ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING AND CREATING RULES

The Legislature in s. 9123 (1) of 1999 Wisconsin Act 9 directed the Department to promulgate rules required under ss. 46.286 (4) to (7), 46.288 (1) to (3) and 50.02 (2) (d), Stats., as created by 1999 Wisconsin Act 9, but exempted the Department from the requirement under s. 227.24 (1) and (3), Stats., to make a finding of emergency. These are the rules.

Analysis Prepared by the Department of Health and Family Services

Legislation establishing a flexible Family Care benefit to help arrange or finance long-term care services to older people and adults with physical or developmental disabilities was enacted as part of 1999 Wisconsin Act 9. The benefit is an entitlement for those who meet established criteria. It may be accessed only through enrollment in Care Management Organizations (CMOs) that meet requirements specified in the legislation.

The Act also authorizes the Department of Health and Family Services to contract with Aging and Disability Resource Centers to provide broad information and assistance services, long-term care counseling, determinations of functional and financial eligibility for the Family Care benefit, assistance in enrolling in a Care Management Organization if the person chooses to do so, and eligibility determination for certain other benefits, including Medicaid, and other services.

Until July 1, 2001, the Department of Health and Family Services is authorized to contract with CMOs and Resource Centers in pilot counties to serve up to 29% of the state's eligible population. Further expansion is possible only with the explicit authorization of the Governor and the Legislature.

When Aging and Disability Resource Centers become available in a county, the legislation requires nursing homes, community–based residential facilities, adult family homes and residential care apartment complexes to provide certain information to prospective residents and to refer them to the Resource Center. Penalties are provided for non-compliance.

These proposed rules interpret this new legislation, the main body of which is in newly enacted ss. 46.2805 to 46.2895, Stats. The Department of Health and Family Services is specifically directed to promulgate rules by ss. 46.286 (4) to (7), 46.288 (1) to (3), 50.02 (2) (d) and 50.36 (2) (c), Stats. Non-statutory provisions in section 9123 of 1999 Wisconsin Act 9 require that the rules are to be promulgated using emergency rulemaking procedures and exempts the Department from the requirements under s. 227.24 (1) (a), (2) (b) and (3) of the Stats., to make a finding of emergency. These are the rules required under the provisions cited above, together with related rules intended to clarify and implement other provisions of the Family Care legislation that are within the scope of the Department's authority. The rules address the following:

- Contracting procedures and performance standards for Aging and Disability Resource Centers.
- Application procedures and eligibility and entitlement criteria for the Family Care benefit.
- Description of the Family Care benefit that provides a wide range of long-term care services.
- Certification and contracting procedures for Care Management Organizations.
- Certification and performance standards and operational requirements for CMOs.
- Protection of client rights, including notification and due process requirements, complaint, grievance, Department review, and fair hearing processes.
- Recovery of incorrectly and correctly paid benefits.

- Requirements of hospitals, long-term care facilities and Resource Centers related to referral and counseling about long-term care options.

ORDER

Pursuant to authority vested in the Department of Health and Family Services by ss. 46.286 (4) to (7), 46.287 (2) (a) 1. (intro.), 46.288, 50.02 (2) (d) and 50.36 (2) (c), Stats., as created by 1999 Wisconsin Act 9, and s. 227.11 (2), Stats., and s. 9123 (1) of 1999 Wisconsin Act 9, the Department of Health and Family Services hereby amends and creates rules interpreting ss. 46.2805, 46.281, 46.283 to 46.289, 50.033 (2r) to (2t), 50.034 (5m) to (5p) and (8), 50.035 (4m) to (4p) and (11), 50.04 (2q) to (2i) and (2m), 50.06 (7), 50.36 (2) (c) and 50.38, Stats., as created or otherwise affected by 1999 Wisconsin Act 9 as follows:

SECTION 1. Chapter HFS 10 is created to read:

Chapter HFS 10

FAMILY CARE

Subchapter I—General Provisions

HFS 10.11 Authority and purpose.
HFS 10.12 Applicability.
HFS 10.13 Definitions.

Subchapter II—Aging and Disability Resource Centers

HFS 10.21 Contracting.
HFS 10.22 General requirements.
HFS 10.23 Standards for performance by resource centers.

Subchapter III—Access to Family Care Benefit

HFS 10.31 Application and eligibility determination.
HFS 10.32 General conditions of eligibility.
HFS 10.33 Conditions of functional eligibility.
HFS 10.34 Financial eligibility and cost sharing.
HFS 10.35 Protections against spousal impoverishment.
HFS 10.36 Eligibility and entitlement.
HFS 10.37 Private pay individuals.

Subchapter IV—Family Care Benefit; Delivery Through Care Management Organizations (CMO)

HFS 10.41 Family care services.
HFS 10.42 Certification and contracting.
HFS 10.43 CMO certification standards.
HFS 10.44 Standards for performance by CMOs.
HFS 10.45 Operational requirements for CMOs.

Subchapter V—Protection of Applicant and Enrollee Rights

HFS 10.51 Client rights.
HFS 10.52 Required notifications.
HFS 10.53 Grievances.
HFS 10.54 Department reviews.
HFS 10.55 Fair hearing.
HFS 10.56 Continuation of services.
HFS 10.57 Cooperation with external advocates.

Subchapter VI—Recovery of Paid Benefits

HFS 10.61 Recovery of incorrectly paid benefits.
HFS 10.62 Recovery of correctly paid benefits.

Subchapter VII—Assuring Timely Long-Term Care Consultation

HFS 10.71 Certification by secretary of availability of resource center.
HFS 10.72 Information and referral requirements for hospitals.
HFS 10.73 Information and referral requirements for long-term care facilities.
HFS 10.74 Requirements for resource centers.

SUBCHAPTER I—GENERAL PROVISIONS

HFS 10.11 Authority and purpose. This chapter is promulgated under the authority of ss. 46.286 (4) to (7), 46.287 (2) (a) 1. (intro.), 46.288, 50.02 (2) (d), 50.36 (2) (c), and 227.11 (2) (a), Stats., to implement a program called family care that is designed to help families arrange for appropriate long-term care services for older family members and for adults with physical or developmental disabilities. The chapter does all the following: establishes functional and financial eligibility criteria, entitlement criteria and cost sharing requirements for the family care benefit, including divestment of assets, treatment of trusts and spousal impoverishment protections; establishes the procedures for applying for the family care benefit; to establish standards for the performance of aging and disability resource centers; establishes certification standards and standards for performance by care management organizations; provides for the protection of applicants for the family care benefit and enrollees in care management organizations through complaint, grievance and fair hearing procedures; provides for the recovery of correctly and incorrectly paid family care benefits; and establishes requirements for the provision of information about the family care program to prospective residents of long-term care facilities and for referrals to resource centers by hospitals and long-term care facilities.

HFS 10.12 Applicability. This chapter applies to the department and its agents; to county agencies designated by the department to determine financial eligibility for the family care benefit; to all organizations seeking or holding contracts with the department to operate an aging and disability resource center or a care management organization; to all persons applying to receive the family care benefit; to all persons found eligible to receive the family care benefit; to all enrollees in a care management organization; to certain private pay individuals who may purchase certain services from a care management organization; and to hospitals, nursing homes, community-based residential facilities, residential care apartment complexes and adult family homes that are required to provide information to patients, residents and prospective residents and make certain referrals to an aging and disability resource center.

HFS 10.13 Definitions. In this chapter:

(1) "Activities of daily living" or "ADL" means bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.

(2) "Adult family home" or "AFH" has the meaning specified in s. 50.01 (1), Stats.

(3) "Adult protective services" means protective services for mentally retarded and other developmentally disabled persons, for aged infirm persons, for chronically mentally ill persons and for persons with other like incapacities incurred at any age as defined in s. 55.02, Stats.

(4) "Appeal" means a fair hearing as defined in ch. HA 3, namely a de novo proceeding before an impartial administrative law judge in which the petitioner or the petitioner's representative presents the reasons why the county agency or department action or inaction in the petitioner's case should be corrected.

(5) "Applicant" means a person who directly or through a representative makes application for the family care benefit.

(6) "Assets" means any interest in real or personal property that can be used for support and maintenance. "Assets" includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.

(7) "Assistance" means cueing, supervision or partial or complete hands-on assistance from another person.

(8) "At risk of losing independence or functional capacity" means having the conditions or needs described in s. HFS 10.33 (4) (b).

(9) "Care management organization" or "CMO" means an entity that is certified as meeting the requirements for a care management organization under s. 46.284 (3), Stats., and this chapter and that has a contract under s. 46.284 (2), Stats., and s. HFS 10.42. "Care management organization" does not include an entity that contracts with the department to operate a PACE or Wisconsin partnership program.

(10) "Client" means a person applying for eligibility for the family care benefit, an eligible person or an enrollee.

(11) "Community-based residential facility" or "CBRF" has the meaning specified in s. 50.01 (1g), Stats.

(12) "Community spouse" means an individual who is legally married as recognized under state law to a family care spouse.

(13) "Complaint" means any communication made by or on behalf of a client expressing dissatisfaction with any aspect of the operations, activities or behaviors of the department, a resource center, a care management organization or a service provider related to access to or delivery of the family care benefit, regardless of whether the communication requests any remedial action.

(14) "Countable assets" means assets that are used in calculating financial eligibility and cost sharing requirements for the family care benefit.

(15) "County agency" means the county department of aging, social services or human services, an aging and disability resource center, a family care district or a tribal agency that has been designated by the department to determine financial eligibility and cost sharing requirements for the family care benefit.

(16) "Department" means the Wisconsin department of health and family services.

(17) "Developmental disability" means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging.

(18) "Eligible person" means a person who has been determined under ss. HFS 10.31 and 10.32 to meet all eligibility criteria under s. 46.286 (1) or (1m), Stats., and this chapter.

(19) "Enrollee" means a person who is enrolled in a care management organization to receive the family care benefit.

(20) "Fair hearing" has the meaning prescribed in ch. HA 3, namely, a de novo proceeding before an impartial administrative law judge in which the petitioner or the petitioner's representative presents the reasons why the county agency or department action or inaction in the petitioner's case should be corrected.

(21) "Family care benefit" has the meaning given in s. 46.2805 (4), Stats., namely, financial assistance for long-term care and support items for an enrollee.

(22) "Family care district" means a special purpose district created under s. 46.2895 (1), Stats.

(23) "Family care spouse" means an individual who is a family care applicant or enrollee and is legally married as recognized under state law to an individual who does not reside in a medical institution or a nursing facility.

(24) "Financial eligibility screen" means a uniform screening tool prescribed by the department that is used to determine financial eligibility and cost-sharing under s. 46.286 (1) (b) and (2), Stats., and ss. HFS 10.32 and 10.34.

(25) "Functional capacity" means the skill to perform activities in an acceptable manner with minimal dependence on devices, persons or the environment.

(26) "Functional screen" means a uniform screening tool prescribed by the department that is used to determine functional eligibility under s. 46.286 (1) (a) and (1m), Stats., and ss. HFS 10.32 and 10.33.

(27) "Grievance" means a written communication submitted by or on behalf of a client expressing dissatisfaction with any aspect of the decisions, actions, operations, activities, or behaviors of the department, a county agency, a resource center, or a CMO that pertain to family

care, and requesting that the operations, activities or behaviors be corrected. A grievance may include issues that have not been resolved to the satisfaction of the client through informal means.

(28) "Home" means a place of abode and lands used or operated in connection with the place of abode.

Note: In urban situations the home usually consists of a house and lot. There will be situations where the home will consist of a house and more than one lot. As long as the lots adjoin one another, they are considered part of the home. In farm situations, the home consists of the house and building together with the total acreage property upon which they are located and which is considered a part of the farm. There will be farms where the land is on both sides of a road, in which case the land on both sides is considered part of the homestead.

(29) "Hospital" has the meaning specified in s. 50.33 (2), Stats.

(30) "Infirmities of aging" has the meaning given in s. 55.01 (3), Stats., namely organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his or her ability to adequately provide for his or her care or custody.

(31) "Instrumental activities of daily living" or "IADL" means management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.

(32) "Long-term care facility" means a nursing home, adult family home, community-based residential facility or residential care apartment complex.

