



FH  
[REDACTED]

**STATE OF WISCONSIN**  
**Division of Hearings and Appeals**

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In the Matter of

[REDACTED]

DECISION

CWA/144469

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**PRELIMINARY RECITALS**

Pursuant to a petition filed October 09, 2012, under Wis. Admin. Code § HA 3.03, to review a decision by the Bureau of Long-Term Support in regard to Medical Assistance (IRIS), a hearing was held on November 21, 2012, at Waupaca, Wisconsin.

The issue for determination is whether the respondent correctly terminated funding of petitioner's vehicle insurance.

There appeared at that time and place the following persons:

**PARTIES IN INTEREST:**

Petitioner:

[REDACTED]

Respondent:

Department of Health Services  
1 West Wilson Street  
Madison, Wisconsin 53703

By: Jill Speer  
Bureau of Long-Term Support  
1 West Wilson  
Madison, WI

**ADMINISTRATIVE LAW JUDGE:**

Peter McCombs (telephonically)  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner (CARES # [REDACTED]) is a resident of Waupaca County. Petitioner is enrolled in the Include, Respect, I Self-direct (IRIS) program.

2. Petitioner has diagnoses that include borderline intellectual functioning, hyperlipidemia, shoulder, knee, and back pain, anxiety, depression, allergic rhinitis, and K2-ADHD and learning disabilities in spelling and reading.
3. On October 1, 2012, the respondent notified petitioner that it was terminating the inclusion of vehicle insurance from his Individual Service and Support Plan (ISSP) because vehicle insurance does not meet the definition of an allowable service as outlined in the IRIS Medicaid Waiver Services Summary definitions.
4. On October 9, 2012, the Petitioner filed an appeal with the Division of Hearings and Appeals.

### DISCUSSION

Petitioner is a participant in the IRIS (Include, Respect, I Self-Direct) program. The Medicaid Eligibility Handbook (MEH) describes the IRIS program:

#### 37.1.1 Introduction

The Include, Respect I Self-Direct (IRIS) program is a fee for service alternative to Family Care, PACE or Partnership for individuals requesting a long-term care support program in Family Care counties.

Under IRIS, the participant will be able to access services comparable to those provided under the Home- and Community-Based Waivers (HCBW) while managing an individual budget to meet their service needs.

The IRIS program is governed in part by the Code of Federal Regulations (CFR). Relevant here is this section of 42 CFR 440.180:

(b) Included services. Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:

- (1) Case management services.
- (2) Homemaker services.
- (3) Home health aide services.
- (4) Personal care services.
- (5) Adult day health services.
- (6) Habilitation services.
- (7) Respite care services.
- (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.
- (9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

42 CFR §440.180(b).

In furtherance of implementing this law, especially subsection (9), the IRIS program has developed policies regarding funding of goods and services. See Policy: SC 16.1, IRIS Funding for Goods, Supports and Services. That policy requires that a requested item be designed to meet the participant's functional, vocational or medical or social needs and advance outcomes in the individual service plan.

Policy 16.1 discusses "customized goods and services" which may be covered by the program. These are goods and services that "enhance a consumer's opportunities to achieve outcomes related to living arrangement, relationship, community inclusion, work and functional medical status." In order to be covered as a customized good or service, it must meet each of the following 4 criteria:

1. The item or service is designed to meet the participant's functional, vocational or medical or social needs and also advances the desired outcomes in his/her ISSP;
2. The service, support or good is documented on the ISSP;
3. The service, support or good is not prohibited by federal and state statutes and regulations, including the state's procurement code;
4. The service, support or good is not available through another source or is not experimental in nature.

In addition to meet all four of the above-listed criteria, the good or service must meet at least one of the following criteria:

1. The service, support or good will maintain or increase the participant's safety in the home or community environment; or
2. The service, support or good will decrease or prevent increased dependence on other Medicaid-funded services; or
3. The service, support or good will maintain or increase the participant's functioning related to the disability;
4. The service, support or good will maintain or increase the participant's access to or presence in the community.

Additionally, the policy notes goods, supports and services that are not covered by IRIS which includes those that are covered by other insurance or by another agency and those that are not directly related to a participant's goals or needs.

The federal Centers for Medicare and Medicaid Services (CMS) has issued an operations memo regarding the use of Medicaid waiver funds for the IRIS program for "individual directed goods and services." CMS SMD #09-007. That memo instructs agencies to make a finding that a requested good or service would decrease the need for other MA services and/or promote inclusion in the community and/or increase the participant's safety in the home environment. Funds may be used for items that increase a participant's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance, and the services or items that are purchased with a service budget must be linked to an assessed participant need or goal established in the service plan.

Further, Policy SC 16.1 requires a participant's ISSP to "utilize services covered by the Medicaid State plan to the fullest possible extent before using waiver funds for any service that is waiver allowable."

Based on the record before me, I cannot agree with petitioner's argument that, because insurance is required for him to operate his vehicle in Wisconsin, he should be entitled to reimbursement. While he certainly requires social contact, this is true of everyone. The petitioner has not presented any evidence indicating that the benefits he receives from that socialization would be distinguishable from the benefits the population at large receives from similar socialization. Medical assistance regulations require the program to provide a service that is consistent with counteracting the effects of the petitioner's disabilities at a reasonable cost. By previously reimbursing for the cost of insurance, the program provided a service that allowed him to transport himself in a manner roughly equivalent to the manner in which the general public transports itself. This is not to say that by providing the insurance reimbursement the medical assistance program has made him whole in the sense that a defendant or insurance company in a tort matter must make the plaintiff whole. But making someone whole by compensating him for his disabilities simply is not the purpose of the medical assistance program. It is meant to provide services that directly treat and alleviate illnesses, injuries, and disabilities.

By requesting reimbursement for vehicle insurance, the petitioner is in effect attaching a medical purpose to everything he does with his vehicle. As a waiver program, IRIS is free of some of the more restrictive regulations pertaining to regular medical assistance, but this does not mean that recipients are entitled to whatever potentially beneficial services the imagination can conjure. IRIS, like all government medical assistance, must provide basic services to a large number of persons at a reasonable cost.

Finally, because this reimbursement does not fit into any of the regular categories of services covered by Waiver programs under 42 CFR § 440.180(b), to be reimbursed it fall into the category of “other services” and can only be approved if it is cost-effective and necessary to prevent him from being institutionalized. There is no evidence that he would be institutionalized if his vehicle insurance reimbursement ends. Therefore, I must uphold the program’s denial.

**CONCLUSIONS OF LAW**

The agency properly denied the Petitioner’s request for vehicle insurance.

**THEREFORE, it is ORDERED**

The petitioner's appeal is dismissed.

**CONCLUSIONS OF LAW**

The agency properly denied the Petitioner’s requests for tennis shoes, an X-Box 360 and gaming components, a guitar and guitar lessons and a sound damping room.

**THEREFORE, it is ORDERED**

That the petition be, and hereby is, dismissed.

**REQUEST FOR A REHEARING**

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

**APPEAL TO COURT**

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Madison,  
Wisconsin, this 21st day of December, 2012

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\sPeter McCombs  
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 December 21, 2012.

Bureau of Long-Term Support