State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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January 15, 2025

[redacted]

Emily Clemens
Dane Cty. Dept. of Human Services
1819 Aberg Avenue
Suite D
Madison, WI 53704-6343

RE: [redacted]
Case No. CWA - 212475

Dear Parties:

Enclosed is a copy of the Final Decision in the above-referenced matter.

Sincerely,

[redacted]

Shannon Buboltz
Legal Associate Supervisor

c: Capital Consortium - email
Bureau of Long-Term Support - email
Attorney [redacted] - email
Katherine Watson - email

FH
[redacted]

STATE OF WISCONSIN
Department of Health Services

In the Matter of

[redacted]

DECISION
Case #: CWA - 212475

The attached proposed decision of the hearing examiner dated May 16, 2024, is modified as follows and, as such, is hereby adopted as the final order of the Department.

PRELIMINARY RECITALS

Pursuant to a petition filed on February 25, 2024, under Wis. Admin. Code § HA 3.03, to review a decision by the Dane Cty. Dept. of Human Services regarding Medical Assistance (MA), a hearing was held on April 17, 2024, by telephone.

The issue for determination is whether the petitioner is eligible to have her IRIS benefits backdated from December 27, 2023, to December 1, 2023.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]
Disability Rights Wisconsin
1502 W Broadway
Suite 201
Monona, WI 53713

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Emily Clemens
Dane Cty. Dept. of Human Services
1819 Aberg Avenue
Suite D
Madison, WI 53704-6343

ADMINISTRATIVE LAW JUDGE:
Jason M. Grace
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a 49 year-old resident of Dane County. She has medical diagnoses that include cerebral palsy. She needs assistance with five Activities of Daily Living (ADLs) and five Instrumental activities of Daily Living (IADLs). She is enrolled in MAPP and IRIS. Her IRIS consultant agency is TMG.

2. On October 13, 2023, TMG issued a notice to the petitioner that indicated she should have received a letter and a renewal packet from the State of Wisconsin Department of Health Services that provided directions on how to renew her Medicaid coverage. It further apprised that if she did not complete the renewal process, her Medicaid coverage would end on November 30, 2023. The notice described what a renewal was, that it was important to act as soon as possible to complete the renewal, and that she must have Medicaid coverage to keep getting IRIS services. It emphasized that if she did not start her renewal by November 16, 2023, her IRIS and Medicaid benefits could end on November 30, 2023. It was also indicated that starting the renewal before November 16, 2023, was the best way to make sure that she did not have a gap in service. The notice also indicated that if she had any additional questions about the process to reach out to her IRIS consultant. The consultant's email address and telephone number were provided.

3. On October 16, 2023, a notice was issued to the petitioner by Income Maintenance (IM) directing Action Required: Your Benefits are Due for Renewal. It further indicated that she needed to complete her renewal to keep getting her Medicaid benefits, and that if she did not act by November 16, 2023, her benefits could end on November 30, 2023, or may have a delay or gap in coverage. She was directed that she may need to provide proof as a part of completing her renewal. She was provided three options to complete her health care renewal: telephone, Online through access.wi.gov, and by mail. The notice indicated that once her renewal was complete, she had a right to a fair hearing if she did not agree with the decision. It further directed that she could find information about fair hearings on her Notices of Decision, in the Enrollment and Benefits booklet, or online at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

4. A Case Note created by TMG dated October 27, 2023, provides the following:

> IC [IRIS consultant] reached out to [redacted] [petitioner] to discuss her MA renewal. IC let [redacted] know that her MA needs to be renewed by 11/30/2023. IC let [redacted] know to have her paperwork to the Consortium by November 14 to make sure it is approved on time. [redacted] stated that she has not received any paperwork from the consortium but will call them and start working on the process online this weekend. IC reminded [redacted] that if her MA lapses, she is no longer eligible for IRIS. [redacted] stated that she understood.

5. Cases Note created by TMG indicate that the IRIS consultant had contact with petitioner on November 14, 2023 and December 1, 2023. There is no indication that the MA renewal was discussed.

6. On November 2, 2023, a Wisconsin Long-Term Care Program Disenrollment Notice was issued to the petitioner by the Division of Medicaid Services (DMS). The notice directed that her long-term

care program enrollment has ended or is scheduled to end due to No Medicaid eligibility. The notice directed that the petitioner's IRIS enrollment had ended or is scheduled to end on November 30, 2023. It also directed that she call her agency if she had any questions about why enrollment was ending. TMG was listed as her agency, and a telephone number for the agency was provided. The notice also indicated she will receive a separate notice that explains why the benefits are ending and how she can ask for a fair hearing if she does not agree with the decision.

7. A Case Note created by TMG dated November 6, 2023, includes the following:

   > IC reached out to [redacted] via phone to discuss new PHW.
   > ...
   > [redacted] is still working on her MA renewal. She is hoping to have it submitted by the end of the week. IC will follow up as needed.

8. A Case Note created by TMG dated November 8, 2023, includes the following:

   > ....
   > IC asked [redacted] if she has started her MA renewal. [redacted] stated that she is not sure what to do on the paperwork where it says that she has MyChoice. IC suggested that she cross it off with one line and put that she now has TMG - IRIS. IC also recommended that she call the consortium to verify that is what they are looking for. IC reminded [redacted] that the paperwork has to be submitted by November 16. ....

9. On November 17, 2023, an About Your Benefits notice was issued to the petitioner. It directs that her Community Waivers and MAPP benefits will be ending December 1, 2023, as her renewal had not been completed. It further directs that if she had not started her renewal and want to keep getting this benefit, contact your agency before your benefits end. The notice also informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding Health Care was indicated to be January 16, 2024. She was also informed that if she is already getting benefits and asks for a hearing before her benefits change, she can keep getting the same benefits until the hearing officer makes a decision.

10. On November 19, 2023, a Wisconsin Long-Term Care Program Disenrollment Notice was issued to the petitioner by the DMS. The notice directed that her long-term care program enrollment has ended or is scheduled to end due to No Medicaid eligibility. The notice directed that the petitioner's IRIS enrollment had ended or is scheduled to end on November 30, 2023. It also directed that she call her agency if she had any questions about why enrollment was ending. TMG was listed as her agency, and a telephone number for the agency was provided. The notice also indicated she will receive a separate notice that explains why the benefits are ending and how she can ask for a fair hearing if she does not agree with the decision.

11. On November 21, 2023, an About Your Benefits notice was issued to the petitioner. It directs that her health care benefits will be ending December 1, 2023, for failing to meet financial eligibility requirements for MAPP and Community Waivers. The notice also informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding Health Care was indicated to be January 16, 2024. She was also informed that if she is already getting benefits and asks for a hearing before her benefits change, she can keep getting the same benefits until the hearing officer makes a decision.

12. A Cares Worker Web Case Comment of November 27, 2023, indicates the petitioner had communication with IM regarding her MA renewal and FoodShare. The following information was included in the Comment: "… she is concerned might not submit it on time, assured they can submit it late in Dec however if received after Dec there may be an impact to case. She understood no further action."

13. On November 29, 2023, an About Your Benefits notice was issued to the petitioner. As to Health Care, it directs that there have been no changes to this benefit. As to FoodShare, it directs that her November 20, 2023, application was denied. The notice informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing for the *FoodShare* determination was indicated to be February 28, 2024.

14. On December 3, 2023, a Wisconsin Long-Term Care Program Disenrollment Notice was issued to the petitioner by DMS. The notice directed that her long-term care program enrollment has ended or is scheduled to end due to No Medicaid eligibility. The notice directed that the petitioner's IRIS enrollment had ended or is scheduled to end on November 30, 2023. It also directed that she call her agency if she had any questions about why enrollment was ending. TMG was listed as her agency, and a telephone number for the agency was provided. The notice also indicated she will receive a separate notice that explains why the benefits are ending and how she can ask for a fair hearing if she does not agree with the decision.

