1997-98 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Joint Committee for Review of Administrative Rules (JCR-AR)

Sample:

- Record of Comm. Proceedings
- 97hrAC-EdR_RCP_pt01a
- 97hrAC-EdR_RCP_pt01b
- 97hrAC-EdR_RCP_pt02

- *Appointments ... Appt*
-
- *Clearinghouse Rules ... CRule*
-
- *Committee Hearings ... CH*
-
- *Committee Reports ... CR*
-
- *Executive Sessions ... ES*
- *97hr_JCR-AR_ES_pt08c*
- *Hearing Records ... HR*
-
- *Miscellaneous ... Misc*
-
- *Record of Comm. Proceedings ... RCP*
-

September 3, 1997

Public Hearing & Exec.

limited exceptions (such as a few weeks post hospital discharge). Given this larger context, it is impossible to argue that 24 hours/day of PDN to children is in fact medically necessary, or that it is in accord with standard practice or established opinion. That is, in effect, what the petitioners are arguing for in this appeal.

Why PDN hours cannot be granted in monthly (or bi-weekly) blocks

As just explained, 24 hours/day of PDN is not usually medically necessary for children. If PDN hours were granted on a weekly, bi-weekly, or monthly basis, there is no feasible limitation to PDN which would preclude the provision of *medically unnecessary* PDN. That is, both a parent and PDN are present and able to monitor (again, with electronic alarms) the child and provide cares during some hours. Thus, it is our view that the PA review criteria and other Medicaid guidelines preclude authorization of PDN hours on yearly, monthly or bi-weekly bases.

One suggestion has been to approve the PDN in monthly blocks with a restriction that it be used only when a parent is absent or unable to provide cares. However, then the PDN is used when parents are absent for vacations. Should WI Medicaid cover 24 hours/day of PDN for a two month old baby while its parents are away on vacation for two weeks? The BHCF can neither develop nor enforce specific guidelines to delineate parental absences. Such judgments are not the purview of a medical insurance program like Medicaid. We believe that the current federal and state Medicaid guidelines make such questions unnecessary, because Medicaid is restricted to medically necessary cares, "not solely for the convenience of the family..." (HFS 101.03 (96m)). The term "convenience" is not here intended as a pejorative; rather, it is a indicator of when home care would be more "respite" than "medically necessary." Respite must be funded through other sources (including county monies or private pay). Respite allows parents to go away for weekends or weeks of vacations. It is not the purpose of a Medicaid program to pay health care providers for providing child care for such absences.

The petitioners' desire for maximum flexibility in PDN hours is understandable. However, the logic of Medicaid guidelines does not allow for that maximum flexibility. As just stated, Medicaid guidelines clearly state that PDN cannot be covered for "respite" nor "convenience." Moreover, if PDN hours were granted in bi-weekly or monthly blocks, *we would be violating PA review criteria* (by ignoring the criterion of medical necessity). Last, if we granted PDN hours in blocks, *we would have no argument to restrict any recipient to less than 24 hours/day, 7 days/week of PDN.* (On what grounds could BHCF limit any PDN to less than 24 hours/day, 365 days/ year?) For Antonio Gaines, we believe that the current PA of "up to 20 hours/day" of PDN is sufficient, appropriate, and does not exceed medical necessity (because parents of a small child are, as parents, present at least 4 hours/day to that child). There is flexibility for them to arrange the PDN as they need on a day-to-day basis-- *up to 20 hours/day and up to 123 hours/week.*

Antonio's independent case coordinator Jennifer Allen, RN submitted a 5/16/97 letter with the amendments which raises serious concerns as to the appropriateness of PDN scheduling. She cites short sleep times for Antonio's foster parents due precisely to "having to wait for the night nurse..." BHCF's 5/21/97 letter expressed concerns about PDN's failing to show up for work as scheduled, and made the same point Ms. Allen raises: It is no more safe for a parent to do a 24-hour shift than for a PDN to do it. (Medicaid allows only 12 hour shifts by PDN's for this very reason of recipient safety and quality of cares.) The excessively long caregiving shifts claimed by the

Grieveldingers appear unsafe, and appear to reflect inappropriate scheduling of PDN hours, The Grieveldingers' covering long time spans due to nurses not showing up raises serious concerns about the child's safety and the providers' practices and case coordination. Every home care plan requires back-up plans for when an individual PDN cannot or does not appear as scheduled. Independent nurses are in fact numerous and available enough to develop an effective back-up or on-call list. Also, if a parent must cover a nurse's shift, the other PDN shifts must be changed to allow the parent to rest. These are issues of *quality* of PDN care and case coordination-- not the *quantity* of PDN hours covered by WI Medicaid. In other words, this is not an argument for more than 20 hours/day of PDN for Antonio.

SUMMARY

Same issue currently under appeal in MPA 67/13569.
PA amendments requested additional PDN hours (as suggested by BHCF during appeal process) , but requested them as 238 hours, plus 8 hours PRN, per 2-week time blocks. The amendments were "modified" to add 13 hours/week, to grant a total of up to 20 hours/day and up to 123 hours/week for Antonio. In effect, the hours per week have been granted, but the BHCF deems more than 20 hours per day of PDN to exceed medical necessity for this child, whose foster parents are competent in his cares.

This case has had extensive review by several BHCF nurse consultants. In light of this fact, we request that the assigned Hearing Officer allow BHCF to review and respond to any new information which may be presented for the following reasons:

1) to expedite approval of covered, medically necessary services in appropriate circumstances;
2) to save time and money for all concerned parties, by resolving disputes at the lowest administrative level, avoiding unneeded administrative hearings;
3) to assist providers and recipients in better understanding PA guidelines and documentation standards; and
4) to ensure that new information is evaluated for relevance by expert clinical consultants and processed according to the PA review criteria outlined in HSS 107.02(3).

We trust this explains the reason for the modification. If you have any questions, please call Ann Pooler, RN; at (608) 267- 9590, or Margaret Guthneck, RN, at (608) 261- 6739. Thank you.

Sincerely,

Ann M. Pooler, RN
Nurse Consultant
Bureau of Health Care Financing

LEGAL AID SOCIETY OF MILWAUKEE, INC.

229 East Wisconsin Avenue, Suite 200
Milwaukee, Wisconsin 53202-4231
(In the historic Railway Exchange Building, southwest corner of Wisconsin & Broadway)
Telephone: (414) 765-0600
Fax: (414) 291-5488

September 3, 1997

Joint Committee on the Review of Administrative Rules
State Capitol
Madison, Wisconsin

Dear Committee Members:

My name is Paula Lorant. I am an attorney with the Legal Aid Society of Milwuakee. I represent several ventillator-dependent children who are facing reductions in their skilled private duty nursing benefit as a result of BHCF's policies concerning parenting and 24 hour care.

All of these children require a skilled caregiver 24 hours per day. That is not to say that the families are requesting Medical Assistance reimbursement for private duty nursing 24 hours per day, seven days per week. Rather, for years, each of these families have developed plans of care, as ordered by the child's treating physician in consultation with the caregivers, and which were approved by BHCF, whereby certain hours of private duty nursing were authorized on a weekly, bi-weekly, or monthly basis. For years, these hours of care were approved by BHCF without a daily cap on how those hours were to distributed over time. For years, these plans of care were approved by BHCF consistent with the skilled care needs of the child, without reference to any vague notions of parenting limitations on Medical Assistance coverage. The only limitation on these approved plans of care was that the private duty nursing hours used not exceed the total hours authorized for the relevant period of time, whether that be weekly, bi-weekly, monthly, or semi-annually. For years, therefore, these fragile recipients and their families had flexibility to distribute the approved hours of care so that the medical needs of the child could be safely and competently met, while still allowing the families to accomodate unforeseen events and meet other family responsibilities.

Recently, BHCF has begun to modify and reduce these long-standing plans of care. BHCF's actions were not compelled by changes in applicable federal or state statutes or regulations; the law has not changed. Similarly, BHCF's modifications were not based on new factual determinations; these children's medical condition and nursing needs did not change or improve so that a reduction in hours of care would be medically or factually

justified, nor did the family's circumstances change so that parents were more available or able to provide additional care than in the past. Instead, these reductions in authorized care were motivated by BHCF's own, newly developed interpretaion of existing law, and creation of a new parenting standard. Recipients and their familes were first notified of this new standard only when it was cited as the basis for the denial of their prior authorization requests.

According to BHCF's parenting standard, all parents must be present for their young children at least a few hours each day and, therefore, there is no medical necessity for private duty nursing when a parent is present and able to provide cares. Based upon this parenting standard, many families experienced a reduction in the total number of authorized private duty nursing hours. Moreover, because this new standard no longer allowed for 24 hour care, all families had, for the first time, a daily cap imposed, limiting the number of private duty nursing hours that could be used in any given day. As a result, children and their families lost critically needed flexibility. Under this standard, the distribution of approved hours of care is now controlled by consultants in Madision rather than by the family and caregivers who are actually responsible for the delivery of such care.

This parenting standard and daily cap, although not reduced to writing in provider handbooks or bulletins, is, nevertheless, a rule, illegally promulgated, and void. These standards meet the statutory definition of a rule. They are policy statements of general application, announcing how BHCF will make decisions on prior authorization requests for private duty nursing for ventillator dependent children now and in the future. The policies are applied uniformly, despite individual differences in cases as to the number of parents in the home, whether one or both parents work outside of the home, whether there are other minor children in the home, and in total disregard for the other demands on parents' time and other family obligations. In describing these parenting and 24 hour standards in various cases, BHCF itself made it clear that they were announcing and applying generalized limits on private duty nursing coverage available for children under Wisconsin's Medical Assistance Program. BHCF has stated; "Parenting is not covered by the WMAP"; "24 hour per day private duty nursing for a child is not covered under the WMAP"; "given the expectation that parents provide some cares for their children, 24 hours/day of private duty nursing is usually not medically necessary under Wisconsin Medicaid guidelines".

