



STATE OF WISCONSIN

In the Matter of

(petitioner)

DECISION

FCP-52/74482

The proposed decision of the hearing examiner dated February 28, 2006 is hereby adopted as the final order of the Department with the following minor modifications:

- Remove the petitioner's Social Security Number from **Findings of Fact** number 1.
- Replace the amount of \$13--\$155 per day on page 4, paragraph 7 of the **Discussion** section with \$130-\$155 per day.

REQUEST FOR A REHEARING

This is a final fair hearing 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. To ask for a new hearing, 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 as "PARTIES IN INTEREST" in the proposed decision. Your request must explain what mistake the examiner 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.

Your request for a new hearing must be received no later than 20 days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in Wisconsin Statutes § 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 filed 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 Wisconsin Department of Health and Family Services. Appeals must be served on the Office of the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 650, P.O. Box 7850, Madison, WI 53707-7850.

The appeal must also be served on the other "PARTIES IN INTEREST" named in the proposed decision. The process for Court appeals is in Wisconsin Statutes §§ 227.52 and 227.53.

Given under my hand at the City of Madison,
Wisconsin, this 12th day of May, 2006.

/s

Susan J. Reinardy, Deputy Secretary
Department of Health and Family Services



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

(petitioner)

PROPOSED
DECISION

FCP-52/74482

PRELIMINARY RECITALS

Pursuant to a petition filed January 18, 2006, under Wis. Stat. § 46.287(2), to review a decision by the Richland County Health & Human Services Department in regards to an agency decision about the sufficiency of the petitioner's service plan under the Family Care Program, a hearing was held on February 15, 2006, at Richland Center, Wisconsin.

The issue for determination is whether the county's Case Management Organization (CMO) has correctly determined the petitioner's provider's rate of reimbursement under a Self-Directed Supports (SDS) plan.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

(petitioner)

Represented by:

(redacted), Guardian

Wisconsin Department of Health & Family Services
Office of Strategic Finance/Center for Delivery Systems Development
P.O. Box 1379
Madison, WI 53701-1379

By: Teri Buros, Long Term Support Manager
Richland County Health & Human Services Department
221 West Seminary Street
Richland Center, WI 53581

ADMINISTRATIVE LAW JUDGE:

Kenneth D. Duren
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (SSN: xxx-xx-xxxx) is a blind and disabled resident of Richland County. He lives with his mother in a private residence. He receives Supplemental Security Income and Supplemental Security Income – Exceptional benefits from the federal Social Security Administration, and pays the Family Care Program a monthly cost share.
2. In 2002, the petitioner's mother, (redacted), was receiving \$59.57 per day for the petitioner's care, as his Adult Family Home provider. On June 24, 2002, signed a negotiated agreement to accept a daily rate of reimbursement of \$120 per day, 365 days per year, to provide all cares to the petitioner, as an agency-certified adult family home (AFH) provider, under the Family Care Program. See, Exhibit #4.

3. Adult Family Home operators are exempt from federal and state income taxes and Social Security withholding for payments made for cares provided.
4. The petitioner's care provider was paid at the (actual) rate of \$122.40 per diem throughout 2005.
5. On October 4, 2005, the provider contacted the county agency and made inquiry about what to do if she does not get a raise in her AFH daily rate in 2006.
6. On or about October 13, 2005, the provider met with agency workers and informed the agency that she no longer desired to provide cares to her son under the AFH contract, and rather was interested in establishing a Self-Directed Support model service provision arrangement.
7. On October 20, 2005, the petitioner's guardian, (redacted), formally requested that the agency change from the petitioner's service package from the "adult family home model" to the "Self-Directed Supports model".
8. In the Self-Directed Supports model, (redacted) would become an employee of the petitioner, by guardian (redacted), and federal and state income taxes and Social Security withholding would be taken from her wages under the daily rate.
9. On October 27, 2005, the county agency determined that it would offer the provider a daily rate of \$156 for the petitioner's care needs based upon the previous daily rate (\$122.40) plus \$34 more to cover estimated federal and state income taxes and the Social Security withholding that (redacted) would need to pay under the new arrangement, and in light of comparable daily rates provided to other clients in similar circumstances in Richland County.
10. On December 13, 2005, the county agency formally offered (redacted) a daily rate of \$156 from the Family Care Program for her to perform the petitioner's cares. At this time, (redacted) rejected the proffered daily rate, citing it as too low in light of comparable patients and services in the area.
11. On December 16, 2005, (redacted), filed a grievance with Richland County Family Care seeking a daily rate of \$200 under the Self-Directed Services plan for the cost of the services to be provided by (redacted) to (petitioner), as an employee of the petitioner's Self-Directed Services plan.
12. On January 16, 2006, the Grievance Committee met and took testimony from the Richland County Family Care representatives and (redacted).
13. On January 16, 2006, the Grievance Committee decided that the rate would be \$156 per day, plus any amount the CMO could help the petitioner get from any source because he is blind; OR, if no funds were available because he is blind, then the rate should increase to \$180 per diem.
14. The petitioner's guardian filed an appeal with the Division of Hearings & Appeals on January 17, 2006, requesting that the Division direct the CMO to increase the daily rate to \$200 per day.