15. On December 8, 2023, an About Your Benefits notice was issued to the petitioner. It directs that her health care benefits (including MAPP and Community Waivers) ended December 1, 2023, for failing to meet financial eligibility requirements. The notice also informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding Health Care was indicated to be January 23, 2024. She was also informed that if she is already getting benefits and asks for a hearing before her benefits change, she can keep getting the same benefits until the hearing officer makes a decision.

16. On December 27, 2023, the petitioner went to an agency office and met with an IM representative. During that meeting, the IM representative was able to complete financial verification. The petitioner was found to have regained eligibility for MAPP and Community Waivers at that time.

17. On December 28, 2023, an About Your Benefits notice was issued to the petitioner. It directs that she is enrolled in Community Waivers as of December 1, 2023, and MAPP as of December 1, 2023. The notice also indicated that her December 19, 2023 application for FoodShare was denied. The notice further informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding her Health Care benefit was indicated to be February 12, 2024. The deadline to request a hearing regarding FoodShare was indicated to be March 28, 2024.

18. On January 14, 2024, a Welcome to Wisconsin Long-Term Care Programs notice was issued to the petitioner by DMS. The notice directed that she is enrolled in IRIS as of December 27, 2023. It directed that if she had any questions to contact TMG.

19. A screenshot provided from the CARES system indicates that the petitioner is eligible (non-financial, asset, and income) for both the MAPP and Community Waivers programs from June 1, 2023 through February 29, 2024.

20. A screenshot from the FowardHealth interchange (FHiC) provides IRIS enrollment for the petitioner of December 1, 2022 through November 30, 2023 and December 27, 2023 through December 31, 2023. It does not reflect enrollment between December 1, 2023 and December 26, 2023.

21. Providers who were authorized to provide petitioner with IRIS approved services prior to December 1, 2023, continued providing those cares to her despite her temporary disenrollment but they have not been paid for those services.

22. On February 25, 2024, the petitioner filed an Appeal with the Division of Hearings and Appeals.

DISCUSSION

The petitioner was enrolled in MAPP and IRIS. Upon submitting her appeal, the Division of Hearings and Appeals opened two case files: CWA-212475 and MGE-212476. The hearing held on April 17, 2024, addressed both files. The case designation for 212476 was changed after the hearing from MGE to MAP. The instant decision (CWA-212475) will address the petitioner's IRIS benefits. A separate decision has already been issued in MAP-212476 addressing the MAPP benefits. The decision in MAP-212476 was issued as a final decision as the appeal regarding the MAPP benefits was found to be moot. This is because her MAPP benefits were backdated to December 1, 2023.

The IRIS program is a Medicaid long term care waiver program that serves elderly individuals and adults with physical and developmental disabilities. IRIS is an alternative to Family Care, Partnership, and PACE—all of which are managed long term care waiver 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 broad purpose of all of these programs, including IRIS, is to help participants design and implement home and community based services as an alternative to institutional care. See IRIS Policy Manual §1.1B, Medicaid Eligibility Handbook §28.1, et. seq., and 42 C.F.R. §441.300, et. seq.

The Department of Health Services is the state agency that oversees and administers the IRIS program and it contracts with and/or assigns specific operational duties to each of the following: Aging and Disability Resource Centers, IRIS consultant agencies, IRIS fiscal employer agents, and income maintenance agencies (IM).

The petitioner filed an appeal because she was involuntarily disenrolled from the IRIS program from December 1, 2023 through December 26, 2023. As a result, her IRIS providers are unable to be paid for care they provided her during that time.

The petitioner was disenrolled from IRIS because she lost Medicaid eligibility for failing to complete her renewal by November 30, 2023. She later completed the renewal on December 27, 2023. This in turn allowed her to regain Medicaid eligibility. Her MAPP benefits were backdated to December 1, 2023. The IRIS consultant agency indicated that the petitioner's IRIS benefits are not able to be similarly backdated. However, the petitioner was provided expediated re-enrollment in IRIS, thereby allowing her IRIS benefits to resume as of December 27, 2023.

The respondent's action in involuntarily disenrolling petitioner from December 1, 2023 through December 26, 2023, is consistent with the following published IRIS policy:

ii. Medicaid Eligibility Renewal

> Once enrolled in BadgerCare Plus or Medicaid, a renewal must be completed at least once each year. The IM agency will mail a letter to the participant the month before the renewal is due. The renewal is conducted by the IM agency and can be done online at access.wi.gov, by phone, by mail, by fax, or in person. The renewal ensures the participant continues to meet all program rules and is receiving appropriate benefits. If continued financial eligibility for Medicaid is not confirmed, then the participant becomes ineligible for the program and will be disenrolled (see Enrollment – Disenrollment and Suspensions)

IRIS Policy and Procedure Publication, P-03515, § B.1.ii.

Timeliness of the Appeal

I would note that the petitioner's appeal was not filed with the Division of Hearings and Appeals until February 25, 2024. This is well after the appeal deadline of January 17, 2024, set forth in the November 17, 2023, About your Benefits notice. I nevertheless find the appeal regarding the termination of IRIS benefits to be timely. This is because on December 28, 2023 (before the original appeal deadline expired), IM issued an About Your Benefits notice to petitioner that indicated she was re-enrolled in Community Waivers as of December 1, 2023. Findings of Fact 17. However, it was not until January 14, 2024, that the petitioner was issued written notice that her IRIS re-enrollment was actually December 27, 2023. Findings of Fact 18. Her appeal was filed within 45 days of the January 14, 2024, notice of IRIS re-enrollment.

The petitioner, by counsel, set forth multiple arguments aimed at the December 1, 2023 through December 26, 2023, gap in IRIS benefits. Those arguments will be addressed in turn below.

Notice of Health Care Renewal

The petitioner, by counsel, argued that she did not receive timely or adequate notice of the termination of her health care benefits. It was argued that the notices issued prior to November 17, 2023, did not provide adequate notice as they did not contain information about the right and process to request a hearing and to continue benefits until a hearing decision was issued. The About Your Benefits notice of November 17, 2023, was acknowledged to provide adequate notice but was argued to be untimely issued. It is petitioner's position that federal regulations require the notice of termination of health care be issued 15 days prior to the date of termination. According to petitioner, the notice of termination needed to be issued on or before November 15, 2023.

The controlling federal regulation requires the notice of action to contain the following:

> (a) A statement of what action the agency … intends to take and the effective date of such action;
> (b) A clear statement of the specific reasons supporting the intended action;
>
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
>
> (d) An explanation of—
>
> > (1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or
> >
> > (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
>
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

42 C.F.R. § 431.210.

As noted above, the petitioner acknowledged that the November 17, 2023, About Your Benefits notice met the above requirements. As to the timeliness of the issuance of that notice, relevant federal regulations require the following:

> **Advance notice.**
> The State or local agency must send a notice at least 10 days before the date of action, except as permitted under … [provisions that do not apply in this case].

42 C.F.R. § 431.211.

While the above regulation indicates that notice be provided at least 10 days prior to the date of action, the petitioner claims that in effect 42 C.F.R. § 431.231 requires the notice be issued at least 15 days prior to the date of action.

> **431.230 Maintaining services.**
>
> **(a)** If the agency sends the 10-day … notice as required under § 431.211 …, and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing….

42 C.F.R. § 431.230.

And:

> **§ 431.231 Reinstating services.**
>
> **(a)** The agency may reinstate services if a beneficiary requests a hearing not more than 10 days after the date of action.
>
> **(b)** The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
>
> **(c)** The agency must reinstate and continue services until a decision is rendered after a hearing if—
>
> > **(1)** Action is taken without the advance notice required under § 431.211 or § 431.214 of this subpart;
> >
> > **(2)** The beneficiary requests a hearing within 10 days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period; and
> >
> > **(3)** The agency determines that the action resulted from other than the application of Federal or State law or policy.
> >
> > …

42 C.F.R. § 431.231.

The above regulations merely require the notice of action be sent "at least 10 days before the date of the action," See, 42 C.F.R. § 431.211. Moreover, 42 C.F.R § 431.231 does not address when the notice of

action is to be issued in relation to the date of action. Both 42 C.F.R. §§ 431.230 and 431.231 address the circumstances under which the Medicaid benefits may be maintained or reinstated pending the appeal.