In addition to being a general statement of policy, these standards meet the remaining critereon of a rule as defined in the statutes. The standards have the effect of law. They have been and apparently will continue to be used as the legal basis for the reduction in levels of care that these children would otherwise be eligible to receive. Finally, they are used by BHCF to implement and interpret the private duty nursing benefit of the Wisconsin Medical Assistance Program in a manner inconsistent with both past interpretation and with the current regulatory language.

These standards are not mere restatements of already existing rules on medical necessity. Current regulations contain the same definition of medical necessity as existed in the past when BHCF found the same plans of care to be medically necessary and appropriate, and approved them without a daily or weekly cap. No parenting exclusion has been added to the list of non-covered services in the private duty nursing benefit. No definition of parenting as been added to the regulations notifying recipients of their obligations and the limits on coverage. The private duty nursing benefit itself has remained the same, with the only hourly requirement being a threshold to eligibility, that the recipient require more than eight hours per day of skilled care. No ceiling has been added which would limit the daily hours to less the 24. No change has been made to BHCF's own provider handbook which makes parental participation in the plan of care voluntary, and not a condition of coverage. In establishing these 24 hour and parenting standards, DHFS through BHCF has abandoned its long standing interpretation and application of existing regulations. When an administrative agency makes such changes in policy, it is engaging in administrative rule-making. The fact that BHCF has yet to reduce these new policies to writing does not make them any less of a rule. The policies meet the statutory definition of a rule and BHCF's failure to promugate them according to the requirements of Chapter 227 render those policies void.

Since these policies were not properly promulgated as rules, the people most affected by them, children and their families, were denied the ability to comment and were left with policies that are arbitrary and capricious, and impose significant hardships. These polices are arbitrary in that there appears to be no ascertainable standards governing their application. For example, what is parenting? Is parenting the same as providing skilled nursing care as BHCF seems to require? What is the general expectation of some care that parents are to provide to medically fragile children? Why is "some care" limited only to hands-on care? Why should the time parents devote to consulting with physicians and nurses, ordering supplies, arranging therapy visits, communicating with schools discounted? When is the parent available for a child? Is mere presnce in the home the same as available? What about a parent's obligation to other minor children? Can BHCF require parents to devote certain hours of a day to the exclusive care of one child but not the other? Should any policy regarding parenting acknowledge the variety of other household tasks parents are required to perform, to say nothing of the normal human need for relaxation and solitude? How did BHCF determine that a few hours of a parents presence means four hours per day? On what basis does BHCF conclude that adequate parenting is determined by quantity rather than quality of time?

BHCF's parenting and 24 hour policies are similarly capricious. Because of the application of these policies, long-standing plans of care have been reduced, or the distribution of approved hours restricted without a corresponding showing that the child's medical needs have changed such that the reduction in care would be factually justified. In many instances, the imposition of the daily cap results in no cost savings to the Department since the total hours of private duty nursing approved matches the hours requested. The only difference is BHCF seeks to control the distribution of those same

hours to less that 24 per day, despite the medical condition of the child or other demands on the family in a given day.

The imposition of these illegally promulgated rules creates a significant hardship on these medically fragile children and the caregivers responsible for their well-being. These children are dependent on the skilled care of others for the most basic life function, breathing. Many require total care around the clock. These children live at home with families who face constant stress associated with their care needs and demands. Medical studies have documented that this stress increases over time, and can impede the parent's ability to safely and alertly deliver the needed care.

In order to maintain these children at home, families have scheduled every aspect of life down to at least the half-hour. However, not every aspect of life is capable of scheduling. Nurses, parents, siblings get sick, other family members need help, parents may need to work overtime or travel, a sibling may have a school performance, a parent may need to sleep later. When unanticipated events occur, these families cannot simply call a baby sitter. What they need and have had up to now is flexibility to distribute the approved hours of care so that accomodations can be made without jeopardizing the child's health or safety. BHCF's daily cap eliminates this flexibility by denying families the ability to extend or rearrange daily schedules as required.

I urge this committee to find that BHCF's parenting and 24 hours policies are rules, illegally promulgated, and void. Additionally, because those policies are both arbitrary and capricious, and create a hardship on recipients and their families, I ask that the policies be suspended.

Thank you for your attention and consideration.

Sincerely yours,

Paula K. Lorant
Attorney at Law

MEDICAID FUNDING CUTS FOR HOME HEALTH CARE OF SEVERELY HANDICAPPED AND TECHNOLOGY-DEPENDENT CHILDREN: PARENTS BEARING THE BURDEN, HOLDING THE BAG

We are writing to express our concern regarding recent cuts in Title-19 (Medicaid) funding for home health care of severely handicapped and/or technology-dependent infants and children in Wisconsin. Not only are these children and their families faced with the physical burden, the out-of-pocket expenses, and the day to day challenges of the medical care in these situations, but face the stress and family disruption which coexist with the care of a technology-dependent child in the home. There are significant quality of life issues in these children and their families under the best of circumstances. This includes high levels of stress due to the chronically ill child's medical condition, the compromise of family functions, and when home nursing care is needed (often), from the intrusion of strangers into the home (references 1-3).

Our youngest child, Andrew (date of birth 1-18-94), is one of seven children, has a chromosome abnormality, is ventilator (breathing machine) dependent and significantly handicapped and developmentally delayed. We receive Title 19 benefits for him through the Katie Beckett program for durable medical equipment, pharmaceuticals, therapies and home health nursing services. We are grateful for these services, for without them he could not live at home and would very likely be much more developmentally delayed, and enjoy even less quality of life than he has now.

Historically, Medicaid funded family support services have attempted to have a positive effect on families such as ours, with stated goals including the care of these children in their homes rather than institutions, reduced family stress, increased time away from the demands of skilled nursing care delivered by the parent, resulting in the capacity to keep up with at least some household routines, to improve skills of coping with the child's habilitating needs, and to improve the overall quality of life (reference 3). Our understanding is that Wisconsin has previously prided itself in providing family-centered care for what one State official has termed this "most fragile" population. We are extremely concerned with recent cuts in funding for these children, particularly involving home care nursing hours. Nursing care is vital to the aforementioned goals, and we have grave doubts regarding the long-term physical and psychological well-being of families affected by the cuts. Deterioration of coping skills for the primary parent or guardian caretaker has already been demonstrated (reference 4). These cuts may be particularly devastating to central city families who already face problems of lack of access to home health providers, lack of adequate social support networks and unsafe neighborhoods.

Under the guise of cutting remarks by some officials of preventing "drop-out parents", these cuts have already left some families with nursing services only for the hours the parent is wage-earning or sleeping (and sometimes even less). Home health nurses are not allowed by regulation to care for these children more than 60 hours per week, yet parents are routinely asked to do this, while at the same time trying to raise their other children, feed, clean, maintain and otherwise run a household. We have been told that the state will not pay for respite care. In the words of one official, "We understand that now and then you and your husband need a night out, or that you may want to do something with your other children, however you may not use state money to do this". We were instructed to seek other sources for respite care. Realistically speaking there <u>are no other sources</u>. Respite care programs (e.g.. Family Support Programs, UCP) have two to three year waiting lists and are generally inadequate for care of complicated cases such as our son. Caring for Andy requires tremendous amounts of mental and physical energy over and above the care of our other six children. We are not asking for a week in the Bahamas every three months, but rather brief respite periods to retain our sanity. The need for families of severely handicapped children to have time away should be intuitively obvious.

There are those officials that deny that any philosophical change has been made regarding funding for these children, however a shift in the State's approach is painfully obvious to the many involved families. There is an appeal process; however, it appears to be of little practical value. The appeal process is not family friendly due to the red tape, time and stress involved, and few appeals are successful. Often demands for reducing home nursing hours are placed at the bottom of the previously approved Prior Authorization, and approved "PAs" cannot be appealed. If families appeal a denied PA within 10 days, it may maintain the requested hours in the home, but if the family loses the appeal, it is financially responsible for the net difference in approved hours. What working class or indigent family could pay for even a few hours of care?

We understand the State's desire to reduce spending, particularly in light of public demand for lower taxes, and we have been told that there just is not the money to go around (although we have also been told of a recent Medicaid surplus). We want to do our part to minimize costs when we can, but parents of these children feel like we will be left holding the bag in this circumstance. The responsibility for the care and well-being of these children has been delivered to us by a medical community which insists that life should be prolonged using whatever medical technology is available, at almost any cost. In our particular case, we sought an ethics committee hearing regarding the appropriateness of the burden to Andrew and society of prolonging his life in this fashion. Part of the "selling" to us of the prolonged extraordinary care was the promise that we would have the resources needed to take care of Andy at home within the context of our family. We would need only "to be the parents". Now it seems that the rug is slowly (or not so slowly) being pulled out from under us. With the impending availability of pediatric nursing homes that may offer rates below that of home care, parents are very frightened of being coerced into accepting extremely burdensome cuts in home nursing in order to avoid institutionalization of their child.

It seems clear that the technological aspects of the care of these children has far outdistanced the sociologic and financial aspects of this care, as well as the ethical reflection upon the prolongation of life in this manner in these children.. The solution is not to lay this burden on the parents of these children. To paraphrase a great statesman, the greatness of a society is measured by how well it takes of its aged, its sick, its poor and its handicapped. We desperately need your help in this matter, and pray that we can count on it.