(33) "Medical assistance" or "MA" means the assistance program operated by the department under ss. 49.43 to 49.499, Stats., and chs. HFS 101 to 108.

(34) "Medical institution" means a facility that meets all of the following conditions:

(a) Is organized to provide medical care, including nursing and convalescent care.

(b) Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health care needs of patients on a continuing basis in accordance with accepted professional standards.

(c) Is authorized under state law to provide medical care.

(d) Is staffed by professional personnel who are responsible for professional medical and nursing services. The professional medical and nursing services include adequate and continual medical care and supervision by a physician, registered nurse or licensed practical nurse supervision and services and nurses' aide services sufficient to meet nursing care needs and a physician's guidance on the professional aspects of operating the institution.

(35) "Nursing home" has the meaning specified in s. 50.01 (3), Stats.

(36) "Older person" means a person who is at least 65 years of age.

(37) "PACE" means a program of all-inclusive care for the elderly authorized under 42 USC 1395 to 1395gg.

(38) "Physical disability" means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.

(39) "Residential care apartment complex" or "RCAC" has the meaning specified in s. 50.01 (1d), Stats.

(40) "Resource center" or "aging and disability resource center" means an entity that meets the standards for operation and is under contract with the department to provide services under s. 46.283 (3), Stats., and this chapter or, if under contract to provide a portion of the services specified under s. 46.283 (3), Stats., meets the standards for operation with respect to those services.

(41) "Respite care" means temporary placement in a long-term care facility for maintenance of care, treatment or services, as established by the person's primary care provider, in addition to room and board, for no more than 28 consecutive days at a time.

(42) "Secretary" means the secretary of the department.

(43) "Target population" means any of the following groups that a resource center or a care management organization has contracted with the department to serve:

(a) Older persons.

(b) Persons with a physical disability.

(c) Persons with a developmental disability.

(44) "Wisconsin partnership program" means a demonstration program known by this name under contract with the department to provide health and long-term care services under a federal waiver authorized under 42 USC 1315.

SUBCHAPTER II – AGING AND DISABILITY RESOURCE CENTERS

HFS 10.21 Contracting. (1) The department may contract for resource center operation only with entities that do all of the following:

(a) Comply with the general requirements specified in s. HFS 10.22.

(b) Meet the standards for performance by resource centers specified in s. HFS 10.23.

(2) The department's contracts with organizations operating resource centers shall specify sanctions that may be taken if certain contract requirements are not met, including the withholding or deduction of funds.

HFS 10.22 General requirements. (1) TARGET POPULATION. Each contract for operation of a resource center shall specify the target population that the resource center will serve. The target population to be served by the resource center includes all members of the specified group who reside in the geographic area served by the resource center regardless of whether they need or are seeking family care or other long-term care services or programs.

(2) NAME. (a) A resource center shall have a name that is appropriate to its target population and includes any of the following phrases:

1. "Aging and disability resource center."

2. "Aging resource center."

3. "Disability resource center."

4. "Developmental disabilities resource center."

(b) The resource center's name may be the primary name of the resource center or a subtitle to another name but shall be included in all advertising and materials, including any telephone book listings.

(3) GOVERNING BOARD. A resource center shall have a governing board that reflects the ethnic and economic diversity of the geographic area served by the resource center. At least one-fourth of the members of the governing board shall be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates. No member of the governing board may have any direct or indirect financial interest in a care management organization.

(4) INDEPENDENCE FROM CARE MANAGEMENT ORGANIZATION. To assure that persons receive long-term care counseling and eligibility determination services from the resource center in an environment that is free from conflict of interest, a resource center shall meet state and federal requirements for organizational independence from any care management organization.

Note: Before July 1, 2001, the Wisconsin Legislature has authorized the Department to contract only with a county, a family care district, the governing body of a tribe or band or the Great Lakes Inter-tribal Council, Inc., or with 2 or more of these entities under a joint application, to operate a Resource Center. After June 30, 2001, the department is authorized to contract with these same entities, or with a private nonprofit organization if the department determines that the organization has no significant connection to an entity that operates a care management organization and if any of the following applies: (1) A county board of supervisors declines in writing to apply for a contract to operate a Resource Center; or (2) A county agency or a family care district applies for a contract but fails to meet the standards for performance for Resource Centers specified in s. HFS 10.23. Certain functions of the Resource Center, such as eligibility determination, must be performed by public employes and counties would be required to perform these functions even if a private organization were under contract for other Resource Center functions. Section 46.285, Stats., further requires that no entity may directly operate both a

Resource Center and a CMO, except that a pilot Resource Center is required to be structurally separate from the provision of CMO services by January 1, 2001.

HFS 10.23 Standards for performance by resource centers. (1) COMPLIANCE. An aging and disability resource center shall comply with all applicable statutes, all of the standards in this section and all requirements of its contract with the department.

(2) SERVICES. A resource center shall ensure that the following services, meeting the standards specified, are available to its target population:

(a) *Information and referral services and other assistance.* A resource center shall provide information, referral and assistance at hours that are convenient to the public and consistent with requirements of this chapter and its contract with the department, using a telephone number that is toll-free to all callers in its service area. The resource center shall be physically accessible and be able to provide information and assistance services in a private and confidential manner. Information and referral services include all of the following:

1. Current information on a wide variety of topics related to aging, physical and developmental disabilities, chronic illness and long-term care, as specified by the department and appropriate to the resource center's target population.

2. Referrals to and assistance in accessing an array of voluntary, purchased and public resources to help older people and people with disabilities secure needed services or benefits, live with dignity and security, and achieve maximum independence and quality of life. Referral and assistance includes all the following:

a. Professional advice and counseling to assist consumers in identifying needs, capacities and personal preferences.

b. Educating consumers regarding available service options and resources.

c. Identifying service providers capable of meeting the person's needs.

d. Actively assisting the consumer in accessing services when necessary.

3. Continued contact with people, as needed, to determine the outcomes of previous contacts and to offer additional assistance in locating or using services as necessary.

(b) *Advocacy.* Advocacy on behalf of individuals and groups when needed services are not being adequately provided by an organization within the service delivery system.

(c) *Long-term care options counseling.* The resource center shall provide members of its target population and their families or other representatives with professional consultation and advice about options available to meet long-term care needs and about factors to consider in making long-term care decisions. The resource center shall offer long-term care options counseling to any person in its target population who is seeking or appears to need long-term care services. Information provided shall be timely, factual, thorough, accurate, unbiased and appropriate to the individual's needs and situation. The resource center shall conduct long-term care options counseling at a location preferred by and at a time convenient to the individual consumer. Long-term care options counseling shall inform and advise the person concerning all of the following:

1. The availability of any long-term care options open to the individual, including home care, community services, case management services, residential care and nursing home options.

2. Sources and methods of both public and private payment for long-term care services, including family care and the fee-for-service system.

3. Factors to consider when choosing among the available programs, services and benefits, including cost, quality, outcomes, estate recovery and compatibility with the person's preferred lifestyle and residential setting.

4. Advantages and disadvantages of the various options in light of the individual's situation, values, capacities, knowledge and resources and the urgency of the individual's situation.

(d) *Benefits counseling.* 1. The resource center shall ensure that people from its target populations have access to the services of a benefit specialist, including information about and assistance in applying for public and private benefits for which they may be eligible, and assistance in preparing and filing complaints, grievances and appeals of complaints or grievances.

2. Notwithstanding sub. (7) (b), a benefit specialist may not disclose information about a client without the informed consent of the client, unless required by law.

(e) *Transitional services.* A resource center that serves young adults shall coordinate with school districts, boards appointed under s. 51.437, Stats., county human services departments or departments of community programs to assist young adults with physical or developmental disabilities in making the transition from children's services to the adult long-term care system.

(f) *Prevention and early intervention.* The resource center shall develop a prevention and early intervention plan based on department priorities and provide prevention and intervention services consistent with the plan and within the limits of available funding.

(g) *Emergency response.* The resource center shall assure that emergency calls to the resource center are received 24 hours a day, seven days a week, responded to promptly and that people are connected promptly with the appropriate providers of emergency services.

(h) *Choice counseling.* The resource center shall provide information and counseling to assist persons who are eligible for the family care benefit with respect to the person's choice of whether or not to enroll in a care management organization and, if so, which available care management organization would best meet his or her needs.

(i) *Disenrollment counseling.* The resource center shall provide information and counseling to assist persons in the process of voluntarily or involuntarily disenrolling from a care management organization, including all of the following:

1. Information about clients' rights and grievance procedures.

2. Advocacy resources available to assist the person in resolving complaints and grievances.

3. Service and program options available to the person if the disenrollment occurs.

(j) *Waiting list management.* The resource center shall manage, as directed by the department, any waiting lists that become necessary under s. HFS 10.36 (2) or (3).

(3) ACCESS TO FAMILY CARE AND OTHER BENEFITS. If it is a county agency, the resource center shall provide to members of its target population access to the benefits under pars. (a) and (b) directly or through subcontract or other arrangement with the appropriate county agency. If it is not a county agency, the resource center shall have a departmentally approved memorandum of understanding with a county agency to which it will make referrals for access to these benefits. The memorandum of understanding shall clearly define the respective responsibilities of the two organizations, and how eligibility determination for the benefits under pars. (a) and (b) will be coordinated with other resource center functions for the convenience of members of the resource center's target population. Benefits to which the resource center shall provide access are all the following:

(a) *Family care.* 1. The requirements specified in s. HFS 10.31 shall govern application and determination of eligibility for the family care benefit.

2. A resource center shall offer a functional screen and a financial eligibility screen to any individual over the age of 17 years and 9 months who appears to have a disability or condition requiring long-term care and who meets any of the following conditions:

a. The person requests or is referred for the screen.

b. The person is seeking access to the family care benefit.

c. The person is seeking admission to a nursing home, community-based residential facility, adult family home, or residential care apartment complex, subject to the exceptions under ss. HFS 10.72 (4) and HFS 10.73 (4) (a).

3. If a person accepts the offer, the resource center or the county agency shall provide the screens.

(b) *Medical assistance, SSI, state supplemental payments and food stamps.* The resource center shall provide, directly or through referral, access to all of the following:

1. Medical assistance under s. 49.46, 49.468 or 49.47, Stats.

2. State supplemental payments under s. 49.77, Stats., to the federal supplemental security income (SSI) program under USC 1381 to 1383d, including the increased or "exceptional" payments (SSI-E) under s. 49.77 (3s), Stats.

3. The federal food stamp program under 7 USC 2011 to 2029.

(4) ELDER ABUSE AND ADULT PROTECTIVE SERVICES. (a) The resource center shall identify persons who may need elder abuse or adult protective services and shall provide or facilitate access to services for eligible individuals under s. 46.90 and chs. 51 and 55, Stats.

(b) The resource center may provide elder abuse and adult protective services directly, if a county agency, or through cooperation with the local public agency or agencies that provide the services. If the resource center is not the county agency designated under s. 46.90 or ch. 55, Stats., it shall have a memorandum of understanding with the designated agency or agencies

regarding how these services are to be coordinated. The memorandum shall specify staff contacts, hours of operation and referral processes and procedures.

(5) STAFF QUALIFICATIONS. Persons providing resource center services, whether directly employed by the resource center or indirectly under subcontract or memorandum of understanding with another organization, shall have the following qualifications:

(a) Persons answering the information and assistance telephone line shall be trained and knowledgeable about all of the following:

1. The mission, operations and referral policies of the resource center.

2. The target populations served and their needs.

3. Telephone etiquette and communication skills, including how to recognize and respond to special hearing or language needs.

4. How to recognize and handle emergencies.

(b) Persons providing information and assistance services, long-term care options counseling, benefits counseling, the functional screen and financial eligibility screen and choice counseling shall:

1. Be competent to provide these services to the resource center's target population.

2. Meet at least one of the following requirements for education and experience:

a. Bachelor of arts or science degree, preferably in a health or human services related field, and at least one year of experience working with at least one of the resource center's target populations.

b. Four years of post-secondary education and experience working with at least one of the target populations or an equivalent combination of education and experience, either in long-term support or a related human services field.

c. Other experience, training or both, as approved by the department based on a plan for providing formal and on-the-job training to develop the required expertise.