42 C.F.R. § 431.230 addresses the maintaining of the Medicaid benefit pending the appeal. To maintain those benefits, the hearing request must be made prior to the date of action (in this case December 1, 2023). If the appeal is not filed prior to the date of action, then § 431.231 allows Medicaid to be reinstated if the individual requests a hearing within 10 days after she received the notice of action. The date of receipt is considered to be 5 days after the date reflected on the notice, unless she is able to show she did not receive the notice within that 5-day period. Neither § 431.230 or § 431.231 control when the notice of action must be issued in relation to the date of action. The controlling regulation is 42 C.F.R. § 431.211, which requires the notice of action be sent at least 10 days prior to the date of action.

The November 17, 2023, About Your Benefits notice was sent 13 days prior to the date of action. Thus, it was timely sent.

The petitioner next argued that she received conflicting information about the status of her health care benefits. It was argued that the November 17, 2023, About Your Benefits notice directed the petitioner to contact the agency by December 1, 2023, if she wanted her health care to continue. The petitioner did contact the agency prior to that date, including by telephone on November 27, 2023. The Case Comment from the November 27, 2023 telephone call provides the following, in part:

> … she [petitioner] is concerned might not submit it on time, assured they can submit it late in Dec however if received after Dec there may be an impact to case. She understood no further action.

Findings of Fact 12 above.

Counsel argued that the above quoted language should be understood to mean that the petitioner was told by IM that her health care benefits would continue (instead of terminating as of December 1, 2023) if she submitted the materials for renewal before the end of December and that her benefits would only be impacted if submitted after December. That interpretation was not supported by testimony from the author of that Case Comment. Nor did the petitioner testify and confirm counsel's version as an accurate interpretation of what was communicated during the telephone call. The record is not sufficient to reach the conclusion argued by counsel.

Counsel further argued that the About Your Benefits notice issued November 29, 2023, was misleading as it indicates the petitioner's health care benefits had not been changed. I understood counsel's argument to be that due to that notice the petitioner believed that her health care would continue uninterrupted after November 30, 2023, even though she had failed to complete her renewal. One of the major flaws in the argument is that it was not supported by testimony from the petitioner indicating that she was confused or misled by the notice.

While the November 17, 2023, About Your Benefits notice may qualify as the only timely notice of action issued prior to the termination of health care, petitioner was issued multiple notices and at least on one occasion was verbally informed by TMG of the need to complete the health care renewal prior to November 30, 2023, or her benefits would end as of December 1, 2023. See Findings of Fact above. The record demonstrates that she received adequate and timely notice regarding the need to complete her renewal and the resulting termination of health care benefits if she failed to do so.

Failure of IRIS program to Issue Notice of Action

It was next argued by counsel that the IRIS program was required to issue a notice of action regarding the termination of IRIS benefits. It was argued that the November 17, 2023, notice of action issued by IM was not sufficient because IM is not part of the IRIS program. In support, counsel cited the following IRIS policy:

> The IRIS program must provide a Notice of Action (NOA) to program participants when an "adverse action," defined as a denial, reduction, termination, or limitation of previously authorized services (meaning services/goods on a participant's plan) exists or when a participant is determined *financially*, or functionally, ineligible for the IRIS program.

Emphasis added. IRIS Policy Manual, § 11.2 (04/2024).

The IRIS Waiver application most recently approved by the Centers for Medicare and Medicaid Services (CMS) is available on-line at: https://www.dhs.wisconsin.gov/iris/hcbw.pdf. See Application for 1915(c) Home and Community-Based Services Waiver (HCBS Waiver): WI.0484.R0300 – Jan 01, 2021.

Appendix E of the HCBS Waiver sets forth the circumstances under which a participant may be involuntarily disenrolled from IRIS which includes loss of financial eligibility. HCBS Waiver, pg. 202. It provides "the participant is notified of the [disenrollment] decision, provided a Notice of Action, and provided information on how to engage the State Fair Hearing process if the participant wishes to appeal the decision."

Appendix F of the HCBS Waiver, "…specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210." HCBS Waiver, pg 8 of 274. Under Appendix F-1: Opportunity to Request a Fair Hearing, it is noted that the state provides opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals whose IRIS services are denied, suspended, reduced, or terminated. HCBS Waiver, pg. 206. It is further indicated that the "*state* provides notice of action as required in 42 CFR §431.210." Id. (*emphasis* added.) The requirements for a valid notice of action under 42 CFR §431.210 was addressed above, wherein the November 17, 2023, About Your Benefits notice was found to meet those requirements.

The HCBS Waiver further provides the following in addressing the issue of the notices to be used to offer an individual the opportunity to request a Fair Hearing:

> IRIS program participants receive information about opportunities to request a state fair hearing at multiple times and in multiple ways, including prior to enrollment, at the time of enrollment, and while enrolled. The opportunities presented to participants are as follows:
>
> • Aging and Disability Resource Centers (ADRCs) provide information about state fair hearings during enrollment counseling and any other time upon request, and the TADRS must follow this provision if they elect to perform eligibility and enrollment functions for the tribe(s) they work with; or
> • *The regional income maintenance (IM) consortium which determines financial eligibility for Medicaid use standardized Notices of Action (NOA) forms to inform participants of ineligibility that include information about the right to a fair hearing;* or
> • ICAs provide participants with SMA approved participant education materials which includes state fair hearing information, at program orientation, whenever the participant materials are updated, or at a minimum, annually; or
> • information is mailed to the participant with every issued notice of adverse benefit determination regarding the IRIS program and includes fair hearing information; or
> • The SMA contracts for ombudsman services which provide assistance to participants in filing a request for fair hearing and to assist the participant at the hearing; or

> • The SMA contracts with an external quality review organization (EQRO) to provide participants with information and support about the complaints and grievance process which includes information about the state fair hearing process; or
> • During the adjudications of appeals of "adverse actions," Administrative Law Judges provides the participant with written information with includes state fair hearing information.

Emphasis added. HCBS Waiver, pgs. 206-207. Thus, the HCBS Waiver recognizes that a notice of action may be issued by IM to an IRIS participant. This is consistent with the information provided by the TMG representative at hearing. That representative indicated that they had been informed by the Department that the notice of action for IRIS disenrollment associated with a health care renewal is to be issued by IM.

I would note that TMG did issue a letter to the petitioner that informed of the need to complete the renewal in order to maintain IRIS benefits. However, that letter does not qualify as a notice of action under 42 CFR §431.210 as it does not include appeal rights. Multiple notices were issued by DMS that also informed petitioner that her IRIS enrollment would be ending November 30, 2023. However, those notices also did not contain appeal rights. The November 17, 2023, About Your Benefits notice is an appropriate notice of action. That the notice of action was issued by IM as opposed to TMG or the DMS was not found to be dispositive. What is ultimately dispositive is whether the petitioner was provided timely and adequate notice under 42 CFR §431.210. That occurred here.

Assistance in maintaining MA eligibility and responsibility to explain rights and appeal process.
Counsel next argued that TMG violated IRIS policy by failing to assist petitioner in maintaining Medicaid eligibility and to explain to her the right and process to appeal. It was noted that a significant change reflected in the most recent HCBS Waiver renewal was that IRIS consultant agencies now must maintain participant long-term care and MA eligibility. HCBS Waiver, pg. 2. The HCBS Waiver provides further clarification of this change in response to public comments asking to "[c]larify the scope of the expanded [IRIS consultant agencies] role to maintain Medicaid eligibility." Id. at pg. 14. IRIS consultant agencies are to provide "resources, access, and content necessary to assist participants with maintaining Medicaid eligibility." Id. at pg. 14; *see also* id. at pg. 19 (IRIS consultant agencies "[p]rovide assistance with regards to maintenance of participant long-term care and Medicaid eligibility[.]"). The HCBS Waiver also indicates that IRIS consultant agencies are to "[][e]xplain participant rights and the appeals and grievance process[][.]" Id. at pg. 19.