Sincerely,

Dennis J. Baumgardner, MD Mary K. Baumgardner

References:
1. Batsaw BM, Parret WM. 1992. Children with Disabilities: A Medical Primer. Baltimore: Paul H. Brookes Publishing Co.
2. Leonard BJ, Brust JD, Choi T. Providing access to home care for disabled children: Minnesota's Medicaid Model Waiver Program. Public Health Report 1989;104:465-72.
3. Knoll J. Being a family: The experience of raising a child with a disability or chronic illness (chapter 2). Monographs of The American Association on Mental Retardation. 1992;18:9-56.
4. Quint RD, Chesterman E, Crain LS, et al. Home care for ventilator-dependent children; psychosocial impact on the family. AJDC 1990;144:1238-41.

Note: The views expressed herein are those personal views of myself and my wife. They are not necessarily the views of my employer or any of its affiliated hospitals, clinics or universities.

My name is Victoria McMurray, I have been providing family, center and community childcare for the past 18 years. Until welfare reform I limited my focus to the children I cared for and their families. Now however I am concerned enough to come here to speak on behalf of the children and families in our community because of the importance of each issue that is handled as we pass through this time of welfare reform.

I hope that all of you are making careful decisions each day about the way that we are supporting our children as the safety net of our society changes. Some people have said that with welfare reform the safety net of our government is gone, not changed. I don't think that we should accept that because we have no reason, as the wealthiest nation in the world, not to provide a safety net to our children. Even if we want to create significant changes for the adult recipients of welfare and how much support they can depend on from the government, we have to ensure that each child who is a Wisconsin citizen, is provided with the opportunity to grow with adequate living standards. Adequate child care is a part of an adequate living standard.

Our state has gotten alot of mileage nationwide out of the money we have put into childcare. We know that the infrastucture of adequate child care will help the welfare transition succeed, so we've touted it. Please do not permit the Department of Workforce Development to make random changes from the base plan that was developed with the support of so many experts in the development of Wisconsin Works and with the adjustments that have followed since. Decisions to create specific co-payments were set for many reasons discussed in great length by a wide range of citizens and governmental representatives. The collective insight is invaluable and while we probably still need to be prepared to make adjustments to the plan as we experience the impact of welfare reform, we can't let administrators of the funds make such critical decisions as increasing parental co-payments by 15% or more without the expertise and the input of others. The decision to alter resources to families has an impact on the whole community, some of which an administrator may not understand and ultimately may not realize the consequences of their decision to change things. Please respect all the people who have given their time and energy to create the best welfare reform transition we know at this time and keep the decision-making in the hands of the citizens of Wisconsin.

As a wealthy nation we have the resources we need to provide "adequate child care" to our children.

As a state that has taken a leadership role in welfare reform we should 'walk the talk'and ensure the money needed to make it work is in place.

And as each of you make the decision that will have an impact on this issue I urge you to protect the collective effort that created the co-payment system by not permitting the Department of Workforce Development the power to change this collective work. Keep the development of welfare reform under the auspices of the State of Wisconsin citizens.

Thank you for caring enough to take the time to listen. Vic McMurray 3 Sep 97

TESTIMONY PRESENTED TO THE
JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES
BY PEGGY L. BARTELS,
DIRECTOR OF THE BUREAU OF HEALTH CARE FINANCING,
DEPARTMENT OF HEALTH AND FAMILY SERVICES

September 3, 1997

Introduction

Good morning, Senator Grobschmidt, Representative Grothman, and members of the Joint Committee for Review of Administrative Rules.

I welcome the opportunity to discuss the issues raised by the request of the Legislative Council Special Committee on Programs for Developmentally Disabled Persons that the JCRAR treat certain Medicaid prior authorization guidelines for private duty nursing (PDN) services as administrative rules. The Special Committee is acting in behalf of some families who have questioned the Department's use of prior authorization guidelines to determine the extent of the recipient's need for private duty nursing because they want assurances Medicaid will cover PDN for their children for 24-hours a day over extended periods of time.

I hope to demonstrate to you that the problems some of these families have encountered with the current PDN guidelines will be accommodated by the Department's proposed guideline revisions, which are nearing completion. It is my hope that the information I will provide your committee today will fill whatever gaps in communication we may have inadvertently allowed to occur between the Department and the Special Committee and with the families whose interests they represent.

In my testimony today, I will specifically address the concerns raised in your August 11, 1997 letter to Secretary Leean.

- First, I will show that the Wisconsin Medicaid PDN benefit is extensive and does, in fact, authorize coverage of 24-hour care, when it is medically necessary and appropriate. Wisconsin's coverage policy is, in fact, extremely generous. However, we do expect parents to participate in the medical care of their children, and I will show you how this expectation is evaluated in our prior authorization decision-making.

- I will also demonstrate that we have heard the concerns families voiced about the policy of prior authorizing PDN on a short-term basis and that we are in the process of revising these policies. I will describe those policy changes to you, even as we move forward with our process for external review and comment, which will culminate in adoption of revised PA guidelines.

- Finally, I will also point out our legal responsibility to limit Medicaid coverage to medically appropriate services only. I will describe to you the use of guidelines in our prior authorization application and review process. It is my hope the JCRAR will see the utility of prior authorization guidelines, which can be revised more efficiently than Administrative Code.

Wisconsin Medicaid PDN Benefit

Private Duty Nursing (PDN) is an optional Medicaid service under federal law. The benefit was first implemented in Wisconsin in 1986 and is limited to Medicaid recipients who require 8 or more hours per day of skilled nursing care, including those who are ventilator-dependent and receive respiratory care services. The purpose of PDN is to help families care at home for medically fragile adults and children.

Wisconsin Medicaid's policy does allow coverage of 24 hours of care. However, we have approved it only under very limited circumstances, including:

- For up to a month after institutional discharge, with significant cares changes, to allow time to teach family caregivers and to stabilize child and routine;
- For a few days or weeks if single parent is hospitalized, or one parent is hospitalized and the other parent is physically or mentally unable to provide any care; and
- To fill the gap until other caregivers can be taught care or until parent can resume them.

Wisconsin is one of only 28 states that has chosen to provide some form of PDN. This year the Department surveyed some of the states that cover PDN services. Of the fifteen states responding to our survey, none pay for 24-hour per day PDN care without some limitations. Most states surveyed have clearly defined limits on PDN services, such as number of hours per day, dollar limits, expenditures equal to equivalent institutional care, or strictly defined medical necessity on a case by case basis. In the Midwest, State Medicaid programs either do not cover 24-hour PDN under any circumstances (Ohio) or cover PDN only under very

exceptional circumstances. All states expect parents to provide some portion of care. (See attached chart.)

Recipients of PDN Care

In CY 1996, the most recent full year for which we have comprehensive data, 410 Medicaid eligibles received PDN care, of whom 335 are children. The children are not easily categorized because of the wide range of their needs for services.

At the low-end are the 65 children whose PDN costs were under $10,000 per child in CY 96. Some are eligible for PDN because they have a continuing medical condition, such as having a tracheostomy, or episodic conditions like seizures or severe breathing problems, requiring skilled nursing on an unpredictable (emergency) basis. Some of those children may be otherwise like their peers--they may run around, go to school, even play on school sports teams. Their care may be quite minimal outside of needing a nurse in case of emergencies or when parents are gone. Some older children can be taught their own tracheotomy care and outgrow the need for PDN.

At the high-end of the range are the 38 children whose PDN costs exceeded $127,000 per child in CY 96. The PDN costs for eleven of these high-end children exceeded $200,000 each. A few of these may be comatose or semi-comatose, such as after a near-drowning or severe oxygen deprivation at birth, and require complete care. Children like these are unable to express any needs. They may need a ventilator. Double alarms systems are used for

possible ventilator problems. These children may have many medications, require tube feedings, or need airway suctioning on a frequent and unpredictable basis. They may need to be turned every two hours, bathed, given range of motion exercises, and continually monitored for problems. Hospitals routinely teach parents to do even the "high-tech" care for these children and ways to respond to emergencies. Hospitals, physicians, and providers continue to advise us that parents should be involved in the medical care of their children. Private duty nurses are needed to supplement the parents' care-giving--at a minimum--when the parents work and sleep. Currently 35 children are receiving 16 or more hours of skilled nursing services per day and 5 receive up to 24 hours per day.

Several factors in the last couple of years have encouraged us to reduce the number of hours of PDN care in selected cases:

- The medical community has developed improved medical equipment and techniques of care whereby ordinary individuals (caregivers) may be taught how to safely and effectively care for the severely disabled under the periodic supervision of PDNs;
- Departmental nurse-consultants have obtained ongoing current expert opinion from UW and Children's Hospital staff intimately involved in the care of the severely disabled children in nursing homes and home settings;
- The Department has hired nurse consultants with personal experience in caring for the severely disabled to perform PDN prior authorization reviews.

These consultants have been able to review current prior authorizations as well as new requests, to insure that the hours authorized conform with the definition of medical necessity found in Administrative Code [HFS 101.03(96m)]. That is, cares requested must be:

- Consistent with the recipient's diagnosis and treatment;
- Appropriate with regard to generally accepted standards of medical practice;
- Not duplicative of other services being provided to the recipient;
- Not solely for the convenience of the recipient or the recipient's family; and
- Cost effective compared to alternative services reasonably available to the recipient's family.

We must also assure that PDN not be authorized as respite care, which is not a covered service under federal law. In addition, we are always concerned about assuring prudent and appropriate expenditures of state taxpayers' money.