DISCUSSION

The Family Care Program, which is supervised by the Department of Health and Family Services, is designed to provide appropriate long-term care services for elderly or disabled adults. It is authorized under Wisconsin Statutes, § 46.286, and is described comprehensively in the Wisconsin Administrative Code, Chapter HFS 10. At present, Family Care is a pilot program that operates in five counties. Richland County is one of the five. The program is operated and administered in each county by a Care Management Organization (hereafter referred to as "CMO").

In this case, the petitioner has requested a fair hearing to assert a right to a higher daily rate of compensation for his service providers, his mother and uncle (i.e., the guardian's husband, (redacted)) than that offered by the CMO. The petitioner, by his guardian, previously grieved the rate determination of \$156 per diem (i.e., \$56,940 per annum) to the CMO, and the CMO Grievance Committee, which effectively decided to increase the rate to \$180 per diem (i.e., \$65,700 per annum). The petitioner now appeals seeking \$200 per diem (i.e., \$73,000 per annum).

An *enrollee* in the Family Care program has the right to file a grievance with the CMO expressing any dissatisfaction about *any matter* that is not a specified "action" in Wis. Admin. Code § HFS 10.13(1). See, Wis. Admin. Code § HFS 10.53; and see, Wis. Admin. Code § 10.13(28). If the matter is not resolved at the level of the

unit of the department that monitors the CMO, the individual has the right to a fair hearing pursuant to Wis. Stat. 227.44. This right is broadly defined, in the part relevant here, as allowing an *enrollee* to "...contest a decision, omission or action of a care management organization..." Wis. Stat. 46.287(2)(b); see also, Wis. Admin. Code § HFS 10.55(2); and see also, Wis. Stat. §§ 46.287(2)(a).

In this particular case, that unit is the Grievance Committee which reviews actions of the Richland County Care Management Organization. At the fair hearing stage, the Division of Hearings and Appeals reviews the actions and decision of the Grievance Committee to determine if the Committee reasonably used its discretion in making its determination.

The county representative first asserts that the instant appeal is without merit because it is a provider appeal, not an enrollee appeal. The remedy sought here is to increase the provider's daily rate. No provision is made under Family Care statute or rule that allows a provider to file such an appeal. And the provider is fairly obviously the real party in interest behind the scene. However, the enrollee, by his legal guardian, filed the grievance and the fair hearing requests. The Family Care statute and rule are broadly drawn, and the enrollee has expressed dissatisfaction with the outcome of the CMO decision on the provider's daily rate. Despite the clear use of the process by the provider to advance her interests in greater compensation for the admittedly extensive services provided by her, I can only conclude that the fair hearing request language is so expansive as to confer jurisdiction on me to review this matter. Wis. Stat. 46.287(2)(b); see also, Wis. Admin. Code § HFS 10.55(2); and see also, Wis. Stat. §§ 46.287(2)(a)

Prior to January 1, 2006, the petitioner received his Family Care services via an "agency directed model". This means that the county agency and the CMO organized his services and directed payment. The services were provided by a certified adult family home (AFH) operated by his mother, (redacted), under a daily rate of \$122.40 (i.e., \$44,690.60 per annum.) Operators of adult family homes receive special treatment under federal and state income tax rules, and adult family home payments for services are tax-exempt.