It was argued at a minimum TMG as the IRIS consultant agency was required to explain to the petitioner her appeal rights, assist her in timely requesting a Medicaid fair hearing, and ensure her IRIS benefits were continued during the appeal process. Counsel argued that petitioner could have maintained IRIS eligibility if TMG had helped her request a hearing before the termination of her health care benefits. Thus, her IRIS benefits would have been maintained during the pendency of the appeal.

The evidence in the record demonstrates that the IRIS consultant agency contacted petitioner three times to discuss her Medicaid renewal, educating petitioner on maintaining eligibility and avoiding disenrollment. The evidence in the record further demonstrates that petitioner understood her Medicaid needed to be renewed by November 30, 2023, or she would lose her IRIS eligibility. Although the evidence in the record does not demonstrate the IRIS consultant agency educated petitioner regarding her appeal rights, which is an agency error, the evidence in the record also does not demonstrate that this error caused a delay in petitioner's enrollment in the IRIS program.

Under the IRIS expedited re-enrollment process, the IRIS program enrollment date may be adjusted by the Department of Health Services when agency error causes an unreasonable delay in enrollment. The existence of an agency error alone does not support adjusting the IRIS program enrollment date. The record

must demonstrate that the agency error caused the unreasonable delay in enrolling in the IRIS program. Because the evidence in the record does not demonstrate that petitioner's enrollment date of December 27, 2023 was caused by the IRIS consultant agency's failure to educate her regarding her appeal rights, petitioner's enrollment in the IRIS program cannot be backdated.

Backdated Coverage Under Late Renewal Policy set forth in the Medicaid Eligibility Handbook

Finally, it was argued by counsel that policy set forth in the Medicaid Eligibility Handbook (MEH) authorizes back payment for IRIS participants when there are gaps in coverage that stem from a late health care renewal. The provisions cited by counsel are as follows:

> **3.1.6 Late Renewals**
>
> Most health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. This policy applies for the following health care programs:
>
> - BadgerCare Plus
> - FPOS
> - SSI-Related Medicaid
> - *HCBW*
> - Institutional Medicaid
> - MAPP
> - Medicare Savings Programs (QMB, SLMB, SLMB+, QDWI)
>
> ...
>
> Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons. Late renewals and renewal-related verifications must be accepted for up to three calendar months after the renewal month. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

Emphasis added. MEH, §3.1.6. Further relevant provisions include:

> *3.1.6.2 Gaps in Coverage*
> If a member has a gap in coverage because of a late renewal, they may request coverage of the past months in which the gap occurred. Backdated coverage under the late renewal policy is available to all health care members who meet program rules (see SECTION 2.8.2 BACKDATED ELIGIBILITY).
>
> If a member requests coverage for past months during a late renewal, they must provide all necessary information and verification for those months (including verification of income and assets for all months requested) and must pay any required premiums to be covered for those months.
>
> Note: QMB coverage is not retroactive. Members cannot receive backdated eligibility for this program.

MEH, § 3.1.6.2.

And:

> 2.8.2 Backdated Eligibility
>
> Medicaid eligibility can be backdated up to three months prior to the month of application.
>
> The backdated eligibility should not go back further than the first of the month, three months prior to the application month. The member may be certified for any backdate month in which he or she would have been eligible had he or she applied in that month. A backdate request can be made at any time except when the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.
>
> If a member has incurred a bill from a Medicaid-certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.
>
> ...
> **Assets**
> A person's asset eligibility in a backdate month is determined by whether or not he or she had excess assets on the last day of the month. If he or she had excess assets on the last day of the month, he or she is ineligible for the entire month. If he or she was asset eligible on the last day of the month, he or she is eligible for the whole month.

MEH, § 2.8.2.

Counsel argued that the IRIS program falls within Home and Community-Based Waivers of the Late Renewals provision of MEH, §3.1.6. It was further indicated that the petitioner had an IRIS gap in coverage (December 1, 2023 – December 26, 2023) due to a late renewal which is addressed by MEH, §3.1.6.2. Finally, it was argued petitioner was eligible for IRIS backdated coverage under the afore-mentioned late renewal policy as she further meets program rules under MEH, § 2.8.2. It was noted that asset eligibility in a backdated month is determined as of the last day of the month. As of the end of December 2023, she was asset eligible. Thus, the petitioner seeks backdated IRIS coverage for December 1, 2023 through December 26, 2023.

In response, TMG provided a policy statement issued on September 18, 2023, by the Bureau of Quality Oversight, titled IRIS Participant Lapse in Program Enrollment after Loss of Medicaid. That policy indicates the following, in part:

> Per IRIS policy, IRIS program eligibility and enrollment can only occur once a participant has established Medicaid, therefore if a participant loses Medicaid, their IRIS enrollment is also ended.
>
> ...
>
> During COVID unwinding DHS has implemented a temporary process that allows for an *expedited re-enrollment* to minimize the impact to IRIS participants supports and services. Participants who lost and regained Medicaid within the following month of their lapse were allowed to re-enroll into the IRIS program without going through the standard enrollment process. The Department uses the CARES system to identify the date in which Medicaid was established to serve as the new IRIS enrollment date.

> In these instances, there is typically several days in which the IRIS participant was not enrolled in the IRIS program which prohibits the Department from paying for services rendered during this period.
>
> Outside of COVID unwinding, if an IRIS participant was disenrolled from the IRIS program due to losing their Medicaid, the participant would need to return to the Aging and Disability Resource Center (ADRC) to determine functional and financial eligibility, as well as options counseling for program and agency selection.
>
> Per IRIS Policy *2.2D Ongoing Eligibility*, "Failure to maintain eligibility may result in disenrollment". Based on the above circumstances, the new IRIS enrollment date serves as the activation date for service authorizations. Per IRIS Policy *5.5B Enrollment Date*, the IRIS program prohibits the payment of providers or participant-hired workers prior to the enrollment date.

TMG argued that IRIS could not be backdated and that the date of re-enrollment was December 27, 2023. It was TMG's position that petitioner is not eligible for IRIS payment to providers or participant-hired workers as sought by petitioner for the period of December 1, 2023 through December 26, 2023.

The IRIS program is a long-term care program administrated under the authority of the HCBS Waiver. HCBS Waiver, pg. 1; *see also* MEH, § 1.1.2. The IRIS program is just one of the subprograms within Wisconsin Medicaid. MEH, § 1.1.2. Eligibility for the IRIS program is not the same as eligibility for Medicaid. *See, e.g.*, HCBS Waiver, Appendix B: Participant Access and Eligibility, pgs. 39-42. The difference between Medicaid eligibility and IRIS program eligibility is recognized in MEH § 2.8. MEH § 2.8 includes two sections, 2.8.1, Begin Dates Introduction, and 2.8.2, Backdated Eligibility. MEH § 2.8.2 is cited above. MEH § 2.8.1 provides:

> 2.8.1 Begin Dates Introduction
>
> Medicaid eligibility begins the first day of the month in which the valid application is submitted and all program requirements are met with the following exceptions. *For these exceptions, begin dates are the date a valid application is submitted, all program requirements are met, and:*
>
> 1. Deductible – The date the deductible was met.
> 2. Person Adds – The date the person moved into the household.
> 3. Recent Moves – The date the member moved to Wisconsin.
>   Exception: The begin date for an SSI recipient who moves to Wisconsin is the 1st of the month of the move.
> 4. *Home and Community-Based Waivers – The program start date provided by the Managed Care Organization (MCO), IRIS Consultant Agency (ICA), or County Waiver Agency (CWA).*
> 5. Institutionalized – The date the person entered into the nursing home or hospital.
> 6. QMB – The first of the month following the eligibility confirmation.
> 7. SeniorCare – The first of the month following the month in which all program requirements have been met.

Emphasis added.

