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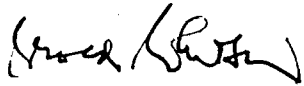
CERTIFICATE

STATE OF WISCONSIN )  
 ) SS  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

I, Gerald Whitburn, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to fiscal management procedures and standards for county administration of the Community Options Program and home and community-based services provided under Medical Assistance program waivers were duly approved and adopted by this Department on December 10, 1992.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 10th day of December, 1992.



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Gerald Whitburn, Secretary  
Department of Health and Social Services

SEAL:

**RECEIVED**

DEC 11 1992  
4:00 pm  
Revisor of Statutes  
Bureau

2-1-93

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DEC 11 1992

Revisor of Statutes  
Bureau

ORDER OF THE  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
ADOPTING RULES

To create HSS 73, relating to fiscal management procedures and standards for county administration of the community options program and home and community-based services provided under Medical Assistance program waivers.

Analysis Prepared by the Department of Health and Social Services

Section 46.27(12) Stats., directs the Department to promulgate rules establishing certain fiscal management procedures for county administration of the Community Options Program (COP) and standards to ensure that the Department makes no more than one payment for an initial case plan prepared by a county agency for a COP participant. Chapter HSS 73 complies with s.46.27(12), Stats., by limiting reimbursement to counties for case plans, requiring a written agreement by the participant, service provider and county agency on the services to be provided, providing guidelines for a county agency to determine when a participant may not receive COP funds directly to pay service providers, requiring supervisory review of the appropriateness and amount of COP funds paid to a participant and incorporating a method for verifying the type and amount of service provided when the participant is the employer. The requirements are made to apply also to administration of home and community-based services funded under a Medical Assistance program waiver.

The Department's authority to adopt these rules is found in ss.46.27(12) and 227.11(2)(a), Stats.. The rules interpret ss.46.27, 46.275(2), 46.277(2) and 46.278(2) Stats.

SECTION I. HSS 73 is created to read:

Chapter HSS 73  
SELECTED FISCAL MANAGEMENT PROCEDURES AND STANDARDS  
UNDER THE COMMUNITY OPTIONS PROGRAM AND MEDICAL ASSISTANCE  
HOME AND COMMUNITY-BASED SERVICES WAIVER

HSS 73.01 Authority and Purpose	HSS 73.06 Development of Service Agreements
HSS 73.02 Applicability	HSS 73.07 Determination of Competence to Receive Service Funds
HSS 73.03 Definitions	HSS 73.08 Supervisory Review of Payment Decisions
HSS 73.04 Assessment and Case Plan	HSS 73.09 Documentation That Services Have Been Provided
HSS 73.05 Reimbursement for Community Options Program Case Plans	

HSS 73.01 AUTHORITY AND PURPOSE. This chapter is promulgated the authority of ss.46.27(12) and 227.11(2)(a), Stats. to establish certain standards and procedures related to assessments, case plans, service agreements, participant payment of service providers and verification that services have been received for county administration of the community options program (COP) under s.46.27, Stats., and county administration of home and

community-based services waivers from medical assistance requirements the department receives from the secretary of the U.S. department of health and human services under 42 USC 1396n(c).

HSS 73.02 APPLICABILITY. This chapter applies to county departments designated under s.46.27(3)(b), Stats., to administer the community options program (COP), and to county departments and private non-profit agencies with which the department contracts to provide home and community-based services through a medical assistance waiver, and to vendors providing assessments, case plans or supportive home care services funded under s.46.27(7), Stats., or under a medical assistance waiver.

HSS 73.03 DEFINITIONS. In this chapter:

(1) "Assessment" means a process for determining a person's functional abilities and disabilities and the person's need for and preferences in regard to medical and social long-term community support services.

(2) "Case manager" means an employe of a county department or vendor agency responsible for locating, managing, coordinating and monitoring the services and informal community supports identified in a participant's case plan.

(3) "Case plan" means a comprehensive community services plan specifying the types and amounts of services to be provided, the methods of service delivery and the coordination with informal community supports.

(4) "COP" means the community options long-term support program under s.46.27, Stats.

(5) "County department" means a county department designated under s.46.27(3)(b), Stats., a county department established under s.46.215, 46.22, 46.23, 51.42 or s.51.437, Stats., which provides home and community-based services under a medical assistance waiver or a private non-profit agency designated by the department to provide services under a medical assistance waiver.