In late 2005, the provider and guardian began to discuss with the CMO the possibility of organizing the petitioner's Family Care services under what is known as "Self-Directed Supports" (SDS). The provider explained at the hearing that this was desirable to her because she was essentially engaged in full-time work as the provider for her son, and she wanted to start banking work quarters for Social Security old age, survivors and dependents insurance (OASDI) purposes. Under the proposed SDS system, the petitioner, by his aunt/guardian, would control and direct his support system, and hire his mother as the provider of his services. As an employee, all relevant tax, Social Security, and Medicare withholdings would be taken from her wages. See also, Wis. Admin. Code § HFS 10.44(6)(c)12.

The provider and guardian broached the proposed schema with the CMO's operational staffers. The agency representative, Teri Buros, ultimately agreed that the petitioner was entitled to attempt to meet his needs using a "self-directed" model and she offered to pay a daily rate of \$156. This was determined as set forth in Finding of Fact #9, above. Basically, the county offered the pre-existing agency directed model's daily rate plus \$34 per day as an estimated amount to account for taxes and employee withholdings for Social Security and Medicare (i.e., approximately 30% of the \$122.40 per diem level that she would "lose" because of withholdings under the new arrangement.)

The provider and guardian replied that this was not enough. They did not assert, however, that this is because the amount of the increase was insufficient to meet the tax and withholding increases. Rather, they asserted that the rate offered was not sufficient vis à vis comparable rates paid to other providers in the community. See, Exhibit A, Attachment #2.

The CMO representative, Ms. Buros, testified that the CMO cannot approve a self-directed support model arrangement that provides for costs higher than the agency directed model that pre-existed, and that the comparables proffered are not comparables to this provider at all.

The petitioner's comparables are: (1) a local skilled nursing facility (Pine Valley) would charge a private pay resident \$197.46 per diem for a private room and skilled nursing care; (2) three local adult family homes charge a daily rate of \$203.84 (Allison Park AFH), \$213.99 (Knapp Preston AFH) and \$246.58 (Mystic Meadows and/or

Mystic Creek AFHs); (3) two local in-home care providers would charge \$234.40 (Schmitt Woodland Hills House Calls) and \$226.44 (Homeward Bound), to provide 16 hours per day of personal and/or supportive home cares sufficient to meet the petitioner's needs. See, Exhibit A, Attachment #2.

Ms. Buros effectively rebuts these comparables with her testimony. She notes that the CMO has an agreement with the Pine Valley SNF, and the CMO would only pay the maximum MA daily rate of \$116 for skilled nursing services; and that the petitioner has quoted both the private pay rate, and the rate for a higher care level than needed by the petitioner, i.e., the Intense Skilled Nursing (ISN) level of care. See, Exhibit A, Attachment #3, p.7; Exhibit A, Attachment #2, p. 7.

Second, she noted that the four AFHs cited all provide 24 hours care, with at least one staffer on call and awake at all times. The petitioner generally sleeps a normal 8 hours per night and does not require cares during the night. In addition, the two Mystic AFHs care for a special population of dually diagnosed (developmental disabled & mentally ill) persons including many sexual predators; and that these patients are risks to the community at large requiring special cares. Finally, Ms. Buros also noted that all of these AFHs were 3-4 bed homes, while (redacted) had been operating her AFH under a 1-2 bed limitation. Buros asserted that the CMO daily rate for 1-2 bed adult family homes, county-wide, is at present \$122.40 for 1 resident and an additional \$100 for a second resident. Having ceased to operate as a certified AFH, it would not seem likely that (redacted) would have a second resident either. See, Exhibit A, Attachment #1, pp. 2-4.

Third, the agency representative stated at the Grievance Committee meeting that the proposed in-home service agencies, Schmitt Woodland Hills House Calls and Homeward Bound, would not be engaged by the CMO at such a rate, because once an enrollee in Family Care reaches a care level of 12-16 hours per day, then the CMO instead looks to providing live-in care or 24 hour per day staffing at a cost of \$13- - \$155 per day. It would not authorize such an extensive part-time care scheduled. See, Exhibit A, Attachment #3, at p.4.