MEH § 2.8.1 sets the program begin date for HCBS waiver programs and specifically identifies it as an exception to general Medicaid eligibility begin date policy. MEH § 2.8.2 must be read in relation to MEH § 2.8.1; while MEH § 3.1.6.2 refers to section 2.8.2, it cannot be read in isolation and must be read as part

of a whole. *See State ex rel. Kalal v. Circuit Court for Dane County*, 2004 WI 58, ¶ 46, 271 Wis.2d 633, 681 N.W.2d 110. When MEH § 2.8.2 is read together with MEH § 2.8.1, the policy regarding backdating aligns with the September 18, 2023, policy statement of the Bureau of Quality Oversight cited above. Further, between MEH § 2.8.1 and MEH § 2.8.2 the more specific provision should prevail. *See In re Paternity of Palmersheim*, 2004 WI App 126, ¶27, 275 Wis. 2d 311. There is no language to support the general policy in MEH § 2.8.2 should apply over the specific exception for HCBS waiver programs found in MEH § 2.8.1.

Medicaid eligibility can be backdated up to three months prior to the month of application *unless* one of the begin date exceptions apply. Because HCBS waivers are a noted exception in MEH § 2.8.1, eligibility for a HCBS waiver program cannot be backdated under MEH § 2.8.2. Accordingly, petitioner is not eligible to have her IRIS benefits backdated under the late renewal policy in MEH § 3.1.6 because petitioner does not meet program rules for backdating eligibility under MEH § 2.8.2.

CONCLUSIONS OF LAW

1. The petitioner's IRIS benefits cannot be backdated to December 1, 2023, under the IRIS expedited re-enrollment process as agency error did not cause petitioner's enrollment in the IRIS program to be unreasonably delayed.

2. The petitioner is not eligible to have her IRIS benefits backdated from December 27, 2023, to December 1, 2023, under the late renewal policy set for in Medicaid Eligibility Handbook § 3.1.6 because petitioner does not meet program rules for backdating eligibility under Medicaid Eligibility Handbook § 2.8.2.

THEREFORE, it is **ORDERED**

That the petitioner's 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, Madison, WI 53705-9100 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, Madison, WI, 53703, 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 request (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 15th day of January, 2025.

[redacted]

Kirsten L. Johnson, Secretary
Department of Health Services

FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

PROPOSED DECISION
Case #: CWA - 212475

PRELIMINARY RECITALS

Pursuant to a petition filed on February 25, 2024, under Wis. Admin. Code § HA 3.03, to review a decision by the Dane Cty. Dept. of Human Services regarding Medical Assistance (MA), a hearing was held on April 17, 2024, by telephone.

The issue for determination is whether the petitioner is eligible to have her IRIS benefits backdated from December 27, 2023, to December 1, 2023.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Attorney Mary Colleen Bradley
Disability Rights Wisconsin
1502 W Broadway
Suite 201
Monona, WI 53713

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Emily Clemens
Dane Cty. Dept. of Human Services
1819 Aberg Avenue
Suite D
Madison, WI 53704-6343

ADMINISTRATIVE LAW JUDGE:
Jason M. Grace
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted] is a 49 year-old resident of Dane County. She has medical diagnoses that include cerebral palsy. She needs assistance with five Activities of Daily Living (ADLs) and five Instrumental activities of Daily Living (IADLs). She is enrolled in MAPP and IRIS. Her IRIS consultant agency is TMG.

2. On October 13, 2023, TMG issued a notice to the petitioner that indicated she should have received a letter and a renewal packet from the State of Wisconsin Department of Health Services that provided directions on how to renew her Medicaid coverage. It further apprised that if she did not complete the renewal process, her Medicaid coverage would end on November 30, 2023. The notice described what a renewal was, that it was important to act as soon as possible to complete the renewal, and that she must have Medicaid coverage to keep getting IRIS services. It emphasized that if she did not start her renewal by November 16, 2023, her IRIS and Medicaid benefits could end on November 30, 2023. It was also indicated that starting the renewal before November 16, 2023, was the best way to make sure that she did not have a gap in service. The notice also indicated that if she had any additional questions about the process to reach out to her IRIS consultant. The consultant's email address and telephone number were provided.

3. On October 16, 2023, a notice was issued to the petitioner by Income Maintenance (IM) directing Action Required: Your Benefits are Due for Renewal. It further indicated that she needed to complete her renewal to keep getting her Medicaid benefits, and that if she did not act by November 16, 2023, her benefits could end on November 30, 2023, or may have a delay or gap in coverage. She was directed that she may need to provide proof as a part of completing her renewal. She was provided three options to complete her health care renewal: telephone, Online through access.wi.gov, and by mail. The notice indicated that once her renewal was complete, she had a right to a fair hearing if she did not agree with the decision. It further directed that she could find information about fair hearings on her Notices of Decision, in the Enrollment and Benefits booklet, or online at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

4. A Case Note created by TMG dated October 27, 2023, provides the following:

> IC [IRIS consultant] reached out to [redacted] [petitioner] to discuss her MA renewal. IC let [redacted] know that her MA needs to be renewed by 11/30/2023. IC let [redacted] know to have her paperwork to the Consortium by November 14 to make sure it is approved on time. [redacted] stated that she has not received any paperwork from the consortium but will call them and start working on the process online this weekend. IC reminded [redacted] that if her MA lapses, she is no longer eligible for IRIS. [redacted] stated that she understood.

5. Cases Note created by TMG indicate that the IRIS consultant had contact with petitioner on November 14, 2023 and December 1, 2023. There is no indication that the MA renewal was discussed.

6. On November 2, 2023, a Wisconsin Long-Term Care Program Disenrollment Notice was issued to the petitioner by the Division of Medicaid Services (DMS). The notice directed that her long-term care program enrollment has ended or is scheduled to end due to No Medicaid eligibility. The notice directed that the petitioner's IRIS enrollment had ended or is scheduled to end on November 30, 2023. It also directed that she call her agency if she had any questions about why enrollment was ending. TMG was listed as her agency, and a telephone number for the agency was provided. The notice also indicated she will receive a separate notice that explains why the benefits are ending and how she can ask for a fair hearing if she does not agree with the decision.

7. A Case Note created by TMG dated November 6, 2023, includes the following:

   IC reached out to [redacted] via phone to discuss new PHW.

   ...

   [redacted]s still working on her MA renewal. She is hoping to have it submitted by the end of the week. IC will follow up as needed.

8. A Case Note created by TMG dated November 8, 2023, includes the following:

   ....

   IC asked [redacted] if she has started her MA renewal. [redacted] stated that she is not sure what to do on the paperwork where it says that she has MyChoice. IC suggested that she cross it off with one line and put that she now has TMG - IRIS. IC also recommended that she call the consortium to verify that is what they are looking for. IC reminded [redacted] that the paperwork has to be submitted by November 16.

   ....

9. On November 17, 2023, an About Your Benefits notice was issued to the petitioner. It directs that her Community Waivers and MAPP benefits will be ending December 1, 2023, as her renewal had not been completed. It further directs that if she had not started her renewal and want to keep getting this benefit, contact your agency before your benefits end. The notice also informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding Health Care was indicated to be January 16, 2024. She was also informed that if she is already getting benefits and asks for a hearing before her benefits change, she can keep getting the same benefits until the hearing officer makes a decision.

10. On November 19, 2023, a Wisconsin Long-Term Care Program Disenrollment Notice was issued to the petitioner by the DMS. The notice directed that her long-term care program enrollment has ended or is scheduled to end due to No Medicaid eligibility. The notice directed that the petitioner's IRIS enrollment had ended or is scheduled to end on November 30, 2023. It also directed that she call her agency if she had any questions about why enrollment was ending. TMG was listed as her agency, and a telephone number for the agency was provided. The notice also indicated she will receive a separate notice that explains why the benefits are ending and how she can ask for a fair hearing if she does not agree with the decision.

11. On November 21, 2023, an About Your Benefits notice was issued to the petitioner. It directs that her health care benefits will be ending December 1, 2023, for failing to meet financial eligibility requirements for MAPP and Community Waivers. The notice also informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding Health Care was indicated to be January 16, 2024. She was also informed that if she is already getting benefits and asks for a hearing before her benefits change, she can keep getting the same benefits until the hearing officer makes a decision.