(6) "Department" means the Wisconsin department of health and social services.

(7) "Home and community-based services" means services that are provided under a medical assistance waiver as an alternative to institutional care.

(8) "Household care" means household tasks and home maintenance activities that do not change the physical structure of the home, including shopping, meal preparation, cleaning, laundry, bed-making, simple home repairs, errands and seasonal chores.

(9) "Medical assistance" means the assistance program operated by the department under ss.49.43 to 49.497, Stats.

(10) "Medical assistance waiver" means a waiver granted to the department by the secretary of the U.S. department of health and human services under 42 USC 1396n(c), authorizing the department to provide home and community-based services as part of the medical assistance program.

(11) "Participant" means a person receiving an assessment, case plan or supportive home care services funded under s.46.27(7), Stats., or under a medical assistance waiver.

(12) "Participant's representative" means a person designated in writing by the participant to act on behalf of the participant in making decisions about or directing the provision of services received by the participant.

(13) "Primary caregiver" means the person providing the majority of unpaid, informal care to the participant.

(14) "Private non-profit agency" has the meaning specified in s.46.27(1)(bm), Stats.

(15) "Respite care" means care and supervision to a participant in a homelike environment for purposes of giving the primary caregiver temporary relief, relieving the primary caregiver of the stress of giving continuous support.

(16) "Service provider" means an individual employed to provide supportive home care services to a participant, whether that individual is employed by the participant, the participant's representative, a county department or a vendor agency.

(17) "Supportive home care" means the provision of services except nursing care that are intended to maintain participants in independent or supervised living in the participant's own home or the home of the participant's friends or relatives, which help the participant meet his or her daily living needs, address the participant's needs for social contact, ensure the participant's well being, and reduce the likelihood that the participant will have to move to a nursing home or other alternate living arrangement.

(18) "Vendor agency" means an agency from which a county department purchases supportive home care services for participants.

HSS 73.04 ASSESSMENT AND CASE PLAN. (1) ASSESSMENT. Within the limits of state and federal funds, a county department shall carry out an assessment in accordance with s.46.27(5)(a) and (6), Stats., of any person residing in a nursing home who wants to be assessed for eligibility to receive support services within the community rather than within the nursing home, any person seeking admission to or about to be admitted to a nursing home for whom community services represent an alternative to nursing home residence or any person whom the county department judges would otherwise require nursing home care in the absence of comprehensive community services. The assessment shall include a face-to-face discussion with the person or the person's guardian and any appropriate family member or caregiver. The assessment shall result in an outline of what would be required to enable the person to live at home or in a

homelike setting integrated with the community and to meet the person's preferences for location, type and manner of services provided.

(2) CASE PLAN. The county department shall develop a case plan for non-institutional community services for a person who is assessed and for whom services are feasible, can be financed with available state and federal funds and are preferred to nursing home care by the person or the person's guardian. The case plan shall specify the types and amounts of services to be provided, the manner of service delivery and the assistance to be provided by informal community supports and shall incorporate the participant's preferences to the maximum extent possible.

HSS 73.05 REIMBURSEMENT FOR COMMUNITY OPTIONS PROGRAM CASE PLANS. (1) LIMITS (a) A county department may not be reimbursed for more than one case plan per community options program participant in a 12 month period, except when:

1. The initial case plan does not result in services funded under either the community options program or a medical assistance waiver;
2. A significant change in the participant's condition or life circumstances has occurred; and
3. A new assessment has been completed.

(b) A county department may not be reimbursed for more than 2 case plans for any participant in a 12 month period.

(2) PROCEDURES. Each county department designated under s.46.27(3)(b), Stats., shall adopt fiscal management procedures to ensure that the requirements of sub. (1) are met.

(3) REQUIREMENTS. All case plans submitted for reimbursement under s.46.27(6)(b), Stats., shall meet the requirements for case plans contained in the Community Options Program Guidelines and Procedures.

Note: To obtain a copy of the Community Options Program Guidelines and Procedures write the Bureau of Long Term Support, Division of Community Services, P.O. Box 7851, Madison, Wisconsin 53707-7851.

