FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: CWA - 217154

PRELIMINARY RECITALS

Pursuant to a petition filed on February 20, 2025, under Wis. Admin. Code § HA 3.03, to review a decision by the Department of Health Services and TMG, an IRIS Consultant Agency, regarding IRIS, a hearing was held on June 3, 2025, by telephone. The hearing was rescheduled twice at Petitioner's request.

The issue for determination is whether the Department of Health Services by its contracted agent, TMG, properly sees to involuntarily disenroll Petitioner from IRIS for health and safety concerns.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Monica Steren, TMG
Bureau of Long-Term Support
PO Box 7851
Madison, WI 53707-7851

ADMINISTRATIVE LAW JUDGE:
Teresa A. Perez
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a 60-year old resident of Marquette County who is enrolled in the IRIS Program. TMG is his IRIS Consultant Agency ("ICA" / "the agency").

2. Petitioner lives in the community in the home of [redacted], who has, until recently, been his primary paid caregiver and also provides natural supports. He has one other paid caregiver who also resides with him.

3. Petitioner's medical diagnoses include but are not limited to: diabetes, hemiparesis resulting from a prior stroke (specifically, weakness on his ride side and limited use of his right hand), foot drop, weakness, generalized anxiety disorder, major depressive disorder, personality disorder, and spasticity. Petitioner also has a history of falls and attempted suicide. Petitioner has some memory loss and relies on his caregivers to help him with more complex decisions.

4. Petitioner requires assistance with bathing, dressing, ambulating in his home, toileting, and transferring. Petitioner requires hands on assistance to move from his chair to his bed and from his bed to his chair. Petitioner is able to stand for very limited periods of time. He sits in his wheelchair most of the day. Petitioner also requires assistance with meal preparation, medication administration / management, laundry / chores, and transportation. He is not currently working but if he were to get a job, he would need assistance weekly or less.

5. Petitioner has the following durable medical equipment and supplies: shower chair, wheelchair, urinal, powerchair, quad cane, gait belt, wrist/hand splint, knee and ankle supports/orthotics, compression stockings, and incontinence supplies.

6. Petitioner's current Individual Support and Servies Plan (ISSP) includes authorization for 11 hours per week of respite care and 18 hours per week of routine supportive home care. He also receives 42 hours per week of self-directed personal cares that is funded by Medicaid.

7. In April 2024, Petitioner underwent an annual long term care functional screen. At that time, he and [redacted] showed the screener photos of petitioner on the floor in his underwear with bruises and scratches on his body and informed the screener that Petitioner had been experiencing grand mal seizures and related falls. Neither Petitioner nor his caregivers had previously reported falls to the agency.

8. Based on the agency's discussions with Petitioner and [redacted] regarding his unreported falls and the presentation of the photographs that showed him on the floor with bruises, in April 2024, the agency made a referral to the County Adult Protective Services Unit.

9. In April and May 2024, Petitioner's IRIS Consultant continued to remind Petitioner and [redacted] that he [redacted] as part of the IRIS Critical Incident Reporting Policy. They indicated that they would not do so because they felt it was a violation of privacy and declined to adopt any mitigation strategies recommended by the agency.

10. In May 2024, the IRIS Consultant presented Petitioner with a Risk Agreement regarding his falls. He declined to sign it at that time but did sign it in August 2024.

11. In September 2024, VA Medical Services, through which Petitioner was receiving respite services made a referral to Adult Protective Services.

12. In November and December 2024, [redacted] reported to the IRIS Consultant that Petitioner continued to have night episodes, which she believes to be seizures, during which he becomes confused, will try to leave the residence, will wipe feces on the wall, and dump urine in different places. She further reported that she has placed a camera in his room and that there was a lock on his bedroom door that she is able to lock from the outside to prevent him from wandering and to keep him safe at night. She also reported that he had a key that he could use to unlock from the inside but indicated that she was unsure whether he would be able to use it during an "episode".

13. Based on the reports that Petitioner was locked in his bedroom at night and the presence of the camera in his bedroom, the agency made another referral to the County Adult Protective Services unit in December 2024.