12. A Cares Worker Web Case Comment of November 27, 2023, indicates the petitioner had communication with IM regarding her MA renewal and FoodShare. The following information was included in the Comment: "... she is concerned might not submit it on time, assured they can submit it late in Dec however if received after Dec there may be an impact to case. She understood no further action."

13. On November 29, 2023, an About Your Benefits notice was issued to the petitioner. As to Health Care, it directs that there have been no changes to this benefit. As to FoodShare, it directs that her November 20, 2023, application was denied. The notice informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing for the *FoodShare* determination was indicated to be February 28, 2024.

14. On December 3, 2023, a Wisconsin Long-Term Care Program Disenrollment Notice was issued to the petitioner by DMS. The notice directed that her long-term care program enrollment has ended or is scheduled to end due to No Medicaid eligibility. The notice directed that the petitioner's IRIS enrollment had ended or is scheduled to end on November 30, 2023. It also directed that she call her agency if she had any questions about why enrollment was ending. TMG was listed as her agency, and a telephone number for the agency was provided. The notice also indicated she will receive a separate notice that explains why the benefits are ending and how she can ask for a fair hearing if she does not agree with the decision.

15. On December 8, 2023, an About Your Benefits notice was issued to the petitioner. It directs that her health care benefits (including MAPP and Community Waivers) ended December 1, 2023, for failing to meet financial eligibility requirements. The notice also informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding Health Care was indicated to be January 23, 2024. She was also informed that if she is already getting benefits and asks for a hearing before her benefits change, she can keep getting the same benefits until the hearing officer makes a decision.

16. On December 27, 2023, the petitioner went to an agency office and met with an IM representative. During that meeting, the IM representative was able to complete financial verification. The petitioner was found to have regained eligibility for MAPP and Community Waivers at that time.

17. On December 28, 2023, an About Your Benefits notice was issued to the petitioner. It directs that she is enrolled in Community Waivers as of December 1, 2023, and MAPP as of December 1, 2023. The notice also indicated that her December 19, 2023 application for FoodShare was denied. The notice further informs of the right and process to request a fair hearing if she believed there was a wrong decision about her application or benefits. The deadline set forth in the notice to request a hearing regarding her Health Care benefit was indicated to be February 12, 2024. The deadline to request a hearing regarding FoodShare was indicated to be March 28, 2024.

18. On January 14, 2024, a Welcome to Wisconsin Long-Term Care Programs notice was issued to the petitioner by DMS. The notice directed that she is enrolled in IRIS as of December 27, 2023. It directed that if she had any questions to contact TMG.

19. A screenshot provided from the CARES system indicates that the petitioner is eligible (non-financial, asset, and income) for both the MAPP and Community Waivers programs from June 1, 2023 through February 29, 2024.

20. A screenshot from the FowardHealth interchange (FHiC) provides IRIS enrollment for the petitioner of December 1, 2022 through November 30, 2023 and December 27, 2023 through December 31, 2299. It does not reflect enrollment between December 1, 2023 and December 26, 2023.

21. Providers who were authorized to provide petitioner with IRIS approved services prior to December 1, 2023, continued providing those cares to her despite her temporary disenrollment but they have not been paid for those services.

22. On February 25, 2024, the petitioner filed an Appeal with the Division of Hearings and Appeals.

DISCUSSION

The petitioner was enrolled in MAPP and IRIS. Upon submitting her appeal, the Division of Hearings and Appeals opened two case files: CWA-212475 and MGE-212476. The hearing held on April 17, 2024, addressed both files. The case designation for 212476 was changed after the hearing from MGE to MAP. The instant decision (CWA-212475) will address the petitioner's IRIS benefits. A separate decision has already been issued in MAP-212476 addressing the MAPP benefits. The decision in MAP-212476 was issued as a final decision as the appeal regarding the MAPP benefits was found to be moot. This is because her MAPP benefits were backdated to December 1, 2023.

The IRIS program is a Medicaid long term care waiver program that serves elderly individuals and adults with physical and developmental disabilities. IRIS is an alternative to Family Care, Partnership, and PACE—all of which are managed long term care waiver 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 broad purpose of all of these programs, including IRIS, is to help participants design and implement home and community based services as an alternative to institutional care. See IRIS Policy Manual §1.1B, Medicaid Eligibility Handbook §28.1, et. seq., and 42 C.F.R. §441.300, et. seq.

The Department of Health Services is the state agency that oversees and administers the IRIS program and it contracts with and/or assigns specific operational duties to each of the following: Aging and Disability Resource Centers, IRIS consultant agencies, IRIS fiscal employer agents, and income maintenance agencies (IM).

The petitioner filed an appeal because she was involuntarily disenrolled from the IRIS program from December 1, 2023 through December 26, 2023. As a result, her IRIS providers are unable to be paid for care they provided her during that time.

The petitioner was disenrolled from IRIS because she lost Medicaid eligibility for failing to complete her renewal by November 30, 2023. She later completed the renewal on December 27, 2023. This in turn allowed her to regain Medicaid eligibility. Her MAPP benefits were backdated to December 1, 2023. The IRIS consultant agency indicated that the petitioner's IRIS benefits are not able to be similarly backdated. However, the petitioner was provided expediated re-enrollment in IRIS, thereby allowing her IRIS benefits to resume as of December 27, 2023.

The respondent's action in involuntarily disenrolling petitioner from December 1, 2023 through December 26, 2023, is consistent with the following published IRIS policy:

> ii. Medicaid Eligibility Renewal
>
> Once enrolled in BadgerCare Plus or Medicaid, a renewal must be completed at least once each year. The IM agency will mail a letter to the participant the month before the renewal is due. The renewal is conducted by the IM agency and can be done online at access.wi.gov, by phone, by mail, by fax, or in person. The renewal ensures the participant continues to meet all program rules and is receiving appropriate benefits. If

> continued financial eligibility for Medicaid is not confirmed, then the participant becomes ineligible for the program and will be disenrolled (see Enrollment – Disenrollment and Suspensions)

IRIS Policy and Procedure Publication, P-03515, § B.1.ii.

Timeliness of the Appeal

I would note that the petitioner's appeal was not filed with the Division of Hearings and Appeals until February 25, 2024. This is well after the appeal deadline of January 17, 2024, set forth in the November 17, 2023, About your Benefits notice. I nevertheless find the appeal regarding the termination of IRIS benefits to be timely. This is because on December 28, 2023 (before the original appeal deadline expired), IM issued an About Your Benefits notice to petitioner that indicated she was re-enrolled in Community Waivers as of December 1, 2023. Findings of Fact 17. However, it was not until January 14, 2024, that the petitioner was issued written notice that her IRIS re-enrollment was actually December 27, 2023. Findings of Fact 18. Her appeal was filed within 45 days of the January 14, 2024, notice of IRIS re-enrollment.

The petitioner, by counsel, set forth multiple arguments aimed at the December 1, 2023 through December 26, 2023, gap in IRIS benefits. Those arguments will be addressed in turn below.

Notice of Health Care Renewal

The petitioner, by counsel, argued that she did not receive timely or adequate notice of the termination of her health care benefits. It was argued that the notices issued prior to November 17, 2023, did not provide adequate notice as they did not contain information about the right and process to request a hearing and to continue benefits until a hearing decision was issued. The About Your Benefits notice of November 17, 2023, was acknowledged to provide adequate notice but was argued to be untimely issued. It is petitioner's position that federal regulations require the notice of termination of health care be issued 15 days prior to the date of termination. According to petitioner, the notice of termination needed to be issued on or before November 15, 2023.

The controlling federal regulation requires the notice of action to contain the following:

> (a) A statement of what action the agency ... intends to take and the effective date of such action;
> (b) A clear statement of the specific reasons supporting the intended action;
>
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
>
> (d) An explanation of—
>
> > (1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or
> >
> > (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
>
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

42 C.F.R. § 431.210.

As noted above, the petitioner acknowledged that the November 17, 2023, About Your Benefits notice met the above requirements. As to the timeliness of the issuance of that notice, relevant federal regulations require the following:

> **Advance notice.**
> The State or local agency must send a notice at least 10 days before the date of action, except as permitted under ... [provisions that do not apply in this case].