3. Be knowledgeable about the range, quality and availability of long-term care services offered within the resource center's service area.

(6) OPERATIONAL REQUIREMENTS. A resource center shall do all of the following:

(a) *Outreach and public education.* 1. Develop and implement an ongoing program of marketing and outreach to inform members of its target population and their families, community agencies, health professionals and service providers of the availability of resource center services.

2. Within 6 months after the family care benefit is available to all eligible persons in its service area, provide information about family care to persons who are members of a target population served by a CMO that operates in the county and who are residents of nursing homes, community-based residential facilities, adult family homes and residential care apartment

complexes in the geographic area of the resource center. The information provided shall include all of the following:

a. The family care benefit.

b. The services of the resource center, including information and assistance, benefits counseling, long-term care options counseling, the functional screen and financial eligibility screen, and eligibility determination and enrollment in family care.

c. The services of any available care management organization, including the comprehensive assessment and care plan.

d. How to contact the resource center for assistance.

(b) *Community needs identification.* Implement a process for identifying unmet needs of its target population in the geographic area it serves. The process shall include input from the local long-term care council, members of the target populations and their representatives, and local government and service agencies including the care management organization, if any. A resource center shall target its outreach, education, prevention and service development efforts based on the results of the needs identification process.

(c) *Complaint and grievance processes.* Implement a process for reviewing client complaints and resolving client grievances as required under s. HFS 10.53 (1).

(d) *Reporting and records.* 1. Except as provided in sub. (7), collect data without interfering with a person's right to receive information anonymously or require personally identifiable information unless the person has authorized the resource center to have or share that information.

2. Report information as the department determines necessary, including information needed for doing all of the following:

a. Determining whether the resource center is meeting minimum quality standards and other requirements of its contract with the department.

b. Determining the extent to which the resource center is improving its performance on measurable indicators identified by the resource center in its current quality improvement plan.

c. Evaluating the effects of providing long-term care options counseling and choice counseling under this section.

d. Evaluating the effects for enrollees and cost-effectiveness of providing the family care benefit.

3. Submit to the department all reports and data required or requested by the department, in the format and timeframe specified by the department.

(e) *Internal quality assurance and quality improvement.* Implement an internal quality assurance and quality improvement program that meets standards prescribed by the department. As part of the program, the resource center shall do all of the following:

1. Develop and implement a written quality assurance and quality improvement plan designed to ensure and improve outcomes for its target population. The plan shall be approved by the department and shall include at least all of the following components:

a. Identification of performance goals, specific to the needs of the resource center's customers, including any goals specified by the department.

b. Identification of objective and measurable indicators of whether the identified goals are being achieved, including any indicators specified by the department.

c. Identification of timelines within which goals will be achieved.

d. Description of the process that the resource center will use to gather feedback from the resource center's customers and staff and other sources on the quality and effectiveness of the resource center's performance.

e. Description of the process the resource center will use to monitor and act on the results and feedback received.

f. A process for regularly updating the plan, including a description of the process the resource center will use for annually assessing the effectiveness of the quality assurance and quality improvement plan and the impact of its implementation on outcomes.

2. Measure resource center performance, using standard measures required by the department, and report its findings on these measurements to the department.

3. Achieve minimum performance levels and performance improvement levels, as demonstrated by standardized measures established by the department through contract.

4. Initiate performance improvement projects that examine aspects of services related to improving resource center quality. These projects shall include all of the following:

a. Measuring performance.

b. Implementing system interventions.

c. Evaluating the effectiveness of the interventions.

d. Planning for sustained or increased improvement in performance based on the findings of the evaluation.

5. Comply with quality standards for services included in the resource center's contract with the department in all of the following areas:

a. Timeliness and accuracy of the functional screen and financial eligibility screen.

b. Timely and accurate eligibility determination and enrollment procedures.

c. Information and assistance services.

d. Protection of applicant rights.

e. Effective processes for considering and acting on complaints and resolving grievances of applicants and other persons who use resource center services.

6. Report all data required by the department related to standardized measures of performance, in the timeframes and format specified by the department.

7. Cooperate with the department in evaluating outcomes and in developing and implementing plans to sustain and improve performance.

(f) *Cooperation with external reviews.* Cooperate with any review of resource center activities by the department, another state agency or the federal government.

(7) CONFIDENTIALITY AND EXCHANGE OF INFORMATION. No record of a resource center that contains personally identifiable information concerning an individual who receives services from the resource center may be disclosed by the resource center without the individual's informed consent, except as follows:

(a) A resource center shall provide information as required to comply with s. 16.009 (2) (p) or 49.45 (4), Stats., or as necessary for the department to administer the family care program under ss. 46.2805 to 46.2895, Stats.

(b) Except as provided in sub. (2) (d) 2., a resource center may exchange confidential information about a client without the informed consent of the client, in the county of the resource center, if the exchange of information is necessary to enable the resource center to perform its duties or to coordinate the delivery of services to the client, as authorized under s. 46.21 (2m) (c), 46.215 (1m), 46.22 (1) (dm), 46.23 (3) (e), 46.284 (7), 46.2895 (10), 51.42 (3) (e) or 51.437 (4r) (b), Stats.

SUBCHAPTER III — ACCESS TO THE FAMILY CARE BENEFIT

HFS 10.31 Application and eligibility determination. (1) DEFINITION. In this section, "agency" means any county agency, or any resource center that is not a county agency, that is responsible for all or part of determination of functional, financial, and other conditions of eligibility for the family care benefit.

(2) GENERAL REQUIREMENT. Application for the family care benefit shall be made and reviewed in accordance with the provisions of this chapter.

(3) ACCESS TO INFORMATION. The agency shall provide information to persons inquiring about or applying for the family care benefit as required under s. HFS 10.23 (2) (c) and (h).

(4) APPLICATION. (a) *Making application.* Any person may apply for a family care benefit on a form prescribed by the department and available from a resource center. Application shall be made to the agency serving the county, tribe or family care district in which the person resides. Application may not be made to an agency in a county or tribe in which the family care benefit is not available.

(b) *Signing the application.* The applicant or the applicant's legal guardian, authorized representative or, where the applicant is incompetent or incapacitated, someone acting responsibly for the applicant, shall sign each application form in the presence of a representative of the

agency. The signatures of 2 witnesses are required when the applicant signs the application with a mark.

(5) VERIFICATION OF INFORMATION. An application for the family care benefit shall be denied when the applicant or enrollee is able to produce required verifications but refuses or fails to do so. If the applicant or enrollee is not able to produce verifications or requires assistance to do so, the agency taking the application may not deny assistance but shall proceed immediately to assist the person to secure necessary verifications.

(6) ELIGIBILITY DETERMINATION. (a) *Decision date*. Except as provided in par. (b), not later than 30 days from the date the agency receives an application that includes at least the applicant's name, address, unless the applicant is homeless, and signature, the agency shall determine the applicant's eligibility and cost sharing requirements for the family care benefit, using a uniform functional screen and a uniform financial eligibility screen prescribed by the department. If the applicant is a family care spouse, as defined in s. HFS 10.34 (1) (i), the agency shall notify both spouses in accordance with the requirements of s. 49.455 (7), Stats.

(b) *Notice*. The agency shall notify the applicant in writing of its determination. If a delay in processing the application occurs because of a delay in securing necessary information, the agency shall notify the applicant in writing that there is a delay in processing the application, specify the reason for the delay, and inform the applicant of his or her right to appeal the delay under s. HFS 10.55.

(7) ENROLLMENT. The agency shall complete and transmit, as directed by the department, all enrollment forms and materials required to enroll persons who are eligible and who choose to enroll in a care management organization.

(8) FRAUD. When the agency director or designee has reason to believe that an applicant or enrollee, or the representative of an applicant or enrollee, has committed fraud, the agency director or designee shall refer the case to the district attorney.

HFS 10.32 General conditions of eligibility. (1) CONDITIONS. To be eligible for the family care benefit, a person shall meet all of the following conditions:

(a) *Age*. The person is at least 18 years of age or will attain the age of 18 years on any day of the application month.

(b) *Residency*. The person is a resident of a county, family care district or service area of a tribe in which the family care benefit is available through a care management organization. This requirement does not apply to a person who is either of the following:

1. An enrollee who was a resident of the county, family care district or tribal area when he or she enrolled in family care, but currently resides in a long-term care facility outside the service area of the CMO under a plan of care approved by the CMO.

2. An applicant who, on the date that the family care benefit first became available in the county, was receiving services in a long-term care facility funded under any of the programs specified under s. HFS 10.33 (3) (b) administered by that county.

(c) *Family care target group.* The person has a physical disability, infirmities of aging or, if the person is a resident of a county that has operated a care management organization before July 1, 2001, a developmental disability.

(d) *Functional eligibility.* The person meets the functional eligibility conditions under s. HFS 10.33.

(e) *Financial eligibility.* The person meets the financial eligibility conditions under s. HFS 10.34.

(f) *Cost sharing.* The person pays any cost sharing obligations as required under s. HFS 10.34 (4).

(g) *Acceptance of medicaid if eligible.* If the person is eligible for medical assistance, he or she applies for and accepts the medical assistance.

(h) *Other non-financial conditions.* The person meets the nonfinancial conditions of eligibility for medical assistance under s. HFS 103.03 (2) to (9).

(i) *Divestment.* The person is not currently ineligible for the family care benefit, under the provisions of ss. 49.453, 49.454 (2) (c) and (3) (b), Stats., and s. HFS 103.065 because he or she divested assets. The divestment provisions of ss. 49.453, 49.454 (2) (c) and (3) (b), Stats., and s. HFS 103.065 shall apply to all family care applicants and enrollees, regardless of whether they are eligible for medical assistance.

(2) PROVISION OF NECESSARY INFORMATION. A client or person acting on behalf of a client shall provide full, correct and truthful information necessary to determine family care eligibility, entitlement status and cost sharing requirements, including the following:

(a) A declaration of assets on a form prescribed by the department.

(b) A declaration of income on a form prescribed by the department.

(c) Information related to the person's health and functional status, as required by the department.

(3) REPORTING OF CHANGES REQUIRED. An enrollee shall report to the county agency any significant change in circumstances that would affect his or her eligibility under this section, including income and asset changes that would affect cost sharing obligations, as specified under s. 10.34 (3) (f).

(4) REVIEW OF ELIGIBILITY. Enrollees' eligibility for the family care benefit shall be re-determined annually or more often when a change in the enrollee's circumstances justifies the need for re-determination.

HFS 10.33 Conditions of functional eligibility. (1) DEFINITIONS. In this section:

(a) "Long-term or irreversible condition" means a physical or cognitive impairment that is expected to last for more than 90 days or result in death within one year.

(b) "Requires ongoing care, assistance or supervision" means having the conditions or needs described in s. HFS 10.33 (2) (a).

(2) DETERMINATION OF FUNCTIONAL ELIGIBILITY. (a) *Determination.* Functional eligibility for the family care benefit shall be determined pursuant to s. 46.286 (1) and (1m), Stats., and this chapter, using a uniform functional screen prescribed by the department. To have functional eligibility for the family care benefit, the functional eligibility condition under par. (b) shall be met and, except as provided under sub. (3), the functional capacity level under par. (c) or (d) shall be met.

(b) *Long-term condition.* The person shall have a long-term or irreversible condition.

(c) *Comprehensive functional capacity level.* The person requires ongoing care, assistance or supervision from another person, as evidenced by any of the following findings from application of the functional screen:

1. The person cannot safely or appropriately perform 3 or more activities of daily living.

2. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living.

3. The person cannot safely or appropriately perform 5 or more IADLs.

4. The person cannot safely or appropriately perform one or more ADL and 3 or more IADLs and has cognitive impairment.

5. The person cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment.

6. The person has a complicating condition that limits the person's ability to independently meet his or her needs as evidenced by meeting both of the following conditions:

a. The person requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or requires frequent changes in service due to intermittent or unpredictable changes in his or her condition; or requires a range of medical or social interventions due to a multiplicity of conditions.

b. The person has a developmental disability that requires specialized services; or has impaired cognition exhibited by memory deficits or disorientation to person, place or time; or has impaired decision making ability exhibited by wandering, physical abuse of self or others, self neglect or resistance to needed care.

