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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: CWA - 213390

PRELIMINARY RECITALS

Pursuant to a petition filed on May 8, 2024, under Wis. Admin. Code § HA 3.03, to review a decision by the Bureau of Long-Term Support regarding IRIS, a Medical Assistance (MA) long term care waiver program, a hearing was held on August 20, 2024, by telephone. The record was held open for three weeks to allow the parties to submit written closing arguments.

The issue for determination is whether the agency, through its agents, correctly seeks to involuntarily disenroll Petitioner from the IRIS program.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

Attorney Lori Kornblum
Law Offices of Lori S. Kornblum
10936 N Port Washington Rd Ste 296
Mequon, WI 53092

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
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 resident of Milwaukee County who has been enrolled in IRIS since August 2010. FirstPerson has been Petitioner's IRIS Consultant Agency ("ICA") since June 2017. Prior to that, TMG was his ICA.

2. Petitioner resides in a home with his mother, [redacted], and her partner, [redacted]. [redacted] is Petitioner's legally appointed guardian and his primary participant hired worker ("PHW"). She is authorized by the IRIS program to provide him both personal care and supportive home care.

3. On September 27, 2016, Petitioner's IRIS consultant (employed by TMG) wrote a case note indicating that, on that date, she met with [redacted], [redacted], and Petitioner; stated that a "FARA visit" was requested because [redacted] had billed for 24 hours in a day; discussed the "forty hour health and safety assurance policy"; advised [redacted] that she could request an exemption to work up to 50 hours per week; and gave [redacted] a "Risk Report".

4. On September 28, 2016, the Department of Health Services notified Petitioner and [redacted] that because they had been "part of an investigation of potential fraud", Petitioner's participant-hired workers would be required to enter their start and end times on their timesheets. The Department specified that all people who had been part of a fraud investigation, whether the allegations of fraud were substantiated or unsubstantiated, were required to use this timesheet. The Department did not indicate whether it had found that [redacted] had engaged in fraud or what the allegations had been.

5. During the time period January 21, 2024 through March 17, 2024, [redacted] approved 2:1 cares for Petitioner on at least ten separate dates which resulted in Petitioner billing for more than 24 hours of total care on each of those dates.

6. In 2022, FirstPerson staff members discussed with [redacted] their concerns about her providing Petitioner with more than 18 hours per day of cares and risking caregiver burnout. [redacted] billed for providing Petitioner more than 18 hours per day on at least 38 days in 2023 at least four days in 2024 prior to the issuance of the Notice of Action in dispute.

7. On June 12, 2023, [redacted] billed supportive home care and personal care that totaled 26 hours.

8. On May 7, 2024, the ICA issued a Notice of Action ("the notice") to Petitioner which stated that his enrollment in IRIS would be terminated as of May 22, 2024 because "the request was determined to be sought under fraudulent circumstances" and included the following specific allegations:

    - Billing for more than 24 hours of total cares in a day on 19 days in 2024 after requesting and being denied authorization for 2:1 Self-Directed Personal Cares.
    - Billing for more than 18 hours in a day, on several days in 2023 and 2024, for care that she provided to Petitioner after being told by the ICA that she should not do so because it creates a risk for caregiver burnout.
    - Billing for 26 hours for care that she provided to Petitioner on June 12, 2023
    - Submitting a forged timesheet for [redacted], a different participant hired worker, for the time period January 28, 2024 to February 10, 2024.

DISCUSSION

The Include, Respect, I Self-Direct (IRIS) program is a Medical Assistance 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 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) HCBS Waiver: WI.0484.R03.00 - Jan 01, 2021.* 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), *IRIS Work Instructions* (available at http://www.dhs.wisconsin.gov/publications/P0/P00708a.pdf), and *IRIS Service Definition Manual* (available at https://www.dhs.wisconsin.gov/publications/p00708b.pdf).