Since the PDN benefit is intended to support, not supplant, parental caregiving, the Department has worked from the assumption that when the parents are available in the home and trained to perform these medical functions, 24-hour care is not medically necessary and appropriate.

You may have heard that we used to cover more cases for 24-hour care than we do now. This is true. We have consistently heard from providers, particularly UW Hospitals and Children's Hospital, that it is critically important that families provide some medical cares for children,

or they will not thrive. In fact, they have told us that, in most cases, they will not discharge children until parents are trained to provide some necessary cares. This change in thinking in the "state of the art" for these highly medically involved children has been reflected in our prior authorization judgments.

Over the last several years, the authorized PDN hours (up to 24 hours a day in some cases) of approximately 50 recipients were reduced. Most families and their providers agreed with these changes. Fourteen families appealed the Department reductions. Of those, 12 have reached the hearing decision stage and in all but one case, the hearing officer has upheld the Department decision.

Responsiveness of Current Process

We have listened to the objections to the current PDN guidelines raised by the families of recipients in their correspondence, in their testimony to the Legislative Council Special Committee, and at the Department's own Home Care Providers Advisory Committee. We understand their need for the flexible use of authorized hours to accommodate changes in the recipient's condition, adapt to unforeseen changes in the family's ability to provide care, to maintain quality of care in the event of an unscheduled absence of a provider, and to allow the provider to utilize the allowed hours to maximum efficiency.

Department staff began the process of review and revision of the PDN guidelines prior to the Special Committee's request. We presented a draft summary of the proposed PDN Guidelines

to the Secretary's Home Care Providers Advisory Committee (HCPAC) for review and comment at its August 12, 1997 meeting. Draft Guidelines are being mailed out this week for review by HCPAC members, the Legislative Council Special Committee on Programs for Developmentally Disabled Persons, and other interested individuals.

The changes the Department proposes in the PDN PA Guidelines will:

- Extend the period of time authorized hours may be used, from hours/day/week to hours/day/two week period to be used flexibly under specific circumstances;
- Add to guidelines the circumstances under which hours may be used flexibly, including:
  - ✓ Failure of PDN provider to show up to provide care (we will follow up, wherever possible, if this is a repeated problem with a provider);
  - ✓ After institutional discharge or after significant change in clinical status while in the home setting;
  - ✓ If a single caregiver is hospitalized or one parent is hospitalized and the other parent is physically or mentally unable to provide any cares;
  - ✓ If caregivers are physically, mentally or intellectually unable to provide the needed cares.
  - ✓ We will continue our policy of authorizing care for periods varying from three months to longer, depending on the specified circumstances of the case.

At the direction of Secretary Leean, no future changes will be made in PDN policy without full review by the Home Care Providers Advisory Committee. I note that, in fact, all

significant changes in Medicaid coverage of home care now go through the Home Care Providers Advisory Committee.

PDN Prior Authorization Process

The levels of care and the hours of skilled nursing care paid for by Wisconsin Medicaid are determined through the prior authorization process for PDN. Providers of care determine their patient's need for care and submit written PA requests to Wisconsin Medicaid. The information in the PA request includes the recipient's diagnoses, medications, physical needs and limitations; it documents physician orders; and it proposes a nursing plan of care and treatment for the recipient.

The Department's nurse and physician consultants review the request and, on the basis of the information provided, determine the appropriate level of coverage using the relevant criteria found in the PDN Prior Authorization Guidelines:

- Physician orders;
- Condition of the patient - ventilator dependent, stability;
- Need for interventions (emergency or number of skilled nursing interventions in a 24-hour period);
- Complexity of care; and
- Availability and capability of family caregivers.

The Department then authorizes or reauthorizes, or modifies, hours or levels of care, or disapproves the PA request. We may seek further information from providers and/or physicians and, in some circumstances, make a home visit. We inform providers and encourage them to work with the families. If the hours or levels of care in the request are modified or disapproved by the Department, the family is notified of appeal rights. Our consultants participate in an administrative hearing, if the family appeals the decision.

The Legal Authority for PDN Guidelines

The Legislative Council Special Committee has also questioned the propriety of the Department developing medical discipline-specific guidelines for the consultants to use to insure consistency across cases to prior authorize covered services. This is a larger question than the number of PDN hours or the flexibility families have to use them. This larger question raises implications for 231,000 prior authorization requests the Department processes each year. There are hundreds of medical procedures, services, drugs, medical supplies and equipment covered by Wisconsin Medicaid, each of which has a set of prior authorization guidelines.

Chapter 49.45(1) of the Wisconsin Statutes invests the Department with the responsibility to provide appropriate health care for eligible persons and obtain the most benefits available under Title XIX of the Social Security Act. The Department is required to administer medical assistance, rehabilitative and other services to help eligible individuals and families attain or retain capability for independence or self-care.

The Wisconsin Administrative Code permits the Department to require prior authorization for any covered service to safeguard against unnecessary or inappropriate care [HFS 107.02(3)(b)]. Among the criteria the Department must consider before approving or disapproving a request for prior authorization are medical necessity, as well as appropriateness, effectiveness and cost of the requested service [HFS 107.02(3)(e)].

There are 72,799 procedure codes payable by Wisconsin Medicaid. The Department develops prior authorization guidelines for each of the 3,800 (approximately .05%) specific medical procedures, services or supplies which require prior authorization based on the Administrative Code criteria. The guidelines are exactly that--guidelines for our medical consultants. They are not fixed criteria by which requested services are adjudicated in a rigid or inhumane manner. As medical technology, clinical criteria, and delivery systems and patterns change, our prior authorization guidelines change, keeping pace with services that are both medically necessary and appropriate.

The Department has used prior authorization guidelines for the last 20 years to translate the provisions of the Administrative Code into technical and clinical terminology for use by the medical consultants from many disciplines who apply them to the specific set of facts contained in a prior authorization request. The guidelines are public documents available on request to providers, recipients or other interested parties. Prior authorization guidelines are continuously reviewed and revised in order to respond to advances in medical technology, the

concerns of providers and recipients, and changes in medical practice. The PDN guidelines are a case in point favoring the flexibility, efficiency and responsiveness of PA guidelines and against treating them as rigidly as Administrative Code.

Summary

I'm pleased to have had the opportunity to talk to you about these issues today. In summary, I'd like to stress the following points:

- We believe we have a sound policy regarding Medicaid coverage of private duty nursing.
- Since parents should be involved in the medical care of their children, there are limited circumstances that warrant 24-hour PDN care.
- Through our usual process of amending PA guidelines, we are proposing guidelines that will allow families to use their approved PDN hours more flexibly to accommodate unforeseen family needs.
- We urge your Committee not to diminish the Department's flexibility to accommodate advances in technology, changes in medical practice, and consumer need by treating these technical guidelines as administrative rules.

Thank you very much for the opportunity to address your concerns. I'd be pleased to respond to questions.

PDN Benefits In Wisconsin and Neighboring States

State	PDN Coverage Under Medicaid		Limitations on PDN Benefit			
	Adults	Children	Hours Per Day	Dollars Per Month	Costs Less Than Alternative Care Facility	Other Limitations
Illinois	No	Yes, under a federal waiver program through the Division of Specialized Care for Children.	Determined case by case and based on medical assessment by an attending physician and case manager, then reviewed by Illinois Department of Public Aid (DPA) physician and nurse	No	Yes	No ongoing 24-hour/day PDN care. 24-hour/day PDN care allowed only in short segments on emergency, case-by-case basis. Requires further DPA review and approval.
Indiana	Yes	Yes	Determined case by case and based on strict medical necessity.	No	Yes	24-hour/day PDN allowed only in special circumstances. Homemaker, chore services, and sitter/companion services are not allowed under PDN.
Iowa	No	EPSDT recipients only	16 hours per day if determined "medically necessary;" e.g., treatment needs which exceed intermittent criteria.	No	No	No 24-hour/day PDN. PDN authorized by hours per day in lieu of hours per week to discontinue application of unused PDN hours for respite, vacations, and weekend trips rather than for strict medical necessity.

PDN Benefits In Wisconsin and Neighboring States

State	PDN Coverage Under Medicaid		Limitations on PDN Benefit			
	Adults	Children	Hours Per Day	Dollars Per Month	Costs Less Than Alternative Care Facility	Other Limitations
Michigan	Yes, under an hourly home care program.	Yes, under an hourly home care program.	16 hours per day	No	Yes	24-hour/day PDN allowed short term under very exceptional conditions-- immediate discharge from hospital, primary care-giver(s) illness. Services are not allowed for temporary relief for the care giver.
Minnesota	Yes	Yes	No	Yes	Yes	24-hour/day PDN determined case by case and based on strict medical necessity. PDN cannot be authorized based on family needs: parents' work schedules, to provide respite, as a substitute for day care or baby-sitting services.
Ohio	Yes	Yes	Under the monthly limit, approximately 11 hours per day.	$3,150 to $9,000, based on recipient's condition.	Yes	No 24-hour/day PDN.
Wisconsin	Yes	Yes	No	No	No	24-hour/day PDN determined case by case.

DHFS/BHCF
August 29, 1997
m:\HH828.xls

(89) "Intermediate care facility" or "ICF" means a facility that:

(a) Provides, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care but whose mental or physical condition requires services that are above the level of room and board and that can be made available only through institutional facilities;

(b) Is certified under s. HSS 105.11 as an intermediate care facility provider; and

(c) Is licensed pursuant to s. 50.03, Stats., and ch. HSS 132 or 134.

(90) "Intermediate care services" means services provided by an intermediate care facility.

(91) "Intermittent nursing services" means nursing services provided to a recipient who has a medically predictable recurring need for skilled nursing services. In most instances, this means that the recipient requires a skilled nursing visit at least once every 60 days.