(d) *Intermediate functional capacity level.* A person is functionally eligible at the intermediate level if the person is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others, as evidenced by a finding from application of the functional screen that the person needs assistance to safely or appropriately perform either of the following:

1. One or more ADL.

2. One or more of the following critical IADLs:

a. Management of medications and treatments.

b. Meal preparation and nutrition.

c. Money management.

(3) GRANDFATHERING. If a person does not meet either of the functional capacity levels under sub. (2) (c) or (d), the department shall deem the person functionally eligible for the family care benefit if all of the following apply:

(a) The person has a long-term or irreversible condition.

(b) The person is in need of services included in the family care benefit.

(c) On the date that the family care benefit became available in the county of the person's residence, he or she was a resident in a nursing home or had been receiving for at least 60 days, under a written plan of care, long-term care services that were funded under any of the following:

1. The long-term support community options program under s. 46.27, Stats.

2. Any home and community-based waiver program under 42 USC 1396n (c), including the community integration program under s. 46.275, 46.277 or 46.278, Stats.

3. The Alzheimer's family caregiver support program under s. 46.87, Stats.

4. Community aids under s. 46.40, Stats., if documented by the county under a method prescribed by the department.

5. County funding, if documented under a method prescribed by the department.

HFS 10.34 Financial eligibility and cost sharing. (1) DEFINITIONS. In this section:

(a) "Actual maintenance costs" means the sum of the following:

1. Shelter costs determined according to s. 49.455 (4) (d), Stats.

2. An amount equal to the maximum food stamp allotment for a household of one under 7 USC 2017.

3. An allowance for clothing as determined by the department.

(b) "Certification period" means a 12-month period for which financial eligibility and cost sharing requirements for the family care benefit are determined for a non-Medicaid eligible person.

(c) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(d) "Earned income" has the meaning given under s. HFS 101.03 (51).

(e) "Unearned income" has the meaning given under s. HFS 101.03 (180).

(2) INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE. A person who is eligible for medical assistance under ch. 49, Stats., and chs. HFS 101 to 108 is financially eligible for the family care benefit. Cost sharing requirements for the family care benefit for a medical assistance-eligible person are those that apply under ch. 49, Stats., and chs. HFS 101 to 108.

(3) INDIVIDUALS NOT ELIGIBLE FOR MEDICAL ASISTANCE. (a) *Conditions of financial eligibility.* Eligibility under this subsection is effective beginning July 1, 2000. For persons who are not eligible for medical assistance, financial eligibility and cost sharing requirements for the family care benefit shall be determined pursuant to applicable provisions of s. 46.286 (1) (b) and (2), Stats., and this chapter. The maximum cost-sharing requirement for a non-MA-eligible person shall be determined by a county agency using a uniform financial eligibility and cost-sharing screen prescribed by the department. A non-MA-eligible person is financially eligible for the family care benefit if the projected cost of the person's care plan exceeds the person's maximum cost-sharing requirement.

(b) *Calculation of maximum cost share requirement at initial determination and annual re-determination of eligibility.* A non-MA-eligible family care enrollee shall contribute to the cost of his or her care an amount that is calculated as provided under this section. Treatment of assets, including assets in trusts, and income shall be as provided under ss. 49.454 and 49.47, Stats., and ss. HFS 103.06 and 103.07 unless specified otherwise in this section. All dollar amounts specified in this section shall be updated annually based on changes in the consumer price index. The following calculation shall determine the applicant's or enrollee's maximum cost-sharing requirement:

1. Determine total countable assets according to ss. 49.454 and 49.47, Stats., and s. HFS 103.06. If the applicant or enrollee is legally married, include the countable assets of both members of the couple.

2. Determine monthly net countable assets by subtracting from total countable assets the following allowances, as applicable, and dividing the result by 12:

a. Subject to subd. 6., if the applicant or enrollee is a family care spouse, the amount of the community spouse resource allowance under s. 49.455 (6) (b), Stats.

b. If the person resides in a nursing home, community-based residential facility or adult family home, an allowance of $9,000.

c. If the person resides in his or her own home, including a residential care apartment complex or in the private home of a relative or other person, an allowance of $12,000.

3. Determine countable monthly income by adding together all of the following:

a. Monthly unearned income less a disregard of $20.

b. Total monthly earned income, less the first $200, less two-thirds of any remaining earned income.

4. Add together the monthly net countable assets and the countable monthly income.

5. Deduct from the amount calculated under subd. 4. all of the following:

a. Subject to subd. 6, if the person is a family care spouse, the community spouse monthly income allowance under s. 49.455 (4) (b), Stats.

b. The amount of any court-ordered payments paid by the person.

c. If the person resides in a nursing home, community-based residential facility or adult family home, a personal maintenance allowance of $65.

d. If the person resides in his or her own home, including a residential care apartment complex or the home of another person, a personal maintenance allowance equal to the greater of the combined benefit amount available under 42 USC 1381 to 1383 and s. 49.77 (3s), Stats., or up to $1,000 of actual maintenance costs, as defined under sub. (1) (a).

e. If the person resides in a medical institution, the monthly cost of maintaining a homestead property when the applicant or enrollee can reasonably be expected to return within 6 months or the anticipated absence of the applicant or enrollee from the home is for more than 6 months but there is a realistic expectation, as verified by a physician, that the person will return to the home. The monthly cost shall not exceed the SSI payment level for one person living in that person's own household.

f. The average monthly out-of-pocket cost of necessary medical or remedial care, including health insurance premiums and cost-sharing requirements for other state or federal programs.

g. An allowance for dependents who live in the home of the person or the person's community spouse equal to the allowance payable under s. 49.455 (4) (a) 3., Stats.

h. Any special allowances approved by the department.

6. If both members of a married couple are family care spouses, the community spouse resource allowance under subd. 2. a. and the community spouse monthly income allowance under subd. 5. a. may be included in the calculation of cost share for either spouse, but not for both.

(c) *Recalculation of maximum cost-sharing requirement during a certification period.* When changes in income, assets or cost of care necessitate a re-determination of a person's maximum cost-sharing requirement during a certification period, the calculation for the remainder of the certification period shall be the same as under par. (b) except that the amount already incurred and paid by the person from countable assets during the certification period shall be added to the amount under par. (b) 4.

(d) *Treatment of assets.* In determining financial eligibility and cost sharing requirements for the family care benefit, the department or the county agency shall treat assets, including assets in trusts, according to ss. 49.454 and 49.47 (4) (b), Stats., and s. HFS 103.06, except as follows:

1. All funds in an independence account shall be considered as an exempt asset. In this subd., "independence account" means one or more separate accounts at a financial institution, approved by the department, that are in the sole ownership of the client, and that consist solely of savings, and dividends or other gains derived from those savings, from earned income received after application for the family care benefit.

2. Spousal impoverishment provisions under s. HFS 10.35 shall apply.

(e) *Treatment of income*. In determining financial eligibility and cost sharing requirements for the family care benefit, the department or the county agency shall treat income according to applicable provisions of s. 49.47 (4) (c), Stats., and s. HFS 103.07 except that worker's compensation cash benefits under ch. 104, Stats., and unemployment insurance benefits received under ch. 108, Stats., shall be treated as earned income for purposes of par. (b) 3. b.

(f) *Certification period*. Cost sharing requirements as determined under this section shall be in effect for a full 12-month certification period except as follows:

1. An enrollee shall report, within 10 days of the change, increases in assets that exceed a total of at least $1000 in a calendar month.

2. At any time, an enrollee may report decreases of any amount in assets other than decreases resulting from payment of required cost sharing under this section.

3. An enrollee shall report any change in income within 10 days of the change.

4. Cost-sharing requirements shall be re-determined whenever any of the following occurs:

a. Reported changes in income, assets, or both, would result in a lower cost-sharing requirement.

b. Countable assets increase more than $1000 in a calendar month.

c. Monthly income increases by any amount.

(4) PAYMENT OF COST SHARE REQUIRED. (a) Except as provided in par. (b), a person who is required to contribute to the cost of his or her care but who fails to make the required contributions is ineligible for the family care benefit.

(b) If the department or its designee determines that the person would incur an undue financial hardship as a result of making the payment, the department may waive or reduce the requirement. Any waiver of cost share shall be subject to review at least every 12 months.

(c) A CMO shall collect or monitor the collection of its enrollees' cost sharing payments. If an enrollee does not meet his or her cost sharing obligations, the CMO shall notify the resource center in the county in which the enrollee resides. The resource center, directly or through arrangement with the county agency, shall notify the enrollee that he or she will be ineligible on a specified date unless cost sharing obligations are met. If the client has not paid the cost share amount due by the date specified, the county agency shall determine the person to be ineligible and disenroll the person from the CMO.

(d) Until an enrollee is disenrolled, a CMO remains responsible for provision of services in the enrollee's plan of care and for payment to providers for those services.

HFS 10.35 Protections against spousal impoverishment. The provisions related to spousal impoverishment under s. 49.455, Stats., and s. HFS 103.075 shall apply to all family care spouses, regardless of their eligibility for medical assistance.

HFS 10.36 Eligibility and entitlement. (1) ENTITLEMENT. Except as provided in sub. (2), a person who meets all of the conditions of eligibility under s. HFS 10.32 is entitled to enroll in a care management organization and to receive the family care benefit if any of the following apply:

(a) The person meets the conditions of functional eligibility at the comprehensive level under s. HFS 10.33 (2) (c).

(b) The person meets the conditions of functional eligibility at the intermediate level under s. HFS 10.33 (2) (d) and at least one of the following applies:

1. The person is in need of adult protective services as substantiated by a county agency under s. 46.90 (2), Stats., or specified in s. 55.05 (1t), Stats.

2. The person is eligible for medical assistance.

(c) The person meets the criteria under s. HFS 10.33 (3).

(2) PHASE-IN OF ENTITLEMENT. (a) *Non-MA eligibles.* A person who is not eligible for medical assistance is not entitled to the family care benefit before July 1, 2000.

(b) *Phase-in of capacity.* Within each county and for each CMO target population, entitlement to the family care benefit first applies on the effective date of a contract under which a CMO accepts a per person per month payment to provide services under the family care benefit to eligible persons in that target population in the county. To provide time for a newly established care management organization to develop sufficient capacity to serve all individuals who meet the conditions of entitlement, a care management organization may limit enrollment. If enrollment is limited during this phase-in period, a resource center may place persons otherwise entitled under sub. (1) on a waiting list until a CMO can accept the enrollment. Any waiting list created under this paragraph shall conform to department requirements.

(3) ELIGIBILITY WITHOUT ENTITLEMENT. A person who is found eligible but who does not meet any of the conditions of sub. (1) (a) to (c) is not entitled to the family care benefit. The person may be placed on a waiting list to receive the family care benefit when funds are available. The county agency shall inform the person of his or her right to receive a new functional screen or financial eligibility screen if the person's circumstances change. Waiting lists under this subsection shall conform to criteria established by the department. While waiting for enrollment, a person who has been found eligible but not entitled may purchase services from a CMO as provided under s. HFS 10.37.

HFS 10.37 Private pay individuals. (1) DEFINITIONS. In this section:

(a) "Case management" means assessment, care planning, assistance in arranging and coordinating services in the care plan, assistance in filing complaints and grievances and obtaining advocacy services, and periodic reassessment and updates to the person's care plan.

(b) "Private pay individual" means any of the following:

1. A person who is a member of a CMO's target population and who does not qualify financially for the family care benefit under s. HFS 10.34.

2. A person who is eligible for the family care benefit under s. HFS 10.32, but who is not entitled to receive the benefit immediately as specified in s. HFS 10.36 (3).

3. A person who meets the entitlement conditions specified in s. HFS 10.36 (1), but who is waiting for enrollment in a CMO under the phase-in provisions of s. HFS 10.36 (2).

(2) CASE MANAGEMENT AVAILABLE FOR PURCHASE. A care management organization shall offer case management services, at a reasonable cost, to private pay individuals who wish to purchase the services. A private pay individual may purchase from the CMO any types and amounts of case management. The types and amounts of case management and the cost of the services shall be specified in a written agreement signed by the authorized representative of the CMO and the individual purchasing the service or the person's authorized representative.

