In this case the IRIS program does not believe that the program is right for petitioner. The agency is concerned that petitioner may suffer harm, injury, or a lack of essential services if he becomes a member of the program because the program lacks the structure that the agency believes is necessary to support his goals. The agency is permitted to deny enrollment under such circumstances.

The agency's decision to deny enrollment is justified and not arbitrary. The petitioner has not established a basis to overturn the agency's determination that it cannot create a plan that keeps petitioner safe. This denial does not prevent the petitioner from seeking assistance through the Family Care program, which has more oversight. Should he qualify, the Family Care program can provide the petitioner with the personal care worker services that he undoubtedly needs. Wis. Admin. Code § DHS 10.41(2), Note.

CONCLUSIONS OF LAW

The agency was within its discretion in denying enrollment to petitioner based on its belief that it could not ensure his safety and health.

THEREFORE, it is ORDERED

That this appeal is dismissed.

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

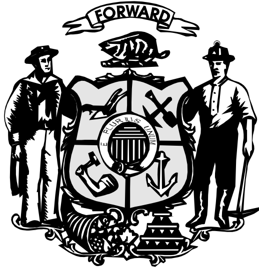
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision 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 2nd day of November, 2023

\s_________________________________
Peter McCombs
Administrative Law Judge
Division of Hearings and Appeals



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The preceding decision was sent to the following parties on November 2, 2023.

Bureau of Long-Term Support