The option for the enrollee to self-manage service funding is contained in Wis. Admin. Code § HFS 10.44(6). But this option still is subject to the general requirements and limitations outlined for an agency-directed case plan under Wis. Admin. Code §§ HFS 10.44(2)(e) & (f). See, Wis. Admin. Code § HFS 10.44(5), Note. This states:

Note: All enrollees in Family Care are encouraged to participate in the direction of their own care and supports as much as they are willing and able. The full range of self-determination is to be encouraged and supported for all enrollees, including identification and setting priorities among long-term care outcomes, and direction of all long-term care services and health care, including end-of-life issues. As provided under s. HFS 10.44(2)(e) and (f), all enrollees are to be full partners in the assessment of needs and strengths and in the development of care plans. Provisions at s. HFS 10.44(2)(h) and (3)(d) require that each enrollee is to be offered the opportunity to take as much responsibility as he or she is willing and able in the selection, arrangement and monitoring of services.

Note: The option provided in the following sub. (6) is one in which the enrollee takes full responsibility for managing the funding for all or part of his or her services, with some oversight from the CMO. Primary differences from the usual Family Care model are: (1) the ability to purchase services from outside the CMO network of providers; (2) the ability to receive assistance in planning, arranging and monitoring services from a broker or case manager outside the CMO; and (3) within the individual's established budget, having a greater degree of control over payment, including adjustments to payment rates, for services received.

Wis. Admin. Code § HFS 10.44(5), Notes.

Wis. Admin. Code § HFS 10.44(2)(f) provides, in the parts relevant here, as follows:

The CMO, in partnership with the enrollee, shall develop an individual service plan for each enrollee, with the full participation of the enrollee and any family members or other representatives that the enrollee wishes to participate. The CMO shall provide support, as needed, to enable the enrollee, family members or other representatives to make informed service plan decisions, and for

the enrollee to participate as a full partner in the entire assessment and individual service plan development process. The service plan shall meet all of the following conditions:

**** (Note: secs. 1 & 2 are omitted as not relevant to the disputed issue here.) ****

3. Is cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes.

This Family Care rule is implemented by the county's CMO in a written policy statement, as repeatedly referenced by Ms. Buross in this protracted rate-setting dispute. That policy statement provides:

Policy

The IDTs (i.e., "*Interdisciplinary Teams*") shall develop SDS (i.e., "*Self-Directed Supports*") Budgets that meet the member's outcomes and needs based on a reasonable estimate of cost of services not to exceed what the cost of services would be using the agency directed model.

See, Exhibit A, Attachment 1, Attachment B, at p. 9, SDS BUDGET SETTING POLICY (eff. 6/29/05). (ALJ's Note: I have added the names in italics that relate to the two acronyms used in this passage for reader comprehension.)

Based upon all of the foregoing, the CMO asserts that the correct daily rate was as it determined initially, i.e., \$156. This is in its essence the same rate being paid by the agency directed model, adjusted for the addition of tax and benefit withholding for the individual provider under the proposed Self-Directed Supports model advanced by the petitioner's representative and relatives. See, Finding of Fact #9, above.

(In addition, it is of note that the average monthly cost for skilled nursing facility care in Wisconsin under the Medical Assistance Program is currently set at \$61,151.99 per annum, i.e., \$5,096 per month, or \$167.54 per day. See, Medical Assistance Eligibility Handbook, App. 4.7.5. While not a binding rate in this case, it certainly is indicative of the rate of compensation the Department pays for a very comparable level of care on a daily basis. See, also, Section 1915(c) Waiver Format – Family Care MR/DD (February, 2001, at p.4; and see, Proposal for a Section 1915(b) Capitated Waiver Program Initial Application Preprint, at pp.7-8.)

At this juncture, the Grievance Committee fully muddies the waters of the dispute. The proceedings of the Committee hearing of the grievance are summarized in contemporaneous notes of the meeting taken by a recording secretary. See, Exhibit A, Attachment #3. Each party related essentially the same arguments as recounted by me, above. The Committee members then engage in a discussion of whether there is not some public funding available for blind persons, like the petitioner, and whether this avenue of funding has been thoroughly researched. The CMO representative then explained that the petitioner is disabled and receives Social Security Administration benefits from Supplemental Security Income (SSI) and SSI-E (Exceptional) benefits every month, and there is no separate benefit simply because he is blind. Rather, his blindness is part of the combined problems he has that renders him disabled. See, Exhibit A, Attachment #3, at pp. 3-4. His total income from these sources is about \$25 per day. Ibid. He has a cost share of approximately \$540 per month under his most recent service plan. Ibid.