(3) LIMITATIONS ON PURCHASE OF OTHER SERVICES. (a) A private pay individual may not enroll in a care management organization, but, subject to pars. (b) and (c), may purchase services other than case management services, on a fee-for-service basis, from a care management organization.

(b) An individual who meets the definition under sub. (1) (b) 1. may purchase any service that the CMO provides directly and offers to the general public, at prices normally charged to the public.

(c) An individual who meets the definition under sub. (1) (b) 2. or 3. may purchase any service purchased or provided by the CMO for its members.

SUBCHAPTER IV - FAMILY CARE BENEFIT; DELIVERY THROUGH CARE MANAGEMENT ORGANIZATIONS (CMOs)

HFS 10.41 Family care services. (1) ENROLLMENT REQUIRED. The family care benefit is available to eligible persons only through enrollment in a care management organization (CMO) under contract with the department.

(2) SERVICES. Services provided under the family care benefit shall be determined through individual assessment of enrollee needs and values and detailed in an individual service plan unique to each enrollee. As appropriate to its target population and as specified in the department's contract, each CMO shall have available at least the services and support items covered under the home and community-based waivers under 42 USC 1396n (c), the long-term support community options program under s. 46.27, Stats., and specified services and support items under the state's plan for medical assistance. In addition, a CMO may provide other services that substitute for or augment the specified services if these services are cost-effective and meet the needs of enrollees as identified through the individual assessment and service plan.

Note: The services that typically will be required to be available include adaptive aids; adult day care; assessment and case planning; case management; communication aids and interpreter services; counseling and therapeutic resources; daily living skills training; day services and treatment; home health services; home modification; home delivered and congregate meal services; nursing services; nursing home services, including care in an intermediate care facility for the mentally retarded or in an institution for mental diseases; personal care services; personal emergency response system services; prevocational services; protective payment and guardianship services; residential services in an RCAC, CBRF or AFH; respite care; durable medical equipment and specialized medical supplies; outpatient speech; physical and occupational

therapy; supported employment; supportive home care; transportation services; mental health and alcohol or other drug abuse services; and community support program services.

(3) PAYMENT MECHANISMS. Payment to a care management organization shall be on a per enrollee per month basis. Any contractual agreements for shared financial risk between the department and a CMO shall meet applicable federal requirements.

HFS 10.42 Certification and contracting. (1) CERTIFICATION REQUIRED. No entity may receive payment of funds for the family care benefit as a care management organization unless it is certified by the department as meeting all of the requirements of s. 46.284, Stats., and this chapter.

(2) APPLICATION FOR CERTIFICATION. (a) To obtain and retain certification, an organization shall submit all information and documentation required by the department, in a format prescribed by the department, including comments it has obtained from each local long-term care council in the area it proposes to serve. The department shall review the application in a timely manner and may conduct any necessary investigation to verify that the information submitted by the organization is accurate. The organization shall consent to disclosure by any third party of information the department determines is necessary to review the application.

(b) Except as required in s. HFS 10.42 (1), if the organization substantially but not completely meets the requirements for certification, the department may contract with it to operate a CMO. The contract may include additional requirements, specify actions and outcomes necessary for the organization to achieve compliance and include a timeline within which the organization must meet the additional requirements.

(c) If the department denies CMO certification for the organization, the department shall provide written notice to the organization that clearly states the reasons for the denial and describes the manner by which the organization may appeal the department's decision.

(3) CONTRACTING NOT REQUIRED. If an organization applying to operate a CMO meets established standards for certification and all requirements of the department's standard CMO contract, the department shall certify the organization as meeting the requirements. Certification by the department does not bind the department to contracting with the organization to operate a CMO. The department shall contract with a certified organization to operate a CMO only if all of the following apply:

(a) A local long-term care council established under s. 46.282 (2), Stats., has advised the department about the organization and its ability to provide the family care benefit, as provided in s. 46.282 (3) (a) 3., and the department has considered that advice.

(b) The local long-term care council and individuals from the local target population that the organization proposes to serve have assisted the department in its review and evaluation of all applications of organizations proposing to serve a geographic area.

(c) The department has determined, after considering the advice of the local long-term council for the geographic area, that the organization's services are needed to provide sufficient access to the family care benefit for eligible individuals.

Note: 1. Until July 1, 2001, the Wisconsin Legislature has authorized the Department to establish Family Care pilots in areas of the state in which not more than 29% of the state's eligible

population lives. After that date, if specifically authorized and funded by the Legislature, the Department may contract with additional entities certified as meeting requirements for a CMO. The Department is required to submit, prior to November 1, 2000, a report to the Governor that describes the implementation and outcomes of the pilots and makes recommendations about further development of Family Care.

2. Before January 1, 2003, the Department may not contract with any organization other than a county or a Family Care District created by a county under s. 46.2895, Stats., unless the county agrees in writing that at least one additional CMO is necessary or desirable or the governing body of a tribe or band or the Great Lakes Inter–Tribal Council, Inc., elects to operate a CMO within the area and is certified by the Department. During 2003, the Department may not contract with a non-county organization unless one of the previous conditions applies or unless either a county fails to meet certification requirements and other performance standards or an additional CMO is needed to assure access to the Family Care benefit to all entitled persons in the county.

(4) INTERMEDIATE SANCTIONS. The department's contracts with CMOs shall specify a range of remedies that may be taken in the event of noncompliance by the CMO with contract requirements. The remedies may include the following:

(a) Suspension of new enrollment.

(b) Enrollment reductions.

(c) Withholding or reduction of payments.

(d) Imposition of damages.

(e) Appointment of temporary management of the CMO.

(f) Contract termination.

HFS 10.43 CMO certification standards. The department shall establish certification standards for CMOs that include at least the following elements:

(1) CASE MANAGEMENT CAPABILITY. Each organization applying to operate a CMO shall demonstrate to the department that it has expertise in determining and arranging for services and supports to meet the needs of its target population. Demonstration of this expertise includes evidence that the organization, a subcontractor, or both, has all of the following:

(a) A sufficient number of qualified and competent staff to meet case management standards under s. HFS 10.44 and as established by the department.

(b) Thorough knowledge of local long-term care and other community resources.

(c) Thorough knowledge of methods for maximizing informal caregivers and community resources and integrating them into individual service plans.

(d) Strong linkages with systems and services that are not directly within the scope of the CMO's responsibility but that are important to the organization's target population, including primary and acute health care services, and the capacity to arrange for those services to be made available to its enrollees.

(e) Mechanisms to coordinate services internally and with services available from community organizations and other social programs.

(2) ADEQUATE AVAILABLITY OF PROVIDERS. Each organization applying to operate a CMO shall demonstrate to the department that it has adequate availability of qualified providers with the expertise and ability to serve its target population in a timely manner. To demonstrate an adequate availability of qualified providers, an organization shall assure the department that it has all of the following:

(a) Agreements with providers who can provide all required services in the family care benefit.

(b) Appropriate provider connections to qualify providers, on a timely basis, as needed to directly reflect the specific needs and preferences of particular enrollees in its target population.

(c) Agreements with a broad array of providers representing diverse programmatic philosophies and cultural orientations to accommodate a variety of enrollee preferences and needs within its target population.

(d) The ability to provide services at various times, including evenings, weekends and, when applicable, on a 24-hour basis.

(e) The ability to provide an appropriate range of residential and day services that are geographically accessible to proposed enrollees' homes, families, guardians or friends.

(f) Supported living arrangements of the types and sizes that meet its target population's preferences and needs and staff to coordinate residential placements who have shown capability in recruiting, establishing and facilitating placements with appropriate matching to enrollee needs.

(g) The ability to recruit, select and train new service providers, including in-home providers, in a timely fashion and a program designed to retain individual providers.

(h) The ability to develop residential options that meet individual needs and desired outcomes of its enrollees.

(i) Mechanisms for assuring that all service providers meet required licensure, accreditation, or other quality assurance standards.

(3) CERTIFICATION AS A MEDICAL ASSISTANCE PROVIDER. The organization shall be certified by the department under s. HFS 105.47.

(4) ORGANIZATIONAL CAPACITY. The organization shall demonstrate that it can meet requirements for organizational capacity established by the department, including those related to:

(a) Financial solvency and stability and the ability to assume the level of financial risk required under the contract.

(b) The ability to collect, monitor and analyze data for purposes of financial management and quality assurance and improvement and to provide that data to the department in the manner required under the contract.

(5) COMPLAINT AND GRIEVANCE PROCESSES. The organization shall have a process for reviewing client complaints and resolving client grievances that meets the requirements under s. HFS 10.53 (2).

HFS 10.44 Standards for performance by CMOs. (1) COMPLIANCE. A care management organization shall comply with all applicable statutes, all of the standards in this subchapter and all requirements of its contract with the department.

(2) CASE MANAGEMENT STANDARDS. The CMO shall provide case management services that meet standards prescribed by the department, including all of the following:

(a) Implementation of procedures that assure full enrollee participation in the development of the enrollee's individual service plan, including CMO support, as needed, to enable the enrollee, family members or other representatives to make informed service plan decisions.

(b) Implementation of a mechanism, as approved by the department, whereby enrollees who choose to manage their own services may do so.

(c) Utilization of case management personnel who meet staff qualification standards prescribed by the department.

(d) Designation of a case management team for each enrollee that includes at least a social service coordinator and a registered nurse.

(e) Utilization of a sufficient number of case management personnel to ensure that enrollees' services continue to meet their needs.

(f) Use of assessment protocols that include a face-to-face interview with the enrollee and that comprehensively assess the needs and strengths of each enrollee in at least the following areas:

1. Activities of daily living and instrumental activities of daily living.

2. Physical health and medical needs.

3. Nutrition.

4. Autonomy and self-determination.

5. Communication.

6. Mental health and cognition.

7. Presence of informal supports.

8. Understanding and exercising rights and responsibilities.

9. Community integration.

10. Safety.

11. Personal values.

12. Education and vocational activities.

13. Economic resources.

(g) Development of an individual service plan for each enrollee that reflects the findings of the comprehensive assessment for the individual and that is agreed to by the individual.

(h) Re-assessment of each enrollee's needs and adjustment to the individual service plan based on the findings of the re-assessment. The CMO shall periodically re-assess each enrollee's needs and adjust his or her service plan as required by the department and shall immediately re-assess needs and adjust the service plan when a significant change in the enrollee's health, living situation or other circumstances occurs.

(i) Provision, arrangement, coordination and monitoring of services to the extent that the enrollee has not chosen to manage his or her own services.

(j) Assistance to enrollees in arranging for and coordinating services that are outside the direct responsibility of the CMO.

(3) SERVICE MONITORING. A CMO shall do all the following:

(a) Develop and implement standards for CMO service provider qualifications and written procedures and protocols for assessing whether providers meet the standards. Provider qualification standards established by a CMO shall meet or exceed standards that are established by the department.

(b) Develop and implement written procedures and protocols that assure that services furnished are consistent with the health and long-term care needs of each enrollee as identified in the enrollee's assessment and individual service plan.

(c) Develop and implement written procedures and protocols that assure that enrollee problems and needs related to services are detected and promptly addressed.

(4) INTERNAL QUALITY ASSURANCE AND QUALITY IMPROVEMENT. The CMO shall implement an internal quality assurance and quality improvement program that meets standards prescribed by the department. As part of the program, the CMO shall do all of the following:

(a) Develop and implement a written quality assurance and quality improvement plan designed to ensure and improve outcomes for its target population. The plan shall be approved by the department and shall include at least all of the following components:

1. Identification of performance goals, specific to the needs of the CMO's enrollees, including any goals specified by the department.

2. Identification of objective and measurable indicators of whether the identified goals are being achieved, including any indicators specified by the department.

3. Identification of timelines within which goals for improvement will be achieved.

4. Description of the process that the CMO will use to gather feedback from enrollees, staff, people who have disenrolled from the CMO and other sources on the quality and effectiveness of the CMO's performance.