The approved IRIS waiver states that program participants may be involuntarily disenrolled for a number of reasons including, of relevance to this case, "mismanagement of Budget Authority responsibilities (misappropriation of funds)", "Mismanagement of Employer Authority responsibilities", and "Substantiated fraud". See Appendix E-1: Overview (12 of 13), p. 201; see also *IRIS Policy Manual*, Sec. 10.1, p. 46.

The agency here issued a Notice of Action to Petitioner's guardian informing her that Petitioner would be disenrolled from the IRIS program due to "fraudulent circumstances" and included the specific allegations set forth in Finding of Fact No. 8, above. In the Notice of Action, the agency quoted the following definition of fraud:

> Fraud refers to "any intentional deception made for personal gain or to damage another individual, group, or entity. It includes any act that constitutes fraud under applicable Federal or State law. Examples include, but are not limited to: • Falsification of provider credentials; • Falsification of participant needs; • Falsification of participant assets, income, or any information used in determination of eligibility; • Intentionally performing or billing services improperly, including false claims, or intentionally denying appropriate services. Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representation, or promises, any of the money or property owned by, or under the custody of control of, any health care benefit program (18 U.S.C. 1347).

The agency also provided the definition for the term "substantiated fraud" and observed that DHS has the authority to disenroll participants identified as the "FARA subject" in substantiated FARA cases due to misappropriation of funds. However, the agency did not assert or provide any evidence that Petitioner or his guardian is a current "FARA subject" or that there has been a finding of substantiated fraud.

The specific allegations that were included in the Notice of Action are addressed in turn below:

FALSIFICATION OF TIMESHEET

The agency alleged that Petitioner submitted a falsified timesheet and, at hearing, contended that [redacted] either forged that timesheet or approved the timesheet despite someone else forging it. The agency offered hearsay statements from the participant hired worker whose timesheet is in question. That worker was fired by [redacted] and the two of them had an altercation on March 1, 2024. Sometime after that, the worker reported to the agency that she had not signed any timesheets. This led the agency to obtain a copy of a timesheet that [redacted] had submitted to the fiscal employer agent ("FEA") and to observe that the "signature" on that timesheet did not match the signature the worker placed on another timesheet in view of [redacted], the agency's primary witness at hearing. However, [redacted] testified that she personally observed the worker sign the timesheet that the agency alleges was forged.

I do not doubt that [redacted] watched the worker sign a timesheet; however, what the agency describes as the worker's "signature" on the timesheet submitted by [redacted] appears to me to be the worker's printed name and not a signature at all. And, the manner in which her name is printed is not dissimilar to the appearance of the writing in other documents apparently completed by that worker and offered as evidence at hearing. I understand the agency's skepticism but the agency bears the burden of proof in this matter. And, the evidence in the record does not support either of the party's contentions regarding the signature on the timesheet in question more strongly. Thus, the agency does not prevail on this point.

BILLING FOR PROVISION OF 26 HOURS OF CARE BY [redacted] IN A SINGLE DAY

The agency presented documentation showing that [redacted] billed for providing 26 hours of care to Petitioner in a single day—something that is plainly not possible. This occurred in June 2023. [redacted] engaged in no similar billing irregularity either prior to or after that. Because it happened only one time and because the monetary benefit of being paid for two extra hours was minimal, I am persuaded this was an error and not an intentional act of fraud. And, as a one-time error, it is not a sufficient basis for involuntary disenrollment.

UNAUTHORIZED 2:1 BILLING

The agency contended that [redacted] had requested and been denied 2:1 care for Petitioner and that she then billed for that time anyway. To support its contention, the agency provided a case note that indicated [redacted] asked a self-directed personal care (SDPC) nurse if Petitioner could receive 2:1 care to assist him with ADLs and that the nurse said no.

[redacted] acknowledged that she billed for 2:1 care for Petitioner on several dates. As counsel for Petitioner correctly noted, the cares billed for Petitioner on the dates in question included both SDPC and supportive home care and the agency did not assert that billing for SDPC and supportive home care at the same time is prohibited. Moreover, the evidence did not establish that two SDPC workers were on duty at the same time on those dates.