42 C.F.R. § 431.211.

While the above regulation indicates that notice be provided at least 10 days prior to the date of action, the petitioner claims that in effect 42 C.F.R. § 431.231 requires the notice be issued at least 15 days prior to the date of action.

> **431.230 Maintaining services.**
>
> **(a)** If the agency sends the 10-day ... notice as required under § 431.211 ..., and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing....

42 C.F.R. § 431.230.

And:

> **§ 431.231 Reinstating services.**
>
> **(a)** The agency may reinstate services if a beneficiary requests a hearing not more than 10 days after the date of action.
>
> **(b)** The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
>
> **(c)** The agency must reinstate and continue services until a decision is rendered after a hearing if—
>
> > **(1)** Action is taken without the advance notice required under § 431.211 or § 431.214 of this subpart;
> >
> > **(2)** The beneficiary requests a hearing within 10 days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period; and
> >
> > **(3)** The agency determines that the action resulted from other than the application of Federal or State law or policy.
> >
> > ...

42 C.F.R. § 431.231.

The above regulations merely require the notice of action be sent "at least 10 days before the date of the action," See, 42 C.F.R. § 431.211. Moreover, 42 C.F.R § 431.231 does not address when the notice of action is to be issued in relation to the date of action. Both 42 C.F.R. §§ 431.230 and 431.231 address the circumstances under which the Medicaid benefits may be maintained or reinstated pending the appeal.

42 C.F.R. § 431.230 addresses the maintaining of the Medicaid benefit pending the appeal. To maintain those benefits, the hearing request must be made prior to the date of action (in this case December 1, 2023). If the appeal is not filed prior to the date of action, then § 431.231 allows Medicaid to be reinstated if the individual requests a hearing within 10 days after she received the notice of action. The date of receipt is considered to be 5 days after the date reflected on the notice, unless she is able to show she did not receive the notice within that 5-day period. Neither § 431.230 or § 431.231 control when the notice of action must be issued in relation to the date of action. The controlling regulation is 42 C.F.R. § 431.211, which requires the notice of action be sent at least 10 days prior to the date of action.

The November 17, 2023, About Your Benefits notice was sent 13 days prior to the date of action. Thus, it was timely sent.

The petitioner next argued that she received conflicting information about the status of her health care benefits. It was argued that the November 17, 2023, About Your Benefits notice directed the petitioner to contact the agency by December 1, 2023, if she wanted her health care to continue. The petitioner did contact the agency prior to that date, including by telephone on November 27, 2023. The Case Comment from the November 27, 2023 telephone call provides the following, in part:

> … she [petitioner] is concerned might not submit it on time, assured they can submit it late in Dec however if received after Dec there may be an impact to case. She understood no further action.

Findings of Fact 12 above.

Counsel argued that the above quoted language should be understood to mean that the petitioner was told by IM that her health care benefits would continue (instead of terminating as of December 1, 2023) if she submitted the materials for renewal before the end of December and that her benefits would only be impacted if submitted after December. That interpretation was not supported by testimony from the author of that Case Comment. Nor did the petitioner testify and confirm counsel's version as an accurate interpretation of what was communicated during the telephone call. The record is not sufficient to reach the conclusion argued by counsel.

Counsel further argued that the About Your Benefits notice issued November 29, 2023, was misleading as it indicates the petitioner's health care benefits had not been changed. I understood counsel's argument to be that due to that notice the petitioner believed that her health care would continue uninterrupted after November 30, 2023, even though she had failed to complete her renewal. One of the major flaws in the argument is that it was not supported by testimony from the petitioner indicating that she was confused or misled by the notice.

While the November 17, 2023, About Your Benefits notice may qualify as the only timely notice of action issued prior to the termination of health care, petitioner was issued multiple notices and at least on one occasion was verbally informed by TMG of the need to complete the health care renewal prior to November 30, 2023, or her benefits would end as of December 1, 2023. See Findings of Fact above. The record demonstrates that she received adequate and timely notice regarding the need to complete her renewal and the resulting termination of health care benefits if she failed to do so.

Failure of IRIS program to Issue Notice of Action

It was next argued by counsel that the IRIS program was required to issue a notice of action regarding the termination of IRIS benefits. It was argued that the November 17, 2023, notice of action issued by IM was not sufficient because IM is not part of the IRIS program. In support, counsel cited the following IRIS policy:

> The IRIS program must provide a Notice of Action (NOA) to program participants when an "adverse action," defined as a denial, reduction, termination, or limitation of

> previously authorized services (meaning services/goods on a participant's plan) exists or when a participant is determined *financially*, or functionally, ineligible for the IRIS program.

Emphasis added. IRIS Policy Manual, § 11.2 (04/2024).

The IRIS Waiver application most recently approved by the Centers for Medicare and Medicaid Services (CMS) is available on-line at: https://www.dhs.wisconsin.gov/iris/hcbw.pdf. See Application for 1915(c) Home and Community-Based Services Waiver (HCBS Waiver): WI.0484.R0300 – Jan 01, 2021.

Appendix E of the HCBS Waiver sets forth the circumstances under which a participant may be involuntarily disenrolled from IRIS which includes loss of financial eligibility. HCBS Waiver, pg. 202. It provides "the participant is notified of the [disenrollment] decision, provided a Notice of Action, and provided information on how to engage the State Fair Hearing process if the participant wishes to appeal the decision."

Appendix F of the HCBS Waiver, "...specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210." HCBS Waiver, pg 8 of 274. Under Appendix F-1: Opportunity to Request a Fair Hearing, it is noted that the state provides opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals whose IRIS services are denied, suspended, reduced, or terminated. HCBS Waiver, pg. 206. It is further indicated that the "*state* provides notice of action as required in 42 CFR §431.210." Id. (*emphasis* added.) The requirements for a valid notice of action under 42 CFR §431.210 was addressed above, wherein the November 17, 2023, About Your Benefits notice was found to meet those requirements.

The HCBS Waiver further provices the following in addressing the issue of the notices to be used to offer an individual the opportunity to request a Fair Hearing:

> IRIS program participants receive information about opportunities to request a state fair hearing at multiple times and in multiple ways, including prior to enrollment, at the time of enrollment, and while enrolled. The opportunities presented to participants are as follows:
>
> • Aging and Disability Resource Centers (ADRCs) provide information about state fair hearings during enrollment counseling and any other time upon request, and the TADRS must follow this provision if they elect to perform eligibility and enrollment functions for the tribe(s) they work with; or
> • *The regional income maintenance (IM) consortium which determines financial eligibility for Medicaid use standardized Notices of Action (NOA) forms to inform participants of ineligibility that include information about the right to a fair hearing;* or
> • ICAs provide participants with SMA approved participant education materials which includes state fair hearing information, at program orientation, whenever the participant materials are updated, or at a minimum, annually; or
> • information is mailed to the participant with every issued notice of adverse benefit determination regarding the IRIS program and includes fair hearing information; or
> • The SMA contracts for ombudsman services which provide assistance to participants in filing a request for fair hearing and to assist the participant at the hearing; or
> • The SMA contracts with an external quality review organization (EQRO) to provide participants with information and support about the complaints and grievance process which includes information about the state fair hearing process; or

> • During the adjudications of appeals of "adverse actions," Administrative Law Judges provides the participant with written information with includes state fair hearing information.

Emphasis added. HCBS Waiver, pgs. 206-207. Thus, the HCBS Waiver recognizes that a notice of action may be issued by IM to an IRIS participant. This is consistent with the information provided by the TMG representative at hearing. That representative indicated that they had been informed by the Department that the notice of action for IRIS disenrollment associated with a health care renewal is to be issued by IM.