5. A description of the process the CMO will use to monitor and act on the results and feedback received.

6. A process for regularly updating the plan, including a description of the process the CMO will use for annually assessing the effectiveness of the quality assurance and quality improvement plan and the impact of its implementation on outcomes.

(b) Measure CMO performance, using standard measures required by the department, and report its findings on these measurements to the department.

(c) Achieve minimum performance levels and performance improvement levels, as demonstrated by standardized measures established by the department through contract.

(d) Initiate performance improvement projects that examine aspects of care and services related to improving CMO quality and enrollee outcomes. These projects shall include all of the following:

1. Measuring performance.

2. Implementing system interventions.

3. Evaluating the effectiveness of the interventions.

4. Planning for sustained or increased improvement in performance, based on the findings of the evaluation.

(e) Comply with quality standards for services included in the CMO's contract with the department in all of the following areas:

1. Health and functional capacity of enrollees.

2. Availability of services and adequacy of the CMO's provider network.

3. Continuity and coordination of care.

4. Coverage and authorization of services.

5. Provision of information to enrollees.

6. Protection of enrollee rights, including processes for protecting confidentiality and for considering and acting on complaints and resolving grievances.

7. Mechanisms to detect and correct both underutilization and overutilization of services.

(f) Report all data required by the department related to standardized measures of performance, in the timeframes and format specified by the department.

(g) Cooperate with the department in evaluating outcomes and in developing and implementing plans to sustain and improve performance.

(5) EXTERNAL REVIEW. A CMO shall comply with all state and federal requirements for external review of quality of care and services furnished to its enrollees. A CMO shall cooperate with any review of CMO activities by the department, another state agency or the federal government.

HFS 10.45 Operational requirements for CMOs. (1) GOVERNING BOARD. A care management organization shall have a governing board that reflects the ethnic and economic diversity of the geographic area served by the CMO. At least one-fourth of the members of the governing board shall be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates who are representative of the CMO's enrollees.

(2) OPEN ENROLLMENT. (a) Except as provided in s. HFS 10.36 (2), a CMO shall conduct a continuous open enrollment period, accepting enrollment of any member of its target population who is enrolled by an aging and disability resource center serving the area of the CMO, without regard to life situation, health or disability status or cost sharing requirements.

(b) A CMO may not disenroll any enrollee without the express approval of the department, unless the enrollee has requested to be disenrolled. When a CMO requests department approval to disenroll an enrollee, the CMO shall refer the enrollee to the resource center for counseling under 10.23 (2) (i). A CMO may not encourage any enrollee to disenroll.

(3) SERVICE TO PRIVATE PAY INDIVIDUALS. The CMO shall provide, on a fee-for-service basis, case management and other services to private pay individuals as necessary to meet the requirements specified in s. HFS 10.37.

(4) REPORTING AND RECORDS. (a) The department shall require each CMO to report information as the department determines necessary, including information needed for all of the following:

1. Determination of whether the CMO is meeting minimum quality standards, including adequate long-term care outcomes for its enrollees.

2. Determination of the extent to which the CMO is improving its performance on measurable indicators identified by the CMO in its current quality improvement plan.

3. Determination of whether the CMO is meeting the requirements of its contract with the department.

4. Determination of the adequacy of the CMO's fiscal management and financial solvency.

5. Evaluation of the effects for enrollees and cost-effectiveness of providing the family care benefit.

(b) A CMO shall submit to the department all reports and data required or requested by the department, in the format and timeframe specified by the department.

(5) CONFIDENTIALITY AND EXCHANGE OF INFORMATION. No record of a CMO that contains personally identifiable information concerning a current or former enrollee may be disclosed by the CMO without the individual's informed consent, except as follows:

(a) A CMO shall provide information as required to comply with s. 16.009 (2) (p) or 49.45 (4), Stats., or as necessary for the department to administer the family care program under ss. 46.2805 to 46.2895, Stats.

(b) A CMO may exchange confidential information about a client without the informed consent of the client, in the county of the CMO, if necessary to enable the CMO to perform its duties or to coordinate the delivery of services to the client, as authorized under s. 46.21 (2m) (c), 46.215 (1m), 46.22 (1) (dm), 46.23 (3) (e), 46.283 (7), 46.2895 (10), 51.42 (3) (e) or 51.437 (4r) (b), Stats.

SUBCHAPTER V—PROTECTION OF APPLICANT, ELIGIBLE PERSON AND ENROLLEE RIGHTS

HFS 10.51 Client rights. Clients shall have the rights in family care that are outlined in the applicant information materials they receive when contacting a resource center and in the member handbook they receive prior to enrollment in a care management organization. The department shall review and approve the statement of client rights and responsibilities in each resource center's applicant information materials and in each CMO's member handbook. Client rights shall, at a minimum, include an explanation of client rights in the following areas:

(1) RIGHTS OF CLIENTS. Clients have the right to all of the following:

(a) Freedom from unlawful discrimination in applying for or receiving the family care benefit.

(b) Accuracy and confidentiality of client information.

(c) Prompt eligibility decisions and assistance.

(d) Access to personal, program and service system information.

(e) Choice to enroll in a CMO, if eligible, and to disenroll at any time.

(f) Support for all clients in understanding their rights and responsibilities related to family care, including due process procedures, and in providing their comments about resource centers, CMOs and services, including through complaints, grievances and appeals. Resource Centers, CMOs and county agencies under contract with the Department shall assist clients to identify all rights to which they are entitled and, if multiple grievance or appeal mechanisms are available, which mechanism will best meet client needs.

(2) RIGHTS OF ENROLLEES. Enrollees have the right to all of the following:

(a) Support from the CMO in all of the following:

1. Self-identifying long-term care needs and appropriate family care outcomes.

2. Securing information regarding all services and supports potentially available to the enrollee through the family care benefit.

3. Actively participating in planning individualized services and making reasonable service and provider choices for achieving identified outcomes.

(b) Receiving services identified in the individualized service plan.

Note: Family Care clients may have rights and available grievance and appeal processes beyond those specified in this chapter. For example, clients receiving treatment for mental illness may have rights under ch. 51, Stats., and review and appeal mechanisms beyond those specified in this chapter. Similarly, a client who resides in a nursing home has rights under ch. 50, Stats., and 42 CFR 483.10.

HFS 10.52 Required notifications. (1) NOTIFICATION OF GENERAL CLIENT RIGHTS AND RESPONSIBILITIES. Each resource center, county agency and CMO shall provide clients written notification of their rights and responsibilities in accordance with timelines and other requirements established in its contract with the department in every instance in which:

(a) The client applies for the family care benefit and is counseled by a resource center about the family care benefit or enrollment in a specific care management organization.

(b) The client enrolls in a care management organization.

(2) NOTIFICATION OF ELIGIBILITY OR ENTITLEMENT. Every applicant for the family care benefit shall be notified in writing of decisions regarding eligibility, entitlement and cost sharing requirements as required under s. HFS 10.31 (5) (b).

(3) NOTIFICATION OF INTENDED ACTION. Clients shall be given written notice of any intended adverse action at least 10 days prior to the date of the intended action.

(a) Notification shall be provided as follows:

1. By the county agency in every instance in which a client's eligibility or entitlement for family care will be discontinued, terminated, suspended or reduced, or in which the client's maximum cost sharing requirement will be increased.

2. By the CMO in every instance in which the CMO intends to reduce or terminate a service or deny payment for a service.

(b) The notification of intended action shall include an explanation of all the following, as applicable:

1. The action the county agency, resource center or CMO intends to take, including how the action will affect any service that the client currently receives.

2. The reasons for the intended action.

3. Any laws that support the action.

4. The client's right to make a complaint or file grievance with the resource center, county agency or CMO, to request a department review and to request a fair hearing.

5. How to file a grievance, or request a department review or a fair hearing.

6. That if the client files a grievance, he or she has a right to appear in person before the county agency, the resource center or CMO personnel assigned to resolve the grievance.

7. The circumstances under which an enrollee's current services provided through the family care benefit will be continued under s. HFS 10.56 pending the outcome of a grievance, department review or fair hearing.

8. The availability of independent advocacy services and other local organizations that might assist a client in a grievance, department review or fair hearing.

9. That the enrollee may obtain, free of charge, copies of client records relevant to the grievance, department review or fair hearing, and how to obtain the copies.

(4) NOTIFICATION OF DUE PROCESS AND FAIR HEARING RIGHTS. Clients shall be provided timely and adequate written notification of due process rights, including the right to a fair hearing in accordance with s. HFS 10.55, an offer of assistance in preparing a written grievance or fair hearing request and information about the availability of advocacy services to assist the client. Resource centers, county agencies and care management organizations shall provide written notification of due process rights, within timelines established in department contracts, in each instance in which:

(a) A county agency makes a determination or redetermination of eligibility for the family care benefit.

(b) A CMO requests or the department approves involuntary disenrollment of an enrollee.

(c) A CMO reduces or discontinues a service or item received by an enrollee without the enrollee's consent.

(d) A CMO denies a service or item requested by an enrollee.

(e) The client registers any complaint with the department, resource center, county agency, CMO or any contracted service provider.

HFS 10.53 Grievances. (1) GRIEVANCE PROCESS IN RESOURCE CENTERS. (a) The governing board of each resource center shall approve and be responsible for the effective operation of a process for reviewing client complaints and resolving client grievances. The board may delegate its responsibility to a committee of the resource center's senior management.

(b) The governing board of each resource center is responsible for reviewing complaints and resolving grievances. The board may delegate its responsibility, in writing, to a grievance committee provided the process ensures that the governing board is made aware of complaints, grievances and appeals.

(c) The department shall review and approve a resource center's complaint and grievance process as part of its contracting with the resource center.

(d) A resource center shall assist individuals to file and resolve complaints or grievances, including assistance with committing an oral complaint or grievance to writing.

(2) GRIEVANCE PROCESS IN CARE MANAGEMENT ORGANIZATIONS. (a) The governing board of each CMO shall approve and be responsible for the effective operation of a process for reviewing client complaints and resolving client grievances. The board may delegate its responsibility to a committee of the CMO's senior management.

(b) The governing board of each CMO is also responsible for reviewing complaints and resolving grievances. The board may delegate its responsibility, in writing, to a grievance committee provided the process ensures that the governing board is made aware of complaints, grievances and appeals.

(c) The department shall review and approve the CMO's complaint and grievance process as part of its certification of a CMO.

(d) A CMO shall assist its enrollees to file and resolve complaints or grievances, including assistance with committing an oral complaint or grievance to writing.

HFS 10.54 Department reviews. (1) GENERAL REVIEW PROCESS. The department shall establish a process for the timely review, investigation and analysis of the facts surrounding client complaints or grievances in an attempt to resolve concerns and problems informally, whenever either of the following occurs:

(a) A client makes a complaint or grievance directly to the department.

(b) A client requests department review of a decision arrived at through a county agency, resource center or care management organization grievance process.

(2) CONCURRENT REVIEW PROCESS. Whenever the department receives notice from the department of administration's division of hearings and appeals that it has received a fair hearing request, the department shall use the process in sub. (1) to conduct a concurrent review in accordance with s. HFS 10.55 (4).

HFS 10.55 Fair hearing. (1) RIGHT TO FAIR HEARING. Except as limited in subs. (2) to (4), a client has a right to a fair hearing under s. 46.287, Stats. The contested matter may be a decision or action by the department, a resource center, county agency or CMO, or the failure of the department, a resource center, county agency or CMO to act on the contested matter within timeframes specified in this chapter or in the contract with the department. The following matters may be contested through a fair hearing:

(a) Denial of eligibility under s. HFS 10.31 (5) or 10.32 (4).

(b) Determination of cost sharing requirements under s. HFS 10.34.

(c) Determination of entitlement under s. HFS 10.36.

(d) Failure of a CMO to provide timely services and support items that are included in the plan of care.

(e) Reduction of services or support items except in accordance with a change, agreed to by the enrollee, in the enrollee's individualized service plan.

(f) An individualized service plan that is unacceptable to the enrollee because any of the following apply:

1. The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a nursing home or other alternative living arrangement as a long term residence, without periodic review of the possibility to live in a less restrictive setting.

2. The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified family care outcomes.

3. The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.

(g) Termination of the family care benefit or involuntary disenrollment from a CMO.