HSS 73.06 DEVELOPMENT OF SERVICE AGREEMENTS. (1) REQUIREMENT FOR NEGOTIATED AGREEMENT. Except when a county department expects services to be provided for less than 30 days, after an assessment and case plan have been completed and within 2 weeks after the initiation of service by the service provider, an agreement or agreements on services to be provided the participant shall be negotiated.

(2) PARTICIPANT EMPLOYMENT OF SERVICE PROVIDER. If the service provider is employed by the participant or participant's representative, there shall be 2 service agreements unless the county department and the participant or participant's representative decide that a single agreement is preferable. A single agreement involving the county department, participant or participant's representative and service provider shall cover all required

items in the 2 agreements. If there are 2 agreements, they shall be the following:

(a) A signed agreement between the county department and the participant or participant's representative, which shall set out in writing:

1. The specific services that will be provided;
2. The amount of funds the county department will provide;
3. Procedures for transfer of funds by the county department;
4. A requirement that any service provider employed by the participant or participant's representative shall be qualified on the basis of experience, training or both to perform required tasks, and that any training needed by the service provider shall be completed within 6 months after beginning employment or after [revisor to insert effective date of the chapter], whichever is later; and
5. That the county department or a vendor for the county department shall act as fiscal agent for the participant or participant's representative for the purpose of performing the tasks required to comply with wage, benefit and tax laws applicable to the employer, unless the participant or participant's representative makes an informed, knowing and voluntary waiver of the use of a fiscal agent; and

(b) Except as provided in sub. (3), a signed agreement between the participant or participant's representative and the service provider, which shall set out in writing:

1. The services the service provider will perform;
2. The service provider's normal schedule of work or a specification of how scheduling will be accomplished;
3. When and how any training needed by the service provider will be furnished and completed;
4. The service provider's rate of compensation; and
5. Verification and payment procedures to be followed consistent with s. HSS 73.09(1) to (3).

(3) EXEMPTIONS. The service agreement between the participant or participant's representative and service provider under sub. (2)(b) is not required when:

- (a) The services provided are limited to household care;
- (b) The services are provided by spouse of the participant or by the parent of a minor participant; or
- (c) The services are for the purpose of providing respite care.

## (4) COUNTY DEPARTMENT OR VENDOR AGENCY EMPLOYMENT OF SERVICE PROVIDER.

(a) If the service provider is employed by the county department or a vendor agency, there shall be either a single signed agreement among the participant or participant's representative, the county department and, where applicable, the vendor agency, or separate signed agreements, one between the participant or participant's representative and the county department and the other between the participant or participant's representative and the vendor agency.

(b) The agreement or agreements required under par. (a) shall contain at least the content specified in sub. (2)(a)1-4 and (b), except that verification and payment procedures under sub. (2)(b) 5 and training arrangements under sub. (2)(b) 3 may be omitted if these do not directly involve the participant and are covered elsewhere either in written policy of the county department or in its contract with the vendor agency.

HSS 73.07 DETERMINATION OF COMPETENCE TO RECEIVE SERVICE FUNDS. (1)  
DEFINITIONS. In this section:

(a) "Incompetent" has the meaning specified in s.880.01(4), Stats.

(b) "Mental retardation" means significant subaverage general intellectual functioning usually defined as an intelligence quotient (IQ) level of 70 or below accompanied by significant deficits or impairments in adaptive functioning with onset before the age of 18.

(c) "Protective payee" means a person designated by a county department of human services established under s.46.23, Stats., or a county department of social services established under s.46.215 or 46.22, Stats., to be the recipient of a participant's total or partial monthly check for financial assistance or for the purchase of social services.

(d) "Representative payee" means a person or organization selected by the U.S. social security administration to receive social security or supplemental security income benefits on behalf of a beneficiary.

(e) "Social security" means the federal old-age, survivors and disability insurance program under 42 USC 401 to 433.

(f) "Supplemental security income" means the assistance program under 42 USC 1381 to 1383c and s.49.177, Stats..