I would note that TMG did issue a letter to the petitioner that informed of the need to complete the renewal in order to maintain IRIS benefits. However, that letter does not qualify as a notice of action under 42 CFR §431.210 as it does not include appeal rights. Multiple notices were issued by DMS that also informed petitioner that her IRIS enrollment would be ending November 30, 2023. However, those notices also did not contain appeal rights. The November 17, 2023, About Your Benefits notice is an appropriate notice of action. That the notice of action was issued by IM as opposed to TMG or the DMS was not found to be dispositive. What is ultimately dispositive is whether the petitioner was provided timely and adequate notice under 42 CFR §431.210. That occurred here.

Assistance in maintaining MA eligibility and responsibility to explain rights and appeal process.
Counsel next argued that TMG violated IRIS policy by failing to assist petitioner in maintaining Medicaid eligibility and to explain to her the right and process to appeal. It was noted that a significant change reflected in the most recent HCBS Waiver renewal was that IRIS consultant agencies now must maintain participant long-term care and MA eligibility. HCBS Waiver, pgs. 2. The HCBS Waiver further indicates that IRIS consultant agencies are to "[][e]xplain participant rights and the appeals and grievance process[][.]" Id at pg. 19.

It was argued at a minimum TMG as the IRIS consultant agency was required to explain to the petitioner her appeal rights, assist her in timely requesting a Medicaid fair hearing, and ensure her IRIS benefits were continued during the appeal process. Counsel argued that petitioner could have maintained IRIS eligibility if TMG had helped her request a hearing before the termination of her health care benefits. Thus, her IRIS benefits would have been maintained during the pendency of the appeal.

The evidence in the record does not demonstrate that the IRIS consultant agency fulfilled its responsibility prior to December 1, 2023, to educate petitioner on the right to appeal an adverse action, the process to file an appeal, or the right and requirements to continue health care benefits pending an appeal of the termination of her benefits. As such, I find there are appropriate grounds to reinstate the petitioner's IRIS benefits during the pendency of the appeal, retroactive to December 1, 2023. This is my understanding of the remedy that was being sought by the petitioner for TMG's failure to fulfill its responsibilities identified above.

In a final decision issued by the Department it was indicated that the Division of Hearing and Appeals does not have the authority to adjust the enrollment date in the IRIS program under the expediated re-enrollment process. It was noted that the Department does, however, have that authority. See DHA Case No. CWA-209367 (dated January 4, 2024).

Backdated Coverage Under Late Renewal Policy set forth in the Medicaid Eligibility Handbook
Finally, it was argued by counsel that policy set forth in the Medicaid Eligibility Handbook (MEH) authorizes back payment for IRIS participants when there are gaps in coverage that stem from a late health care renewal. The provisions cited by counsel are as follows:

3.1.6 Late Renewals

Most health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. This policy applies for the following health care programs:

- BadgerCare Plus
- FPOS
- SSI-Related Medicaid
- *HCBW*
- Institutional Medicaid
- MAPP
- Medicare Savings Programs (QMB, SLMB, SLMB+, QDWI)

...

Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons. Late renewals and renewal-related verifications must be accepted for up to three calendar months after the renewal month. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

Emphasis added. MEH, §3.1.6. Further relevant provisions include:

3.1.6.2 Gaps in Coverage
If a member has a gap in coverage because of a late renewal, they may request coverage of the past months in which the gap occurred. Backdated coverage under the late renewal policy is available to all health care members who meet program rules (see SECTION 2.8.2 BACKDATED ELIGIBILITY).

If a member requests coverage for past months during a late renewal, they must provide all necessary information and verification for those months (including verification of income and assets for all months requested) and must pay any required premiums to be covered for those months.

Note: QMB coverage is not retroactive. Members cannot receive backdated eligibility for this program.

MEH, § 3.1.6.2.

And:

2.8.2 Backdated Eligibility

Medicaid eligibility can be backdated up to three months prior to the month of application.

The backdated eligibility should not go back further than the first of the month, three months prior to the application month. The member may be certified for any backdate month in which he or she would have been eligible had he or she applied in that month.

> A backdate request can be made at any time except when the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.
>
> If a member has incurred a bill from a Medicaid-certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.
>
> ...
>
> **Assets**
>
> A person's asset eligibility in a backdate month is determined by whether or not he or she had excess assets on the last day of the month. If he or she had excess assets on the last day of the month, he or she is ineligible for the entire month. If he or she was asset eligible on the last day of the month, he or she is eligible for the whole month.

MEH, § 2.8.2.

Counsel argued that the IRIS program falls within Home and Community-Based Waivers of the Late Renewals provision of MEH, §3.1.6. It was further indicated that the petitioner had an IRIS gap in coverage (December 1, 2023 – December 26, 2023) due to a late renewal which is addressed by MEH, §3.1.6.2. Finally, it was argued petitioner was eligible for IRIS backdated coverage under the afore-mentioned late renewal policy as she further meets program rules under MEH, § 2.8.2. It was noted that asset eligibility in a backdated month is determined as of the last day of the month. As of the end of December 2023, she was asset eligible. Thus, the petitioner seeks backdated IRIS coverage for December 1, 2023 through December 26, 2023.

In response, TMG provided a policy statement issued on September 18, 2023, by the Bureau of Quality Oversight, titled IRIS Participant Lapes in Program Enrollment after Loss of Medicaid. That policy indicates the following, in part:

> Per IRIS policy, IRIS program eligibility and enrollment can only occur once a participant has established Medicaid, therefore if a participant loses Medicaid, their IRIS enrollment is also ended.
>
> ...
>
> During COVID unwinding DHS has implemented a temporary process that allows for an *expedited re-enrollment* to minimize the impact to IRIS participants supports and services. Participants who lost and regained Medicaid within the following month of their lapse were allowed to re-enroll into the IRIS program without going through the standard enrollment process. The Department uses the CARES system to identify the date in which Medicaid was established to serve as the new IRIS enrollment date.
>
> In these instances, there is typically several days in which the IRIS participant was not enrolled in the IRIS program which prohibits the Department from paying for services rendered during this period.
>
> Outside of COVID unwinding, if an IRIS participant was disenrolled from the IRIS program due to losing their Medicaid, the participant would need to return to the Aging and Disability Resource Center (ADRC) to determine functional and financial eligibility, as well as options counseling for program and agency selection.

> Per IRIS Policy *2.2D Ongoing Eligibility*, "Failure to maintain eligibility may result in disenrollment". Based on the above circumstances, the new IRIS enrollment date serves as the activation date for service authorizations. Per IRIS Policy *5.5B Enrollment Date*, the IRIS program prohibits the payment of providers or participant-hired workers prior to the enrollment date.

TMG argued that IRIS could not be backdated and that the date of re-enrollment was December 27, 2023. It was TMG's position that petitioner is not eligible for IRIS payment to providers or participant-hired workers as sought by petitioner for the period of December 1, 2023 through December 26, 2023.

Based on the above-cited MEH provisions, I find that the petitioner is eligible to have her IRIS enrollment backdated to December 1, 2023. However, given the conflict between the MEH and the September 18, 2023, policy statement of the Bureau of Quality Oversight cited above, along with my understanding that this conflict in policy has not been previously addressed, I find it appropriate to issue the decision as a proposed decision.

CONCLUSIONS OF LAW

1. The petitioner's IRIS benefits are to be backdated to December 1, 2023, as her IRIS consultant agency failed to explain her right to appeal disenrollment, the process to file an appeal, or the right and process to continue benefits during the pendency of the appeal.

2. The petitioner is eligible to have her IRIS benefits backdated from December 27, 2023, to December 1, 2023, under the late renewal policy set for in Medicaid Eligibility Handbook, § 3.1.6.

THEREFORE, it is **ORDERED**

That if this Proposed Decision is adopted by the Secretary of the Department of Health Services as the Final Decision in this matter, the agency shall, within 10 days of the date of the Final Decision, take all necessary administrative steps to revise the petitioner's IRIS enrollment date to December 1, 2023.

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 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 16th day of May, 2024

[redacted]

Jason M. Grace
Administrative Law Judge
Division of Hearings and Appeals