(h) Determinations of protection of income and resources of a couple for maintenance of a community spouse under s. HFS 10.35 to the extent a hearing would be available under s. 49.455 (8) (a), Stats.

(i) Recovery of incorrectly paid family care benefit payments as provided under s. HFS 108.03 (3).

(j) Hardship waivers, as provided in s. HFS 108.02 (12) (e), and placement of liens as provided in s. HFS 104.01 (5).

(k) Determination of temporary ineligibility for the family care benefit resulting from divestment of assets under s. HFS 10.32 (1) (i).

(2) LIMITED RIGHT TO FAIR HEARING. A client may contest any of the following matters through fair hearing only after the department has conducted a review and investigation of facts in an attempt to resolve concerns and problems informally and the department's review has not resulted in an informal resolution that is acceptable to the client:

(a) The client's individualized service plan fails to provide services, items and providers requested or chosen by the enrollee for meeting the enrollee's needs and identified family care outcomes that are of a reasonable amount, cost, type and duration, in comparison to the services, items and providers used by persons who have similar needs and circumstances.

(b) Any decision, omission or action of a CMO other than those specified under sub. (1) (d) to (f).

(3) REQUESTING A FAIR HEARING. A client shall request a fair hearing within 45 days after receipt of notice of a decision in a contested matter, or after a resource center or CMO has failed to respond within timeframes specified by this chapter or the department. A client shall file his or her request for a fair hearing in writing with the division of hearings and appeals in the department of administration. A request is considered filed when received by the division of hearings and appeals. If a client asks the department, a county agency, a resource center or CMO for assistance in writing a fair hearing request, the department, resource center or CMO shall provide that assistance.

Note: A hearing request should be addressed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707, 608-266-3096. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI.

(4) DEPARTMENT CONCURRENT REVIEW OF FAIR HEARING REQUESTS. (a) When the division of hearings and appeals receives a request for a fair hearing under this chapter, it shall set the date for the hearing in accordance with ch. 227, Stats., and ch. HA 3 and notify the department that it has received the request.

(b) When a client has requested a fair hearing under sub. (1) (a) to (i), the department shall concurrently review and investigate the facts surrounding the client's request using the process established under s. HFS 10.54 in an attempt to resolve the problem informally.

(c) The fair hearing shall proceed as scheduled unless before the hearing date either of the following occurs:

1. An informal resolution is proposed that is acceptable to the client, and the client withdraws the request for fair hearing.

2. An informal resolution acceptable to the client appears imminent to all parties, and the client withdraws the request for fair hearing without prejudice. If the informal resolution that was anticipated is, in fact, not acceptable to the client, a new hearing date shall be set promptly.

(5) FAIR HEARING PROCEDURES. (a) The division of hearings and appeals shall conduct a fair hearing pursuant to this section in accordance with ch. 227, Stats., and ch. HA 3, in response to each fair hearing requested unless, prior to the scheduled hearing date, any of the following occurs:

1. The client withdraws the request in writing.

2. The contested matter is resolved under sub. (4).

3. In the case of an enrollee grievance against a CMO, the person voluntarily disenrolls from the CMO.

(b) In accordance with ch. 227, Stats., and ch. HA 3, the division of hearings and appeals:

1. Shall issue a decision within 90 days of the date of receipt of the request for fair hearing.

2. May dismiss the petition if the client does not appear at a scheduled hearing and does not contact the division of hearings and appeals with good cause for postponement.

(c) An applicant for or recipient of medical assistance is not entitled to a hearing concerning the identical dispute or matter under both this section and 42 CFR 431.200 to 431.246.

HFS 10.56 Continuation of services. (1) REQUEST FOR CONTINUATION OF SERVICES. Prior to reducing or terminating services under the family care benefit, a CMO shall provide to the enrollee prior notification of its intent to reduce or terminate the services in accordance with s. HFS 10.52 (3). If an enrollee who has received a notice that services will be reduced or terminated files a grievance under s. HFS 10.53 (2), or requests a department review under s. HFS 10.54 or a fair hearing under s. HFS 10.55 related to the reduction or termination of

services and before the effective date of the reduction or termination, the enrollee may request that the CMO continue to provide the services pending the outcome of the grievance, department review or fair hearing.

(2) REQUIREMENT FOR CONTINUATION. The CMO may not reduce or terminate services under dispute pending the outcome of the enrollee's grievance under s. HFS 10.53 (2), department review under s. HFS 10.54 or fair hearing under s. HFS 10.55 if a request for continued benefits was made under sub. (1).

(3) CURRENT LIABILITY. The enrollee shall be liable for the cost of services provided during the period in which services have been continued under this section if the outcome of the grievance, department review or fair hearing is unfavorable to the enrollee. The CMO shall notify in writing an enrollee who requests continuation of services under this section of the potential for liability under this subsection and the time period during which the enrollee will be liable. If the department or its designee determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided, the department may waive or reduce the enrollee's liability under this subsection.

HFS 10.57 Cooperation with advocates. (1) DEFINITIONS. In this section:

(a) "Advocate" means an individual or organization whom a client has chosen to assist him or her in articulating the client's preferences, needs and decisions.

(b) "Cooperate" means to provide any information related to the client's eligibility, entitlement, cost sharing, care planning, care management, services or service providers to the extent that the information is pertinent to matters in which the client has requested the advocate's assistance.

(2) COOPERATION WITH ADVOCATES. The department and each resource center and CMO shall cooperate with any advocate selected by a client. Nothing in this section allows the unauthorized release of client information or abridges a client's right to confidentiality.

SUBCHAPTER VI – RECOVERY OF PAID BENEFITS

HFS 10.61 Recovery of incorrectly paid benefits. County agencies, on behalf of the department, shall recover benefits incorrectly paid under the family care benefit, whether paid on behalf of individuals eligible for medical assistance or not, according to provisions of s. 49.497, Stats., s. HFS 108.03 (3) and policies established by the department or by the department of workforce development. The amount to be recovered is the amount actually paid by a CMO on behalf of a family care enrollee.

HFS 10.62 Recovery of correctly paid benefits. (1) RECOVERY FROM THE ESTATE OF AN ENROLLEE. The department shall file a claim against the estate of an enrollee to recover for the costs the family care benefits provided under s. 46.286, Stats., on and after January 1, 2000. Recoveries from the estates of all family care enrollees shall be made in accordance with the provisions in ss. 49.496(1), (3), (6m) and (7) and 867.035, Stats., and s. HFS 108.02 (11) and (12), except as follows:

(a) The amount to be recovered under this section shall be the actual cost of services received by an enrollee through the family care benefit as reported to the department by the CMO in which the person was enrolled.

(b) Recovery under this section from the estate of an enrollee who was not found eligible under s. 46.286 (1) (b) 1. b., Stats., and who did not receive services that are recoverable under s. 46.27 (7g), 49.496 (3) or 49.682, Stats., shall be treated as follows:

1. Except as provided in subd. 2., an amount of the liquid assets owned by the enrollee on the date of death, equal to the amount of countable assets that were disregarded under s. HFS 10.34 (3) (b) 2. b. or c. at the enrollee's initial eligibility determination for the family care benefit, shall be unavailable to pay the department's claim to the extent that the amount of liquid assets exceeds the amount of claims paid having a higher priority than the department's claim under s. 859.25, Stats.

2. Assets that come to an enrollee's estate from an independence account under s. HFS 10.34 (3) (d) are available to pay the department's claim.

(2) LIENS ON THE HOMES OF NURSING HOME RESIDENTS AND INPATIENTS AT HOSPITALS. The department may obtain a lien on an enrollee's home if the enrollee resides in a hospital and is required to contribute to the cost of care, or if the enrollee resides in a nursing home, and the enrollee cannot reasonably be expected to be discharged from the hospital or nursing home and return home. The department shall obtain liens under this subsection in accordance with the provisions in s. 49.496 (1) and (2), Stats. The lien is for the amount that is recoverable under sub. (1) and for costs that are recoverable under ss. 49.496 and 867.035, Stats.

(3) USE OF FUNDS. The department shall deposit amounts recovered under this section as follows:

(a) Amounts that were recovered for MA eligible enrollees shall be paid to the appropriation under s. 20.435 (4) (im), Stats.

(b) Amounts that were recovered for non-MA eligible enrollees shall be paid to the appropriation under s. 20.435 (7) (im), Stats.

(4) HEARING RIGHTS. An enrollee's exclusive administrative hearing rights are those specified in s. 49.496 (2), Stats., and s. HFS 104.01 (5) for liens and in s. HFS 108.02 (12) for hardship waivers.

SUBCHAPTER VII — ASSURING TIMELY LONG-TERM CARE CONSULTATION

HFS 10.71 Certification by secretary of availability of resource center. When the secretary determines that a resource center is prepared to receive referrals from hospitals and long-term care facilities under ss. HFS 10.72 and 10.73, the secretary shall certify to each county, hospital and long-term care facility that serves residents of the geographic area served by the resource center the date on which the resource center is first available to provide pre-admission consultation and functional and financial screens for the family care benefit. To facilitate phase-in of services of resource centers, the secretary may certify that the resource center is available for a specified target population or for specified facilities in the area of the resource center. The

secretary may make more than one certification for a resource center during the time that it phases in its services.

HFS 10.72 Information and referral requirements for hospitals. (1) PURPOSE. This section implements s. 50.36 (2) (c), Stats., which directs the department to promulgate rules requiring hospitals to refer certain patients to a resource center and s. 50.38, Stats., which establishes penalties for hospitals that do not comply with the requirements.

(2) APPLICABILITY. This section applies to a hospital only to the extent that the secretary has certified under s. HFS 10.71 that one or more resource centers are available for referrals from the hospital of a specified target population.

(3) REQUIRED REFERRALS. Except as provided in sub. (4), prior to discharging a patient who is aged 65 or older or who has a physical or developmental disability and whose disability or condition requires long-term care that is expected to last at least 90 days, the hospital shall refer the patient to the resource center serving the county in which the person resides. When the hospital makes the referral, the hospital shall provide information to the patient about resource center services and the family care benefit, as specified by the department.

(4) EXEMPTIONS. The hospital shall refer an individual in accordance with sub. (3) unless any of the following apply:

(a) The person is under the age of 17 years and 9 months.

(b) A functional screen under s. HFS 10.33 has been completed for the person within the previous 6 months.

(c) The person is an enrollee of a care management organization.

(5) PENALTIES. (a) *Forfeiture.* If the department finds that a hospital has not complied with the requirements of this section, it may directly impose on the hospital a forfeiture of not more than $500 for each violation. If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the hospital. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the hospital of the right to a hearing under par. (b).

(b) *Right to fair hearing.* A hospital may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (a), a written request for a hearing under s. 227.44, Stats., to the division of hearings and appeals in the department of administration. The hearing shall be scheduled and conducted in accordance with the requirements of s. 50.38, Stats.

Note: A hearing request should be addressed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI.

(c) *Payment of forfeitures.* All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (b), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund.

HFS 10.73 Information and referral requirements for long-term care facilities. (1) PURPOSE. This section implements ss. 50.033 (2r) to (2t), 50.034 (5m) to (5p) and (8), 50.035 (4m) to (4p) and (11) and 50.04 (2g) to (2i), Stats., which establish requirements for adult family homes, residential care apartment complexes, community-based residential facilities and nursing homes to provide information to prospective residents and to refer certain prospective or newly admitted residents to a resource center and establish penalties for non-compliance.

(2) APPLICABILITY. Except as otherwise specified, this section applies to nursing homes, community-based residential facilities, adult family homes and residential care apartment complexes. This section applies to a long-term care facility only to the extent that the secretary has certified under s. HFS 10.71 that one or more resource centers are available for referrals from the facility for one or more specified target groups.

(3) PROVISION OF INFORMATION REQUIRED. Subject to sub. (2), the long-term care facility shall give to each prospective resident, the resident's guardian, or a representative designated by the resident written information about the services of a resource center, the family care benefit and the availability of screening to determine the prospective resident's eligibility for the family care benefit. The facility shall provide the information at the time it first provides, in response to a request from the person or his or her representative, any written information about the facility, its services or potential admission, or at the time that it accepts an application for admission from the person, whichever is first. The written information shall be provided to the facility by the department or by the resource center that is the subject of the information. The facility shall obtain written verification from the resident, the resident's guardian, or a representative designated by the resident, that the information was provided.