(92) "Laboratory" or "clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobiassay cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention or treatment of any disease or assessment of a medical condition.

(a) "Independent laboratory" means a laboratory performing diagnostic tests which is independent both of an attending or consulting physician's office and of a hospital.

(b) "Hospital laboratory" means a laboratory operated under the supervision of a hospital or its organized medical staff that serves hospital patients.

(c) "Physician's office laboratory" means a laboratory maintained by a physician for performing diagnostic tests for his or her own patients.

Note: A physician's office laboratory which accepts at least 100 specimens in any category during any calendar year on referral from other physicians is considered an independent laboratory.

(93) "Legally responsible" means a spouse's liability for the support of a spouse or a parent's liability for the support of a child as specified in s. 49.90, Stats.

(94) "Legend drug" means, for the purposes of MA, any drug requiring a prescription under 21 USC 353 (b).

(95) "Medical assistance" or "MA" means the assistance program operated by the department under ss. 49.43 to 49.497, Stats., any services or items under ss. 49.45 to 49.47 and 49.49 to 49.497, Stats., and this chapter and chs. HSS 102 to 108, or any payment or reimbursement made for these services or items.

(96) "Medical assistance group" or "MA group" means all persons listed on an application for MA who meet non-financial eligibility requirements, except that each AFDC recipient, SSI recipient, and each child with no legally responsible relative comprises a separate MA group.

(96m) "Medically necessary" means a medical assistance service under ch. HSS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and, consistent with s. HSS 107.035, is not experimental in nature;

6. Is not duplicative with respect to other services being provided to the recipient;

7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

(97) "Medically needy" means the group of persons who meet the non-financial eligibility conditions for AFDC or SSI, but whose income exceeds the financial eligibility limits for those programs.

(98) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 and 42 CFR subchapter B.

(99) "Modality" means a treatment involving physical therapy equipment that does not require the physical therapist's personal continuous attendance during the periods of use but that does require setting up, frequent observation, and evaluation of the treated body part by the physical therapist prior to and after treatment.

(100) "Net income" means the amount of the applicant's income that is left after deductions are made for allowable expenses and income disregards.

(101) "Net market value" means for the purposes of divestment the fair market value of the resource on the date it was disposed of less the reasonable costs of the transaction on the open market.

(102) "Non-billing performing provider number" means the provider number assigned to an individual who is under professional supervision in order to be an eligible provider. A non-billing provider is not directly reimbursed for services rendered to an MA recipient.

(103) "Non-covered service" means a service, item or supply for which MA reimbursement is not available, in-

(3m) "Developmentally disabled" has the meaning specified in s. 51.01 (5).

(3r) "Group health plan" has the meaning given in P.L. 101–508, section 4402 (a) (2).

(4) "Home health agency" has the meaning specified in s. 50.49 (1) (a).

(5) "Hospital" means an institution, approved by the appropriate state agency, providing 24–hour continuous nursing service to patients confined therein; which provides standard dietary, nursing, diagnostic and therapeutic facilities; and whose professional staff is composed only of physicians and surgeons, or of physicians and surgeons and doctors of dental surgery.

(6) "Inpatient psychiatric hospital services for individuals 21 years of age or for individuals under 22 years of age who are receiving such service immediately prior to reaching age 21" has the same meaning as provided in section 1905 (h) of the federal social security act.

(6m) "Institution for mental diseases" has the meaning specified in 42 CFR 435.1009.

(7) "Intermediate care facility" means either of the following:

(a) An institution or distinct part thereof, which is:

1. Licensed or approved under state law to provide, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing home is designated to provide but who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities; and

2. Qualifies as an "intermediate care facility" within the meaning of Title XIX of the social security act.

(b) A public institution, or distinct part thereof, which is:

1. Licensed or approved under state law for the mentally retarded or persons with related conditions, the primary purpose of which is to provide health or rehabilitative services for mentally retarded individuals according to rules promulgated by the department; and

2. Qualifies as an "intermediate care facility" within the meaning of Title XIX of the social security act.

(8) "Medical assistance" means any services or items under ss. 49.45 to 49.47 and 49.49 to 49.497, or any payment or reimbursement made for such services or items.

(9) "Physician" means a person licensed to practice medicine and surgery, and includes graduates of osteopathic colleges holding an unlimited license to practice medicine and surgery.

(10) "Provider" means a person, corporation, limited liability company, partnership, unincorporated business or professional association and any agent or employe thereof who provides medical assistance.

(10m) "Public medical institution" has the meaning designated in Title XIX of the federal social security act.

(10s) "Secretary" means the secretary of health and family services.

(11) "Skilled nursing home" means a facility or distinct part thereof, which:

(a) Is licensed or approved under state law for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care;

(b) Employs sufficient registered nursing practitioners for supervision of those giving nursing care to patients; and

(c) Qualifies as a "skilled nursing facility" within the meaning of Title XIX of the social security act.

(12) "Spouse" means the legal husband or wife of the beneficiary, whether or not eligible for medical assistance.

History: 1977 c. 29 ss. 583m, 591; 1977 c. 418 s. 929 (18); 1979 c. 221; 1981 c. 20 s. 2202 (20) (m); 1981 c. 93; 1983 a. 189; 1987 a. 27; 1987 a. 403 s. 256; 1987 a. 413; 1991 a. 39; 1993 a. 27, 99, 112, 437; 1995 s. 27 ss. 2649, 2661, 2943 to 2946, 9126 (19).

49.45 Medical assistance; administration. (1) PURPOSE. To provide appropriate health care for eligible persons and obtain the most benefits available under Title XIX of the federal social security act, the department shall administer medical assistance, rehabilitative and other services to help eligible individuals and families attain or retain capability for independence or self–care as hereinafter provided.

(2) DUTIES. (a) The department shall:

1. Exercise responsibility relating to fiscal matters, the eligibility for benefits under standards set forth in ss. 49.46 to 49.47 and general supervision of the medical assistance program.

2. Employ necessary personnel under the classified service for the efficient and economical performance of the program and shall supply residents of this state with information concerning the program and procedures.

3. Determine the eligibility of persons for medical assistance, rehabilitative and social services under ss. 49.46, 49.468 and 49.47 and rules and policies adopted by the department and may designate this function to the county department under s. 46.215 or 46.22.

4. To the extent funds are available under s. 20.435 (1) (bm), certify all proper charges and claims for administrative services to the department of administration for payment and the department of administration shall draw its warrant forthwith.

5. Cooperate with the division for learning support, equity and advocacy in the department of education to carry out the provisions of Title XIX.

NOTE: Subd. 5. is shown as amended by 1995 Wis. Acts 27 and 417. The treatment by Act 27 s. 9145 (1) was held unconstitutional and declared void by the Supreme Court in Thompson v. Craney, case no. 95–2168–OA. Subd. 5. as not affected by Act 27 s. 9145 (1) reads as follows:

5. Cooperate with the division for learning support, equity and advocacy in the department of public instruction to carry out the provisions of Title XIX.

6. Appoint such advisory committees as are necessary and proper.

7. Cooperate with the federal authorities for the purpose of providing the assistance and services available under Title XIX to obtain the best financial reimbursement available to the state from federal funds.

8. Periodically report to the joint committee on finance concerning projected expenditures and alternative reimbursement and cost control policies in the medical assistance program.

9. Periodically set forth conditions of participation and reimbursement in a contract with provider of service under this section.

10. After reasonable notice and opportunity for hearing, recover money improperly or erroneously paid, or overpayments to a provider either by offsetting or adjusting amounts owed the provider under the program, crediting against a provider's future claims for reimbursement for other services or items furnished by the provider under the program, or by requiring the provider to make direct payment to the department or its fiscal intermediary.

11. Establish criteria for the certification of eligible providers of services under Title XIX of the social security act and certify such eligible providers.

12. Decertify or suspend a provider from the medical assistance program, if after giving reasonable notice and opportunity for hearing, the department finds that the provider has violated federal or state law or administrative rule and such violations are by law, regulation or rule grounds for decertification or suspension. No payment may be made under the medical assistance program with respect to any service or item furnished by the provider subsequent to decertification or during the period of suspension.

12r. Notify the medical examining board, or any affiliated credentialing board attached to the medical examining board, of any decertification or suspension of a person holding a license granted by the board or the affiliated credentialing board if the grounds for the decertification or suspension include fraud or a quality of care issue.

(f) Services provided by a provider who fails or refuses to prepare or maintain records or other documentation as required under s. HSS 106.02 (9);

(g) Services provided by a provider who fails or refuses to provide access to records as required under s. HSS 106.02 (9) (e) 4;

(h) Services for which the provider failed to meet any or all of the requirements of s. HSS 106.03, including but not limited to the requirements regarding timely submission of claims;

(i) Services provided inconsistent with an intermediate sanction or sanctions imposed by the department under s. HSS 106.08; and

(j) Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under ch. HSS 105 applicable to that provider.