The Committee then went into closed session and deliberated without notes being taken. It then reconvened, still in closed session, inviting the parties back into the meeting room, and informed the parties, with the discussion summarized as follows in the meeting notes:

Mr. Ferguson stated that it was the committee's suggestion for the rate to remain at \$156 with the CMO's assistance in looking at getting any funding that may be available for being blind. If there isn't any money available due to the blindness then the rate should be increased to \$180. Mr. Ferguson asked what people thought.

Ms. Gillingham though it was best to try to seek the funding for the blind.

Mr. Ferguson advised (redacted) to seek out resources such as Senator Dale Schultz or Congressman Steve Fries for answers. The library may also offer some answers and assistance in this matter.

Motion made by Joe Simon to return to open session, seconded by Verna Mary Gillingham. Motion carried.

Mr. Ferguson inquired if there was anything else. All replied no.

Motion to adjourn by Joe Simon, Seconded by Verna Mary Gillingham. Meeting adjourned at 11:32 A.M.

See, Exhibit A, Attachment #3, pp. 7-8.

As the CMO was unable to find any “benefits for the blind” outside of the SSI and SSI-E benefits the petitioner already receives because he is disabled, the parties informed this judge that the prevailing rate under the Committee’s contingent ruling, above, is therefore \$180 per day.

The petitioner timely appealed the decision of the Grievance Committee and requests that the DHA increase the daily rate to \$200.

The CMO argues that the administrative law judge should reverse the Committee decision and *reduce* the daily rate back to the \$156 it awarded in December, 2005. By way of explanation for the Committee’s decision, she merely opined that the Committee had been confused by the evidence presented it.

An experienced finder of fact reviewing this case history can only observe that Grievance Committee was completely out of its depth in its ability to understand the complexities of the underlying care arrangements, and appropriate rate-setting. No real rationale or rational decision-making process for the outcome achieved exists other than the obviously misplaced belief in what was a mythical “blind” benefit other than the Social Security benefits that the petitioner already receives. The evidence indicates to me that the Committee erroneously *increased* the daily rate to \$180. The part of the decision that denied the enrollee’s request to further increase it to \$200 per day was fully correct.

But my authority to render a fair hearing decision in this matter is premised upon the petitioner’s appeal of the decision of the CMO, as rendered by its Grievance Committee. See, Wis. Stat. § HFS 10.55(2). That Committee decision appealed was the negative action to deny the request for \$200 per day. Based upon my review of the entire record, and the evidence and testimony presented at hearing, I can only conclude that the Grievance Committee reviewed the petitioner’s request for a \$200 daily rate for his care provider, and the Committee reasonably exercised its discretion based upon the information presented to arrive at the \$180 daily rate. Had the Committee sustained the CMO agency decision of the \$156 per day rate, I would have affirmed that decision instead; but it did not. The actual decision taken by the Committee is what I must review, and I can only conclude that the \$180 per day rate must be affirmed on this record.

The CMO would be well-advised to consider a regimen of additional training and education on the “nuts and bolts” of the parameters of the Family Care Program for the Grievance Committee.

CONCLUSIONS OF LAW

That the Grievance Committee reasonably exercised its discretion when it increased the daily rate paid to his service provider from \$156 to \$180 per day, 365 days per year, or a total of \$65,700 per annum.

NOW, THEREFORE, it is ORDERED

That the petition for review herein be and the same is hereby dismissed, *if and only if*, this Proposed Decision is adopted by the Secretary of the Department of Health & Family Services in a Final Decision.

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 IMPLMENTED 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 Department of Health and Family Services for final decision-making.

The process relating to Proposed Decision is described in WI Stat § 227.46(2).

Given under my hand at the City of Madison,
Wisconsin, this 28th day of February, 2006.

/s

Kenneth D. Duren
Administrative Law Judge
Division of Hearings and Appeals
327/KDD