14. In December 2024, the IRIS Consultant prepared a risk agreement regarding the lock on Petitioner's bedroom door, which the agency explained was a prohibited restrictive measure, and advised him that he was at rick of involuntary disenrollment. In January 2025, the agency presented Petitioner with a Risk Agreement. Petitioner declined to sign it and declined options the agency identified as alternatives to keep him safe at night. [redacted] told the IRIS Consultant that she intended to talk to a judge about "filing an injunction against TMG" and to get a restraining order to prevent TMG from telling them that they need to remove the lock from petitioner's bedroom door. [redacted] reported that although she had reversed the lock, she had begun to use "barricades" on all the other doors. When asked by agency staff to explain what she meant by "barricades", [redacted] was non-responsive.

15. The County APS reported to the agency that none of the three referrals were opened because Petitioner is "his own person" and reported to APS staff that he felt safe and did not wish to answer their questions.

16. On an unspecified later date, [redacted] reported that she "reversed the lock" so that it would no longer lock from the outside; however, Petitioner and [redacted] stated that they believed Petitioner's rights were being violated by the agency because it was his wish to be locked in his bedroom for his safety.

17. Via notice dated February 7, 2025, the agency informed Petitioner that he would be disenrolled from IRIS due to health and safety concerns; specifically, concerns regarding prohibited restrictive measures.

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. See also, 42 C.F.R. §441.300, et. seq. 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 IRIS 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 Work Instructions* (available at http://www.dhs.wisconsin.gov/publications/P0/P00708a.pdf).

The waiver requires IRIS Consultant Agencies ("ICAs") to monitor health and safety as part of service planning, to try to eliminate health and safety concerns, when they arise, in partnership with the participant, and to disenroll participants when health and safety concerns remain despite remediation efforts. Specifically, the waiver provides:

> Regular meetings . . . provide the opportunity for the [IRIS Consultant] to monitor the participant's back-up plan and health and safety. ICs may mitigate risk of threats to health and safety by connecting participants with resources for addressing their own health and safety risks. . . If the participant refuses, or is unable, to address his or her own health and safety, or refuses the assistance of the IRIS Consultant, the IRIS Consultant has the responsibility to recommend involuntary disenrollment.

Application for a 1915(c)Home and Community Based Services Waiver WI.0485.R01.00, Appendix D-2a.; see also Appendix E-1m. and Appendix D-1e.

Consistent with the above-quoted waiver language, IRIS program policy issued by the Department of Health Services includes the following directions regarding the involuntary disenrollment of IRIS participants:

> **2. Program Requested Disenrollment**
>
> **a. Disenrollment Process**
>
> . . . ICAs are responsible for recommending program requested disenrollments when a reason for disenrollment is identified and applicable remediation attempts have not resolved the issue . . . The reasons for program requested disenrollment, their definitions, and any required remediation include the following:
>
> iii. **Health and Safety**: The ICA selects this reason when they are unable to ensure the health and safety of the participant.
> 1. Remediation/Documentation Required: The ICA must provide documentation of efforts to assist the participant in resolving the health and safety issue, including any applicable attempts at risk mitigation.

Program Enrollment Addendum to *IRIS Policy Manual* and *Work Instructions* (available at https://www.dhs.wisconsin.gov/publications/p03547.pdf).

It is thus clear that an IRIS participant may be disenrolled from the program based on health and safety risks but that the ICA has an obligation to make efforts to remediate health and safety risks before disenrolling a participant. Here, the ICA argued that Petitioner must be involuntarily disenrolled based on concerns they have regarding his caregiver's actions of locking him in his bedroom and/or barricading him in the house as a means to keep him safe when he experiences episodes of disorientation or when he has what his caregiver believes to be are seizures. To support its disenrollment decision, the ICA cited a publication by the Department of Health Services, *Restrictive Measures Guidelines and Standards* which states on the cover that, "Individuals enrolled in IRIS who fail to obtain approval for use of restrictive measures may be subject to involuntary disenrollment due to health and safety risks that participants are unwilling or unable to provide." That publication includes a specific prohibition on "any use of seclusion where the door to the room would remain locked without someone having to remain present to apply constant pressure or control to the locking mechanism." See Ex. G.