(2m) SERVICES REQUIRING A PHYSICIAN'S ORDER OR PRESCRIPTION. (a) The following services require a physician's order or prescription to be covered under MA:

1. Skilled nursing services provided in a nursing home;

2. Intermediate care services provided in a nursing home;

3. Home health care services;

4. Independent nursing services;

5. Respiratory care services for ventilator-dependent recipients;

6. Physical and occupational therapy services;

7. Mental health and alcohol and other drug abuse (AODA) services;

8. Speech pathology and audiology services;

9. Medical supplies and equipment, including rental of durable equipment, but not hearing aid batteries, hearing aid accessories or repairs;

10. Drugs, except when prescribed by a nurse practitioner under s. HSS 107.122, or a podiatrist under s. HSS 107.14;

11. Prosthetic devices;

12. Laboratory, diagnostic, radiology and imaging test services;

13. Inpatient hospital services;

14. Outpatient hospital services;

15. Inpatient hospital IMD services;

16. Hearing aids;

18. Hospital private room accommodations;

19. Personal care services; and

20. Hospice services.

(b) Except as otherwise provided in federal or state statutes, regulations or rules, a prescription or order shall be in writing or be given orally and later be reduced to writing by the provider filling the prescription or order, and shall include the date of the prescription or order, the name and address of the prescriber, the prescriber's MA provider number, the name and address of the recipient, the recipient's MA eligibility number, an evaluation of the service to be provided, the estimated length of time required, the brand of drug or drug product equivalent medically required and the prescriber's signature. For hospital patients and nursing home patients, orders shall be entered into the medical and nursing charts and shall include the information required by this paragraph. Services prescribed or ordered shall be provided within one year of the date of the prescription.

(c) A prescription for specialized transportation services for a recipient not declared legally blind or not determined to be permanently disabled shall include an explanation of the reason the recipient is unable to travel in a private automobile, or a taxicab, bus or other common carrier. The prescription shall specify the length of time for which the recipient shall require the specialized transportation, which may not exceed 90 days.

(3) PRIOR AUTHORIZATION. (a) *Procedures for prior authorization.* The department may require prior authorization for covered services. In addition to services designated for prior authorization under each service category in this chapter, the department may require prior authorization for any other covered service for any reason listed in par. (b). The department shall notify in writing all affected providers of any additional services for which it has decided to require prior authorization. The department or its fiscal agent shall act on 95% of requests for prior authorization within 10 working days and on 100% of requests for prior authorization within 20 working days from the receipt of all information necessary to make the determination. The department or its fiscal agent shall make a reasonable attempt to obtain from the provider the information necessary for timely prior authorization decisions. When prior authorization decisions are delayed due to the department's need to seek further information from the provider, the recipient shall be notified by the provider of the reason for the delay.

(b) *Reasons for prior authorization.* Reasons for prior authorization are:

1. To safeguard against unnecessary or inappropriate care and services;

2. To safeguard against excess payments;

3. To assess the quality and timeliness of services;

4. To determine if less expensive alternative care, services or supplies are usable;

5. To promote the most effective and appropriate use of available services and facilities; and

6. To curtail misutilization practices of providers and recipients.

(c) *Penalty for non-compliance.* If prior authorization is not requested and obtained before a service requiring prior authorization is provided, reimbursement shall not be made except in extraordinary circumstances such as emergency cases where the department has given verbal authorization for a service.

(d) *Required information.* A request for prior authorization submitted to the department or its fiscal agent shall,

unless otherwise specified in chs. HSS 101 to 108, identify at a minimum:

1. The name, address and MA number of the recipient for whom the service or item is requested;

2. The name and provider number of the provider who will perform the service requested;

3. The person or provider requesting prior authorization;

4. The attending physician's or dentist's diagnosis including, where applicable, the degree of impairment;

5. A description of the service being requested, including the procedure code, the amount of time involved, and dollar amount where appropriate; and

6. Justification for the provision of the service.

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

1. The medical necessity of the service;

2. The appropriateness of the service;

3. The cost of the service;

4. The frequency of furnishing the service;

5. The quality and timeliness of the service;

6. The extent to which less expensive alternative services are available;

7. The effective and appropriate use of available services;

8. The misutilization practices of providers and recipients;

9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;

10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;

11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and

12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

(f) *Professional consultants.* The department or its fiscal agent may use the services of qualified professional consultants in determining whether requests for prior authorization meet the criteria in par. (e).

(g) *Authorization not transferable.* Prior authorization, once granted, may not be transferred to another recipient or to another provider. In certain cases the department may allow multiple services to be divided among nonbilling providers certified under one billing provider. For example, prior authorization for 15 visits for occupational therapy may be performed by more than one therapist working for the billing provider for whom prior authorization was granted. In emergency circumstances the service may be provided by a different provider.

(h) *Medical opinion reports.* Medical evaluations and written medical opinions used in establishing a claim in a tort action against a third party may be covered services if they are prior-authorized. Prior authorization shall be issued only where:

1. A recipient has sustained personal injuries requiring medical or other health care services as a result of injury, damage or a wrongful act caused by another person;

2. Services for these injuries are covered under the MA program;

3. The recipient or the recipient's representative has initiated or will initiate a claim or tort action against the negligent third party, joining the department in the action as provided under s. 49.65, Stats.; and

4. The recipient or the recipient's representative agrees in writing to reimburse the program in whole for all payments made for the prior-authorized services from the proceeds of any judgment, award, determination or settlement on the recipient's claim or action.

(i) *Significance of prior authorization approval.* 1. Approval or modification by the department or its fiscal agent of a prior authorization request, including any subsequent amendments, extensions, renewals, or reconsideration requests:

a. Shall not relieve the provider of responsibility to meet all requirements of federal and state statutes and regulations, provider handbooks and provider bulletins;

b. Shall not constitute a guarantee or promise of payment, in whole or in part, with respect to any claim submitted under the prior authorization; and

c. Shall not be construed to constitute, in whole or in part, a discretionary waiver or variance under s. HSS 106.13.

2. Subject to the applicable terms of reimbursement issued by the department, covered services provided consistent with a prior authorization, as approved or modified by the department or its fiscal agent, are reimbursable provided:

a. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, renewals and reconsideration requests, is truthful and accurate;

b. The provider's approved or modified prior authorization request and supporting information, including all subsequent amendments, extensions, renewals and reconsideration requests, completely and accurately reveals all facts pertinent to the recipient's case and to the review process and criteria provided under s. HSS 107.02 (3);

c. The provider complies with all requirements of applicable state and federal statutes, the terms and conditions of the applicable provider agreement pursuant to s. 49.45 (2) (a) 9, Stats., all applicable requirements of chs. HSS 101 to 108, including but not limited to the requirements of ss. HSS 106.02, 106.03, 107.02, and 107.03, and all applicable prior authorization procedural instructions issued by the department under s. HSS 108.02 (4);

d. The recipient is MA eligible on the date of service; and

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

DATE 9/3/97 Executive Session X Public Hearing ____ Rule ____

Moved by Grothman Seconded by Schultz

+ LRB 3824/1 in the Senate

MOTION: That the JCRAR recommends LRB 3348/1, relating to prohibiting the use of telephone solicitation to solicit the sale of burial agreements, cemetery merchandise, cemetery lots, mausoleum spaces, insurance contracts to pay for funeral merchandise or services or cemetery merchandise, or burial, funeral or preneed insurance, and providing a penalty, for introduction.

LEGISLATOR	AYE	NO	ABSENT
Senator GROBSCHMIDT	X		
Senator POTTER	X		
Senator WIRCH	X		
Senator WELCH	X		
Senator SCHULTZ	X		
Representative GROTHMAN	X		
Representative GUNDERSON	X		
Representative SERATTI			X
Representative YOUNG			X
Representative KREUSER	X		
Totals			

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

DATE_____ Executive Session_____ Public Hearing_____Rule_____

Moved by Welch Seconded by Schultz

MOTION: That the JCRAR recommend AB 254 for passage.

LEGISLATOR	AYE	NO	ABSENT
Senator GROBSCHMIDT	X		
Senator POTTER	X		
Senator WIRCH	X		
Senator WELCH	X		
Senator SCHULTZ	X		
Representative GROTHMAN	X		
Representative GUNDERSON	X		
Representative SERATTI			X
Representative YOUNG			X
Representative KREUSER	X		
Totals			

MOTION CARRIED ¨ **MOTION FAILED** ¨

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

DATE_____ Executive Session_____ Public Hearing_____Rule_____

Moved by_____Seconded by _____

MOTION: That the JCRAR requests that the Department of Workforce Development agree to consider making modifications to the objected-to portion of Clearinghouse Rule 97-023 as follows:

If the department does not notify the JCRAR of its agreement to consider modifications by 5 PM, September 5, 1997, the JCRAR concurs in the objection of the Senate Committee on Labor, Transportation and Financial Institutions, on the grounds set forth in section 227.19(4)(d)6.,Stats.

.15% → 10%

LEGISLATOR	AYE	NO	ABSENT
Senator GROBSCHMIDT	✓		
Senator POTTER	✓		
Senator WIRCH		✓	
Senator WELCH			
Senator SCHULTZ	✓		
Representative GROTHMAN		✓	
Representative GUNDERSON		✓	
Representative SERATTI			
Representative YOUNG			
Representative KREUSER	✓		
Totals			

MOTION CARRIED ¨ MOTION FAILED ¨

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

DATE 9/3/97 Executive Session X Public Hearing ____ Rule CR97-023

Moved by Grobschmidt Seconded by Schultz

MOTION: That the JCRAR requests that the Department of Workforce Development agree to consider making modifications to the objected-to portion of Clearinghouse Rule 97-023 as follows. 10% limit on schedule increase before rules are required.

If the department does not notify the JCRAR of its agreement to consider modifications by 5 PM, September 5, 1997, the JCRAR concurs in the objection of the Senate Committee on Labor, Transportation and Financial Institutions, on the grounds set forth in section 227.19(4)(d)6.,Stats.