(4) REQUIRED REFERRAL. (a) Subject to sub. (2) and at the time that required information under sub. (3) is provided, a long-term care facility shall refer to the resource center serving the county in which the person resides, a person whose disability or condition is expected to last at least 90 days and who is at least 65 years of age or has a developmental or physical disability, unless any of the following applies:

1. The person is under the age of 17 years and 9 months.

2. A functional screen under s. HFS 10.33 has been completed for the person within the previous 6 months.

3. The person is seeking admission to the long-term care facility only for respite care.

4. The person is an enrollee of a care management organization.

5. The long-term care facility has been notified that the person was referred to the resource center by another entity within the previous 30 days.

(b) If the long-term care facility admits a person without referral because the person's disability or condition is not expected to last at least 90 days, the facility shall later refer the person to the resource center if the person's disability or condition is later expected to last at least 90 days. The facility shall refer the person within three business days of determining that the person's disability or condition is likely to last longer than was expected at the time of admission.

(c) A person seeking admission or about to be admitted to a long-term care facility on a private pay basis who is referred to a resource center need not provide financial information to a

resource center or county agency, unless the person is expected to be eligible for medical assistance within 6 months or unless the person wishes to apply for the family care benefit.

(5) PENALTIES FOR RCACs AND CBRFs. (a) *Forfeiture*. If the department finds that a residential care apartment complex or a community-based residential facility has not complied with the requirements of this section, it may directly impose a forfeiture of not more than $500 for each violation. If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the facility. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the facility of the right to a hearing under par. (b).

(b) *Right to hearing.* A residential care apartment complex or a community-based residential facility may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (a), a written request for a hearing under s. 227.44, Stats., to the division of hearings and appeals in the department of administration. The hearing shall be scheduled and conducted in accordance with the requirements of ss. 50.034 (8) (c) and 50.035 (11) (c), Stats.

Note: A hearing request should be addressed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI.

(c) *Payment of forfeitures*. All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (b), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund.

(6) PENALTIES FOR NURSING HOMES. Failure to comply with the requirements of ss. 50.04 (2g) and (2h), Stats., and this section is a class "C" violation under s. 50.04 (4) (b) 3., Stats.

HFS 10.74 Requirements for resource centers. The department shall establish, through its contracts with resource centers, minimum timeliness requirements for completion of resource center duties related to responding to referrals from hospitals and long-term care facilities. Minimum timeliness requirements shall specify that the resource center initiate contact with the person who was referred or the person's designated representative as soon as practical following receipt of a request or referral for the screen or for long term care services. The resource center's initial contact is for the purpose of informing the person about the family care benefit and the availability of functional and financial eligibility screens and long-term care options consultation, and for setting an appointment to provide further consultation and to conduct the screen. The consultation provided by the resource center shall meet the requirements for long-term care options counseling under s. HFS 10.23 (2) (b) and shall be provided in conjunction with performance of the functional and financial eligibility screens or at another mutually agreed upon time.

SECTION 2. HFS 68.04 (1) is amended to read:

HFS 68.04 (1) PROGRAM ADMINISTRATION. (a) The program shall be administered in each county by a county agency or, if the county board is not participating in the program, by a private nonprofit organization selected by the department under sub. (3).

(b) The department may suspend the requirement in par. (a) for a county in which a care management organization is under contract with the department to deliver the family care benefit under ch. HFS 10.

SECTION 3. HFS 82.06 (2m) is created to read:

HFS 82.06 (2m) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the home under s. HFS 10.71, an adult family home shall provide information to prospective residents and refer residents and prospective residents to an aging and disability resource center as required under s. 50.033 (2r) to (2t), Stats., and s. HFS 10.73.

SECTION 4. HFS 83.06 (7) is created to read:

HFS 83.06 (7) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the facility under s. HFS 10.71, the facility shall provide information to prospective residents and refer residents and prospective residents to an aging and disability resource center as required under s. 50.035 (4m) to (4p), Stats., and s. HFS 10.73.

SECTION 5. HFS 88.06 (1) (a) 4. and (4) are created to read:

HFS 88.06 (1) (a) 4. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the home under s. HFS 10.71, information about the services of an aging and disability resource center, the family care benefit and the availability of screening to determine the prospective resident's eligibility for the family care benefit, as required under s. 50.033 (2r) and (2t), Stats., and s. HFS 10.73 (3).

(4) REFERRAL TO RESOURCE CENTER. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the home under s. HFS 10.71, an adult family home shall refer a prospective resident to the aging and disability resource center as required under s. 50.033 (2s) and (2t), Stats., and s. HFS 10.73 (4).

SECTION 6. HFS 89.29 (1m) is created to read:

HFS 89.29 (1m) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the residential care apartment complex under s. HFS 10.71, the residential care apartment complex shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.034 (5m) to (5p), Stats., and s. HFS 10.73.

SECTION 7. HFS 105.47 (1) is amended to read:

HFS 105.47 (1) CONTRACTS AND LICENSING. ~~For~~ Except as provided in sub. (3), for MA certification, a health maintenance organization or prepaid health plan shall enter into a written contract with the department to provide services to enrolled recipients and shall be licensed by the Wisconsin commissioner of insurance.

SECTION 8. HFS 105.47 (3) is created to read:

HFS 105.47 (3) CARE ORGANIZATIONS PROVIDING THE FAMILY CARE BENEFIT. A care management organization under contract with the department under s. HFS 10.42 is not required to be licensed by the Wisconsin commissioner of insurance if both of the following apply:

(a) The organization enrolls only individuals who are eligible under s. 46.286, Stats.

(b) The services offered by the organization do not include hospital or physician services.

SECTION 9. HFS 107.28 (1) (c) is created to read:

HFS 107.28 (1) (c) *Family care benefit.* A care management organization under contract with the department to provide the family care benefit under s. HFS 10.41 shall provide those MA services specified in its contract with the department and shall meet all applicable requirements under ch. HFS 10.

SECTION 10. HFS 124.255 is created to read:

HFS 124.255 Referral to aging and disability resource center required. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the hospital under s. HFS 10.71, the hospital shall refer patients to the aging and disability resource center as required under ss. 50.36 (2) (c) and 50.38, Stats., and s. HFS 10.72.

SECTION 11. HFS 132.52 (7) is created to read:

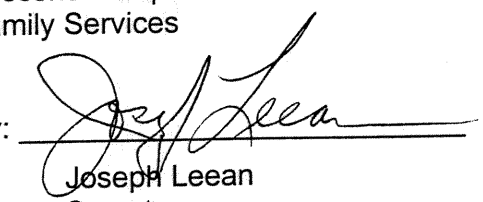
HFS 132.52 (7) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the facility under s. HFS 10.71, the facility shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.04 (2g) to (2i), Stats., and s. HFS 10.73.

SECTION 12. HFS 134.52 (5) is created to read:

HFS 134.52 (5) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (40), is available for the facility under s. HFS 10.71, the facility shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.04 (2g) to (2i), Stats., and s. HFS 10.73.

The rules contained in this order shall take effect as emergency rules upon publication in the official state newspaper as provided in s. 227.24 (1) (c), Stats.

Wisconsin Department of Health and Family Services

By: 

Joseph Leean
Secretary

Dated: January 25, 2000

SEAL:

SENATOR JUDITH B. ROBSON
CO-CHAIR

P.O. Box 7882
MADISON, WI 53707-7882
(608) 266-2253

REPRESENTATIVE GLENN GROTHMAN
CO-CHAIR

P.O. Box 8952
MADISON, WI 53708-8952
(608) 264-8486

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

June 23, 2000

Joe Leann, Secretary
Department of Health and Family Services
1 West Wilson Street, Ste. 650
Madison, WI 53702

Dear Secretary Leann:

The Joint Committee for the Review of Administrative Rules met in Executive Session on June 21, 2000 and adopted the following motions:

Emergency Rule HFS 10

Relating to familycare. Submitted by the Department of Health and Family Services.

Moved by Representative Grothman, seconded by Senator Welch that, pursuant to s. 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective date of HFS 10 by 60 days, at the request of the Department of Health and Family Services.

Ayes: (10) Representatives Grothman, Gunderson, Seratti,Kreuser and Black; Senators Robson, Grobschmidt, Shibilski, Schultz and Welch.

Noes: (0)

Absent: (0)

Emergency Rule HFS 12 and App. A

Relating to caregiver background checks. Submitted by the Department of Health and Family Services.

Moved by Representative Grothman, seconded by Senator Welch that, pursuant to s. 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective date of HFS 12 by 51 days, at the request of the Department of Health and Family Services.

Ayes: (10) Representatives Grothman, Gunderson, Seratti,Kreuser and Black; Senators Robson, Grobschmidt, Shibilski, Schultz and Welch.

Noes: (0)

Absent: (0)

Pursuant to s. 227.24(2)(c) Stats, we are notifying the Secretary of State and the Revisor of Statutes of the Committee's action through copies of this letter.

Sincerely,

Senator Judith Robson
Senate Co-Chair

Representative Glenn Grothman
Assembly Co-Chair

JBR:GSG:mjg

cc: Secretary of State Doug LaFollette
Revisor of Statutes Gary Poulson

JUL 27 2000

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

July 27, 2000

The Honorable Judy Robson, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Senator Robson:

The Department of Health and Family Services has an emergency rulemaking order in effect that will expire before the emergency rules are replaced by permanent rules unless the effective period of the emergency order is extended. Pursuant to s. 227.24 (2), Stats., I ask the Joint Committee to extend the effective period of the emergency order by the number of days indicated below. The emergency rule is as follows:

Family Care. The order creating ch. HFS 10, the Department's rules for the family care program, allowed the Department to administer a flexible Family Care benefit to help arrange or finance long-term care services to older people and adults with physical or developmental disabilities. The Family Care program was enacted as part of 1999 Wisconsin Act 9. The benefit is an entitlement for those who meet established criteria. It may be accessed only through enrollment in Care Management Organizations (CMOs) that meet requirements specified in the legislation.

The Act also authorizes the Department of Health and Family Services to contract with Aging and Disability Resource Centers to provide broad information and assistance services, long-term care counseling, determinations of functional and financial eligibility for the Family Care benefit, assistance in enrolling in a Care Management Organization if the person chooses to do so, and eligibility determination for certain other benefits, including Medicaid and other services.

The emergency rules interpret 1999 Wisconsin Act 9, the main body of which is in ss. 46.2805 to 46.2895, Stats. The Department of Health and Family Services is specifically directed to promulgate rules by ss. 46.286 (4) to (7), 46.288 (1) to (3), 50.02 (2) (d) and 50.36 (2) (c), Stats. Non-statutory provisions in section 9123 of 1999 Wisconsin Act 9 require that the rules are to be promulgated using emergency rulemaking procedures and exempts the Department from the requirements under s. 227.24 (1) (a), (2) (b) and (3) of the Stats., to make a finding of emergency. The rules required under the provisions cited above accompany related rules intended to clarify and implement other provisions of the Family Care legislation that are within the scope of the Department's authority.

The emergency rulemaking order creating ch. HFS 10 was published and effective on February 1, 2000. Replacement permanent rules were sent to the Legislative Council for review on March 8, 2000 and taken to several public hearings ending with the hearing held on May 8th. The Department submitted its Legislative Report to the Presiding Officers on June 12, 2000. On June 21, 2000, the Joint Committee extended the effective period of the rule by 60 days, **until August 29, 2000**. On July 25, 2000, the Committee on Human Services and Aging held a hearing on the rules. Given this hearing, I request an extension of the effective period of the emergency rules by **60 days**, through October 28, 2000. If the effective period of the emergency rules is not extended, in the interim, the Department will not have the authority to continue the implementation of the changes defined in Act 9.

A copy of the emergency rulemaking order is attached to this letter. If you have any questions about the emergency rules relating to Family Care, you may contact Charles Jones at 266-0991.

Sincerely,

for Joe Leean
Secretary

Attachments

cc Representative Grothman