It may be that Petitioner did not have authorization from his care team to receive 2:1 care of any type and that the billing for 2:1 care was therefore a violation of policy and of budget management and/or employer authority but the agency did not assert that; it asserted that [redacted]'s request was made to and denied by an SDPC nurse. For the reasons set forth above, and based on the evidence provided, I find that the agency did not demonstrate that the 2:1 billing submitted by [redacted] is a proper basis for involuntary disenrollment.

To be clear, 2:1 billing submitted by a participant without prior authorization could, under certain circumstances and with sufficient evidence, serve as a proper basis for involuntary basis. This decision is not intended to suggest that [redacted] is entitled to bill for services, even those that are undisputedly necessary for Petitioner, without proper authorization. And, this decision should not be interpreted to mean that the ICA couldn't properly seek to disenroll Petitioner in the future if [redacted] bills for unauthorized services or if she allows participant hired workers to work more than they are individually authorized to work.

BILLING FOR MORE THAN 18 HOURS A DAY FOR CARE PROVIDED BY [redacted]

There is no dispute that [redacted] billed for more than 18 hours per day for care that she herself provided to Petitioner. And, [redacted] acknowledged at hearing that at some point, ICA staff advised her that working that created a risk of caregiver burnout. The agency did not however present a copy of any Risk Agreement or other documentation indicating that [redacted] was advised that billing in excess of 18 hour in a day could serve as a basis for involuntary disenrollment. Moreover, the agency did not assert, or present evidence to prove, that [redacted] much fraudulently billed for care that she did not provide to Petitioner. (Notes included in the record suggest that the agency suspects [redacted] of that behavior but the agency presented no evidence to substantiate those suspicions). It is also undisputed that Petitioner requires someone to be present with him at all times.

BILLING FOR MORE CARE THAN AN INDIVIDUAL WORKER IS AUTHORIZED TO PROVIDE

I note that the Notice of Action did not include any language regarding [redacted] repeatedly billing for more hours than she was personally authorized to care for Petitioner in a week. Nevertheless, the agency discussed that billing pattern at length during the hearing and in written submissions. I will therefore address that allegation here.

The evidence in the record showed that Petitioner received a copy of the *IRIS Participant Education Manual* in 2022 and in 2023. That manual describes a participant's obligations regarding budget and employer authority management including but not limited to: "You should not schedule providers to work more than what is authorized" and "You should not sign timesheets that go over what the worker is authorized to provide". The manual also indicates that a participant may be disenrolled for fraud, mismanagement of their budget, or mismanagement of their employer authority. Despite being provided this information, [redacted], as established by copies of ISSPs and timesheets offered by the agency, billed for more than 92 hours in a week, which was during the relevant time period, the number of hours of care that she was authorized to provide to Petitioner. In fact, she did so during at least eleven weeks between late 2023 and early 2024. The agency therefore showed that [redacted] has repeatedly failed to properly exercise employer authority (which does not require a showing that Petitioner's annual budget was overspent or that [redacted] acted with fraudulent intent).

Although the agency provided evidence at hearing showing that [redacted] worked in excess of her authorized 92 hours during several weeks, the agency did not include that as a basis for disenrollment in the *Notice of Action*. Without ruling on whether her actions in that regard could serve as a proper basis for involuntary disenrollment, I find that those actions are not a proper basis for disenrollment in this case because they were not included in the Notice of Action. I cannot uphold an action for which a participant did not receive proper notice and part of proper notice is an accurate statement of the basis of an adverse action.

CONCLUSIONS OF LAW

The agency did not establish by a preponderance of the evidence that there is a proper basis to involuntarily disenroll Petitioner from IRIS.

THEREFORE, it is ORDERED

That the matter is remanded to the agency to rescind the disenrollment and provide notice of that rescission to Petitioner's guardian. The agency shall comply with these instructions within ten calendar days of the date of this decision.

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 18th day of October, 2024

\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 October 18, 2024.

Bureau of Long-Term Support
Attorney Lori Kornblum