LEGISLATOR	AYE	NO	ABSENT
Senator GROBSCHMIDT	X		
Senator POTTER	X		
Senator WIRCH		X	
Senator WELCH	X		
Senator SCHULTZ	X		
Representative GROTHMAN		X	
Representative GUNDERSON		X	
Representative SERATTI			X
Representative YOUNG			X
Representative KREUSER	X		
Totals	5	3	2

MOTION CARRIED ¨ **MOTION FAILED** ¨

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

DATE_____ Executive Session_____ Public Hearing_____Rule_____

Moved by_____Seconded by _____

MOTION: That the JCRAR ~~recommend AB 254 for passage.~~ Attendance —

LEGISLATOR	AYE	NO	ABSENT
Senator GROBSCHMIDT	✓		
Senator POTTER			
Senator WIRCH	✓		
Senator WELCH	✓		
Senator SCHULTZ	✓		
Representative GROTHMAN	✓		
Representative GUNDERSON	✓		
Representative SERATTI			A
Representative YOUNG			A
Representative KREUSER	✓		
Totals			

MOTION CARRIED ¨ **MOTION FAILED ¨**

Committee Meeting Attendance Sheet

Joint Committee for Review of Administrative Rules

Date Sept. 3, 1997 Meeting Type Public Hearing

Location LL Rm 1 MLK

COMMITTEE MEMBER	PRESENT	ABSENT	EXCUSED
1. Senator GROBSCHMIDT	X		
2. Senator POTTER	X		
3. Senator WIRCH	X		
4. Senator WELCH	X		
5. Senator SCHULTZ	X		
6. Representative GROTHMAN	X		
7. Representative GUNDERSON	X		
8. Representative SERATTI			X
9. Representative YOUNG			X
10. Representative KREUSER	X		
Totals			

s:\comclerk\attend

John Sumi / Steve Krieser, Committee Clerk

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

DATE 9/3/97 Executive Session X Public Hearing ____ Rule ____

Moved by Welch Seconded by Schultz

MOTION: That the JCRAR extend the emergency rule of the Department of Health and Family Services relating to certification for lead abatement, other lead hazard reduction work and lead management activities, and accreditation of training courses, for a period of 46 days.

LEGISLATOR	AYE	NO	ABSENT
Senator GROBSCHMIDT	X		
Senator POTTER	X		
Senator WIRCH	X		
Senator WELCH	X		
Senator SCHULTZ	X		
Representative GROTHMAN	X		
Representative GUNDERSON	X		
Representative SERATTI			X
Representative YOUNG			X
Representative KREUSER	X		
Totals			

MOTION CARRIED ¨ **MOTION FAILED** ¨

WISCONSIN COALITION FOR ADVOCACY

Advocacy for citizens with disabilities

Date: September 3, 1997

To: Sen. Richard Grobschmidt, Co-Chair
Rep. Glenn Grothman, Co-Chair
Members
Joint Committee for Review of Administrative Rules

From: Jeffrey Spitzer-Resnick
Attorney

Subject: DHFS Policies on Parental Responsibility to Provide Private-Duty-Nursing-Level Services

Is there a rule?

The first issue for this committee is whether the policies which are being challenged do constitute a rule. The policies concern children who are in need of skilled private duty nursing care covered by the Medical Assistance program. DHFS has adopted policies under which parents must provide cares for these children during some period of every day, including extended periods when the children need services which could ordinarily only be provided by a nurse. The policies are complex and detailed, and appear to include the following general principles:

- WMAP will not cover "parenting." "Parenting" for children with "extensive medical needs" includes learning and providing PDN-level services.
- Parents are considered unavailable to provide care only for purposes of work and sleep. Other household duties and parenting responsibilities are not considered.
- WMAP will not cover 24 hours of PDN on any single day, although there are apparently unspecified exceptions

These policies meet the definition of policies which must be adopted as rules under §§ 227.01(13) and 227.10, Wis. Stats:

- **The policies have general application.** WCA has been involved in at least five cases under the policy. We have talked to other affected families from all parts of the state. We have also talked to nurses and physicians about what they are seeing over their caseloads. There is no question that DHFS reviewers, starting in late 1995, have been uniformly applying a new policy on parental responsibility for cares under which covered nursing hours have been significantly cut back. All the reviewers are applying the same policies across the board.

- **The policy has the force of law.** The policy is used uniformly to determine Medical Assistance coverage, a literally life-or-death issue for many families. They are cited as controlling in prior authorization determinations. Clearly, they have the force of law.

The fact that these rules are not written does not affect the fact that they are rules: policies only announced in individual cases can still be rules if they are statements of general application. *Frankenthal v. Wisconsin R.E. Broker's Board*, 3 Wis. 2d 249, 257c (1958). The fact that they are not published in any other form only makes the violation of ch. 227 worse: it deprives consumers and providers of even the opportunity to know what the policy is before it is applied, and makes it less likely that the Legislature will detect unauthorized rule-making.

The fact that a rule has been created is demonstrated by the abrupt about-face that occurred in coverage for many children in 1995 and 1996. Children' coverage had remained unchanged for many years, in accordance with policies which did not require that parents provide nursing-level services. Then, children whose condition had not improved suddenly had their hours cut back. In our most recent case, the child's coverage had remained unchanged for six years. In 1995, the only comment in approving a full year of coverage was "excellent [Plan of Care." However, the following year the rule went into effect: "WMAP does not cover parenting...; ...Need new POC...that indicates family...to cover some hours of care daily."

The rules are arbitrary and capricious, and impose undue hardships.

The stated basis for the department's policy is not to cover cares when parents are "available" to provide it. However, the policies do not consider the other responsibilities of parents in determining whether they are available. No allowance is made for the time it takes to arrange for the many other special care, educational and transportation needs of children with special needs. Even more arbitrary, there is no consideration given to the parent's responsibility to provide care and parenting to other children: DHFS seems to assume that parents must hire child care for their other children while providing nursing care to the child with medical needs.

As other testimony will demonstrate, these policies work many hardships, including the following:

- The presumption has been applied to require parents to provide cares they do not feel comfortable or safe providing.

- Parents exhausted from a full day at work and other parenting responsibilities are expected to act as nurses for 4-8 hours, when they may be too tired to safely do so.

- Other children in the family are deprived of basic parenting.
- Parents never get a day off: they cannot legally hire child care by anyone other than a skilled nurse.

SEP 05 1997

WISCONSIN LEGISLATURE

P.O. Box 7882 • Madison, WI 53707-7882

September 5, 1997

Sen. Richard Grobschmidt, Co-Chair
Joint Committee for Review of Administrative Rules
100 N. Hamilton St., #404
Madison, WI 53707

Rep. Glenn Grothman, Co-Chair
Joint Committee for Review of Administrative Rules
125 West, State Capitol
Madison, WI 53708

Dear Co-Chairmen Grobschmidt and Grothman:

Thank you once again for holding a public hearing on the issue of skilled private-duty nursing (PDN) care to medically-fragile children. As you know, we are very concerned about the Department of Health and Family Services (DHFS) amending their prior authorization guidelines, which has reduced the flexibility and number of available hours for PDN care.

We strongly feel that rules should be promulgated for DHFS to administer prior authorizations especially toward ***severely medically fragile*** children. These are the ones that require eight or more hours per day of skilled nursing care, including those who need ventilators and receive respiratory care services. Although we realize the department is in the process of revising their policy towards prior authorizations and PDN care, we feel these families need the security of rule promulgation of these guidelines. This will prevent the department from suddenly changing their guidelines without the legislature and families being aware of it.

As you observed at the hearing, the lack of flexibility of PDN hours on the families of these children is very trying. These parents need to be able to run their lives as they see fit and not have a state department being so evasive. Many of these children's medical conditions will never change, and as pointed out at the hearing medical technology does not affect these families so drastically as to warrant only a one or two week prior authorization period.

Please take this information into account when considering your action on this issue. It is very important that we not only do what is best for these children, but also for the families that care for them. If you would like to discuss this matter further or have any questions, please feel free to contact us.

Thank you again for your time and attention to this matter.

Sincerely,

Bonnie Ladwig
State Representative
63rd Assembly District

Kim Plache
State Senator
21st Senate District

My name is Victoria McMurray, I have been providing family, center and community childcare for the past 18 years. Until welfare reform I limited my focus to the children I cared for and their families. Now however I am concerned enough to come here to speak on behalf of the children and families in our community because of the importance of each issue that is handled as we pass through this time of welfare reform.

I hope that all of you are making careful decisions each day about the way that we are supporting our children as the safety net of our society changes. Some people have said that with welfare reform the safety net of our government is gone, not changed. I don't think that we should accept that because we have no reason, as the wealthiest nation in the world, not to provide a safety net to our children. Even if we want to create significant changes for the adult recipients of welfare and how much support they can depend on from the government, we have to ensure that each child who is a Wisconsin citizen, is provided with the opportunity to grow with adequate living standards. Adequate child care is a part of an adequate living standard.

Our state has gotten alot of mileage nationwide out of the money we have put into childcare. We know that the infrastucture of adequate child care will help the welfare transition succeed, so we've touted it. Please do not permit the Department of Workforce Development to make random changes from the base plan that was developed with the support of so many experts in the development of Wisconsin Works and with the adjustments that have followed since. Decisions to create specific co-payments were set for many reasons discussed in great length by a wide range of citizens and governmental representatives. The collective insight is invaluable and while we probably still need to be prepared to make adjustments to the plan as we experience the impact of welfare reform, we can't let administrators of the funds make such critical decisions as increasing parental co-payments by 15% or more without the expertise and the input of others. The decision to alter resources to families has an impact on the whole community, some of which an administrator may not understand and ultimately may not realize the consequences of their decision to change things. Please respect all the people who have given their time and energy to create the best welfare reform transition we know at this time and keep the decision-making in the hands of the citizens of Wisconsin.