In this case, Petitioner's IRIS Consultant, Amie Berndt, and Restrictive Measures Lead, Theresa Post, both offered credible, first-hand testimony on the agency's behalf regarding meetings they had with Petitioner and [redacted] at which they discussed the rules regarding restrictive measures and the use of locks and unspecified "barricades" as safety measures. The agency also presented case notes corroborating their testimony and a copy of the Risk Agreement presented to Petitioner in January 2025. The agency established that Petitioner was advised that he was at risk of involuntary disenrollment, that agency workers attempted to engage Petitioner and [redacted] in conversations regarding alternatives to protecting Petitioner that did not entail seclusion, and that agency workers endeavored to provide education on the prohibited use of restrictive measures.

Petitioner and [redacted] testified at hearing. They both expressed frustration with the ICA and both insisted that it was Petitioner's wish to be locked in his bedroom for his own safety. [redacted] argued that TMG was abusing Petitioner by not authorizing around the clock care for him and by trying to strip his rights away from him by not allowing him to do what he wants to do in his own home (i.e., have the lock on the outside of his bedroom door).

Petitioner did not file an appeal regarding the amount of authorized supportive home care or other cares. [redacted]'s complaints that Petitioner has not been granted a sufficient amount of care are thus outside the scope of this hearing. Moreover, she did not assert that she had resorted to seclusion because Petitioner did not have enough authorized care. To the contrary, even at hearing, she was insistent that the use of the lock was an appropriate measure that the State has no authority to regulate or restrict. She is incorrect. See *Restrictive Measures Guidelines and Standards*, Bureau of Quality and Oversight, Bureau of Programs and Policy, Division of Medicaid Services, P-02572 (01/2024)/

Based on the evidence in the record, I, like the ICA, am uncertain whether there is or is not an impermissible lock on Petitioner's bedroom door and do not know whether there are barricades being used to seclude him. Even without that information, there is sufficient evidence that involuntary disenrollment on health and safety grounds is necessary in this case. As the agency observed, [redacted] reported both that Petitioner requires round the clock care and cannot walk or transfer independently and that he is a wandering risk. [redacted] asserted both that Petitioner has the right to make his own decisions within his own home and that he is frequently incapacitated, confused, and unaware of what is going on. Her incompatible assertions are troubling and make it difficult to know what care Petitioner requires and what care he is receiving.

I am going to uphold the agency's disenrollment because a preponderance of the evidence established that the agency has identified a valid health and safety concern and that Petitioner has been unable or unwilling to remediate those concerns.

I note that there have apparently been at least three APS referrals regarding Petitioner--two made by the ICA and one made by the VA. [redacted] argued that APS determined that Petitioner was not being abused or neglected. ICA staff, on the other hand, testified that APS reported that they did not conduct an investigation because Petitioner would not cooperate, because he stated that he felt safe, and because he is his own person. No APS records or direct testimony from APS staff were offered at hearing so I have no way of knowing what actions APS took to follow up on the three referrals they received, whether they concluded that no abuse or neglect was occurring after a full investigation, or whether they declined to conduct a full investigation.

[redacted] included photographs, apparently of Petitioner, in the exhibits she submitted on behalf of Petitioner. See Petitioner's Exhibits, p. 14. It is my understanding that she included these photographs to demonstrate that he needs more care than IRIS has authorized. Again, this hearing was not an appeal of a service authorization and I am therefore not making any findings regarding what amount or types of care

Petitioner requires or is entitled to receive. However, these photographs are concerning. One of them shows Petitioner lying on a mattress naked from the waist down with what appears to be feces under and next to him. Another shows his feet with several red sores. I do not know when these photographs were taken or for what purpose. Without that type of context, they are of limited value to me as the decisionmaker. However, they raise additional red flags regarding Petitioner's health and safety.

Petitioner will be referred to the Aging and Disability Resource Center upon disenrollment from IRIS and will likely be eligible to enroll in Family Care, a managed long term care program that can provide a level of assistance and oversight that is not available through a self-directed program.

CONCLUSIONS OF LAW

The agency properly seeks to disenroll Petitioner from IRIS due to health and safety concerns that remain present in his home despite the agency's efforts to address those concerns.

THEREFORE, it is ORDERED

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, 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 17th day of June, 2025

\s_____
Teresa A. Perez
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on June 17, 2025.

Bureau of Long-Term Support
[redacted]