(2) COUNTY DEPARTMENT RESPONSIBILITY. (a) A county department may give cash grants to COP participants to pay for supportive home care services funded under s.46.27(7). Stats. If a county department gives cash grants to COP participants for this purpose, the county department shall ensure that participants with a demonstrated mental incapacity to make personal decisions about their well-being or a demonstrated lack of ability to use funds properly do not receive funds to pay a service provider. The county department shall establish written criteria for determining when a participant may not receive the funds. The county department's criteria shall, at a minimum, specify that a participant may not receive these funds if any of the following applies:

1. The participant has been adjudged mentally incompetent by a court under s. 880.33, Stats., or is judged by the county department to require a competency hearing according to s. 880.33, Stats., and a petition has been filed;

2. The participant has a representative payee receiving social security benefits or supplemental security income on behalf of the participant, or is determined by the county department to require appointment of a representative payee and a petition has been filed with the U.S. social security administration;

3. The participant has a protective payee;

4. The participant is under the age of 18; or

5. The participant has a diagnosis of mental retardation and the county department has determined the severity to be such that it would preclude the ability to act as an employer and competently manage funds.

(b) The county department shall, upon request, make available a copy of the written criteria under par. (a) to an applicant for services and the applicant's representative or guardian, if any.

(c) If the county department determines that a participant may not receive funds to pay a service provider, the county department may designate a guardian or other person acting as the participant's representative who is willing to receive the funds and, in the county department's judgment, can be counted on to expend the funds properly.

(d) A county department may not give cash grants to participants to pay for supportive home care services funded under a medical assistance waiver.

HSS 73.08 SUPERVISORY REVIEW OF PAYMENT DECISIONS. (1) The county department shall develop and implement written procedures for supervisory review of staff decisions regarding the competence of a participant to receive funds to pay a service provider and appropriateness of the levels of funds based upon the needs identified in the participant's assessment and services authorized in the case plan for the participant.

(2) In conducting a review of a case in which a participant or participant's representative receives funds, the supervisor shall examine:

(a) The capability of the participant or participant's representative to manage funds and act as employer of the service provider;

(b) The adequacy of the funds provided compared to the level of need identified in the participant's assessment; and

(c) The adequacy of any training provided to the participant or the participant's representative to enable the participant or participant's representative to manage funds and serve as an employer.



(3) The supervisor's review shall occur within 3 months after the initial disbursement of funds to a participant who receives funds for the first time on or after [revisor to insert effective date of the chapter] and within 9 months after [revisor to insert effective date of the chapter] for a participant who was receiving payments prior to [revisor to insert effective date of the chapter], and thereafter whenever there is a substantial change to the participant's condition or need for services. Alternatively, the county department may conduct a supervisor's review on a random sample of at least 10% of cases or 25 cases, whichever is greater, in which a participant receives funds. County departments with fewer than 25 cases shall review all cases. This review shall be completed within 12 months after [revisor to insert effective date of the chapter] and within every 12 months thereafter.

(4) A county department may contract with a third party for supervisory review under this section.

HSS 73.09 DOCUMENTATION THAT SERVICES HAVE BEEN PROVIDED. (1) If a participant or the participant's representative employs a service provider, the county department shall verify the type and amount of service for which reimbursement is sought. A verification form developed and available from the county department shall either be submitted to the county department by the participant or participant's representative or be reviewed by the case manager at the participant's residence at least every 6 months.

(2) The completed verification form shall include the following information:

- (a) The type or types of services provided;
- (b) The number of hours of service provided in the past month or, if the service provider lives in the residence of the participant, the number of days of service provided in the past month;
- (c) The total dollar amount paid for the services;
- (d) The month in which the services were provided;
- (e) The dated signature of the participant or participant's representative; and
- (f) The dated signature of the service provider.

(3) The county department may provide in the form under sub.(2) that the information in sub. (2)(b) does not have to be maintained or reported if:

- (a) The services provided are limited to household care;
- (b) The services are for the purpose of providing respite care; or
- (c) The services are provided by the spouse of the participant or by the parent of a minor participant.

(4) If a county department directly provides services or purchases services from a vendor agency, the county department and vendor agency, if any, shall establish procedures sufficient to document the amount of services provided to each participant each month.

The rules contained in this order shall take effect on the first day of the month following their publication in the Wisconsin Administrative Register, as provided by s.227.22(2), Stats.

Wisconsin Department of Health and  
Social Services

Dated: December 10, 1992

By: *Gerald Whitburn*

Gerald Whitburn  
Secretary

SEAL:

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