As a wealthy nation we have the resources we need to provide "adequate child care" to our children.

As a state that has taken a leadership role in welfare reform we should 'walk the talk'and ensure the money needed to make it work is in place.

And as each of you make the decision that will have an impact on this issue I urge you to protect the collective effort that created the co-payment system by not permitting the Department of Workforce Development the power to change this collective work. Keep the development of welfare reform under the auspices of the State of Wisconsin citizens.

Thank you for caring enough to take the time to listen. Vic McMurray 3 Sep 97

MEMORANDUM

To: Members, JCRAR
From: Senator Richard Grobschmidt, Co-Chairman
Representative Glenn Grothman, Co-Chairman
Date: September 8, 1997
Re: Receipt of modification to Clearinghouse Rule 97-023

Pursuant to s. 227.19(5)(b)2, Stats, the Joint Committee for Review of Administrative Rules has received a modification to Clearinghouse Rule 97-023, relating to the administration of child care funds and required copayments. The modification was submitted in response to the JCRAR motion adopted at its executive session held on September 3, 1997 A copy of the modification and a letter of submittal from the Department of Workforce Development is attached.

Statutory procedures governing legislative rule review give the JCRAR 10 working days following the receipt of the modification to take further action on the rule. If you have questions concerning the modification, or would like the JCRAR to take additional action on this issue prior to Friday, September 19th, please do not hesitate to contact us.

Tommy G. Thompson
Governor

Linda Stewart
Secretary

State of Wisconsin

Department of Workforce Development

OFFICE OF THE SECRETARY
201 East Washington Avenue
P.O. Box 7946
Madison, WI 53707-7946
Telephone: (608) 266-7552
Fax: (608) 266-1784
http://www.dwd.state.wi.us/

September 5, 1997

The Honorable Richard Grobschmidt, Co-Chair
Jt. Committee for Review of Administrative Rules
Room 404, 100 N. Hamilton
Madison, WI 53707

The Honorable Glenn Grothman, Co-Chair
Jt. Committee for Review of Administrative Rules
Room 125 West, State Capitol
Madison, WI 53703

Dear Co-Chairs Grobschmidt and Grothman:

Yesterday, the Joint Committee for Review of Administrative Rules requested the Department of Workforce Development to consider adopting a modification to CR 97-023, relating to the administration of child care funds and required copayments. The requested modification would limit increases in the copayment schedule to 10% before promulgation of administrative rules is required.

The Department agrees to make the modification requested by the Joint Committee. I have attached the new language, offered as a germane modification to the original rule, for the Committee's review.

Please contact me if you have any questions regarding this issue.

Sincerely,

Linda Stewart

Linda Stewart
Secretary

cc: Members, JCRAR
Senator Kim Plache
Representative John Gard

File Ref:

Modification to CR 97-023
Proposed September 5, 1997

SECTION 1. DWD 56.08(3)(c) is amended to read:

DWD 56.08(3)(c) If the department proposes to make adjustments to the copayment schedule that would increase parental copayments by 10% or more, the department shall promulgate an administrative rule to make such adjustments, and the department shall not issue an emergency rule to implement such adjustments before providing advance public notice of at least one month.

(End)

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH

1 WEST WILSON STREET
P. O. BOX 309
MADISON WI 53701-0309

September 8, 1997

The Honorable Glenn Grothman, Co-Chairman
Joint Committee for Review of Administrative Rules
Wisconsin State Assembly
P.O. Box 8952
Madison, WI 53708

Dear Representative Grothman:

Thank you for the opportunity to provide testimony to the Joint Committee for Review of Administrative Rules on September 3, 1997, regarding Medicaid prior authorization guidelines for private duty nursing (PDN).

As a consequence of the testimony I heard, I have directed staff in the Bureau of Health Care Financing to further revise the proposed PDN prior authorization guidelines and to implement several other administrative actions, effective immediately. The purpose of this letter is to inform you of these changes.

Prior Authorization Guidelines

I have directed staff to amend the proposed PDN guidelines to allow families more flexibility to use authorized hours within a 60-day time period and to make it explicitly clear that additional hours of PDN coverage may be authorized retroactively in the event of an emergency.

The additional time required to amend the proposed guidelines will delay their release for review and comment. However, we expect to be able to send them out to members of the Home Care Provider Advisory Committee, the Legislative Council Special Committee on Programs for Developmentally Disabled Persons, and the Joint Committee for Review of Administrative Rules within two weeks. I have also directed staff to mail the proposed new guidelines to all persons currently receiving PDN services so that the persons most directly affected by these services will have an opportunity to comment directly.

Administrative Actions

I have directed staff to take the following administrative steps:

- Allow the use of authorized PDN hours over a 60-day period to allow greater flexibility for the provider and the family, until the new prior authorization guidelines are implemented. The 60-day time period is compatible with the Administrative Rule requirement that the written plan of care be reviewed by the recipient's physician at least every 62 days. We will not oppose any pending appeals based solely on provider/family request for flexibility within allowed hours.

- Discontinue the use of the term "parenting" in reference to the expectation that parents or caregivers provide some medical cares. Unfortunately, our use of the term has given offense where none was intended. Although we do not propose changing the expectation that parents should provide some medical cares in the prior authorization guidelines, we will not refer to it as "parenting."

- Continue to provide assurances that adjudication of all prior authorization requests are internally consistent with our standards for PDN, that responses to prior authorization requests are completed timely and legibly, and that we closely monitor to assure that families are informed when providers' requests for reduced hours are submitted.

- Develop a Prior Authorization Information Sheet for recipients of PDN and their families to advise them about the prior authorization process, the recourses open to them if the request is modified or denied, and a telephone number to call for further information.

- Find ways in which recipients and their families can provide routine and measured input on Medicaid coverage policy, including but not limited to membership on the Home Care Provider Advisory Committee.

It is important to note that these administrative actions do not reflect any change in basic coverage policy, as I described it to you in my testimony. Rather, they are consistent with the changes we had already contemplated and go even further to address the concerns expressed by the persons testifying and some committee members.

Later this fall a new voluntary program called Health Care Connections (HCC) may be helpful to these families. HCC is designed to help individuals with high-cost multiple health needs and their families link up with a case manager who will help them locate and coordinate health care and social services.

I would be happy to meet with you to answer any questions.

Sincerely,

Peggy L. Bartels, Director
Bureau of Health Care Financing

PLB:dd
CH09038.SC

cc: Senator Richard Grobschmidt
Senator Kimberly M. Plache
Representative Bonnie Ladwig
Members of the Joint Committee for
Review of Administrative Rules
Joe Leean, Secretary, DHFS
John D. Chapin, Deputy Administrator, DOH

SENATOR RICHARD GROBSCHMIDT
CO-CHAIRMAN

Room 404 • Hamilton
Madison, WI 53707
Phone: 608-266-7505

REPRESENTATIVE GLENN GROTHMAN
CO-CHAIRMAN

Room 125 West, • State Capitol
Madison, WI 53703
Phone: 608-264-8486

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

September 9, 1997

Linda Stewart, Secretary
Department of Workforce Development
Room 400X
201 East Washington Avenue
Madison, WI 53702

Dear Secretary Stewart:

We are writing to notify you that on September 3, 1997, the Joint Committee for Review of Administrative Rules held a public hearing on Clearinghouse Rule 97-023, relating to the administration of child care funds and required copayments. Following the public hearing the joint committee met in executive session and adopted the following motion:

"Moved by Senator Grobschmidt and seconded by Senator Schultz, that the JCRAR requests that the Department of Workforce Development agree to consider making modifications to the objected-to portion of Clearinghouse Rule 97-023 as follows:

- Limit increases in the schedule to 10% before rules are required.

The motion was adopted by a vote of five members in favor, three against, with two members absent. We would ask that the department notify us of its agreement to consider making this modification by 5 PM, September 5, 1997.

If you you have any questions concerning the action taken by the joint committee please do not hesitate to contact us. We look forward to the department's reply.

Sincerely,

RICHARD GROBSCHMIDT
Senate Co-Chair

GLENN GROTHMAN
Assembly Co-Chair

RG:GG:js

SENATOR RICHARD GROBSCHMIDT
CO-CHAIRMAN

Room 404 • Hamilton
Madison, WI 53707
Phone: 608-266-7505

REPRESENTATIVE GLENN GROTHMAN
CO-CHAIRMAN

Room 125 West, • State Capitol
Madison, WI 53703
Phone: 608-264-8486

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

September 9 , 1997

Joe Leean, Secretary
Department of Health and Family Services
Room 650
1 West Wilson Street
Madison, WI 53702

Dear Secretary Leean:

We are writing to inform you that the Joint Committee for Review of Administrative Rules met in executive session on September 9, 1997 and adopted the following motion:

"Moved by Senator Welch and seconded by Senator Schultz, that the Joint Committee for Review of Administrative Rules extend the effective date of the emergency rule of the Department of Health and Family Services relating to certification for lead abatement, other lead hazard reduction work and lead management activities, and accreditation of training courses, for a period of 46 days."

The motion carried by a vote of eight in favor, none against, and two members absent.

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

Sincerely,

RICHARD GROBSCHMIDT
Senate Co-Chair

GLENN GROTHMAN
Assembly Co-Chair

RG:GSG:js
cc: Secretary of State La Follette
Gary Poulson, Asst. Revisor of Statute

DWD 56.08, Wis. Adm. Code

PROPOSED PERMANENT RULE RELATING TO THE ADMINISTRATION OF CHILD CARE FUNDS AND REQUIRED COPAYMENTS

Pursuant to the authority vested in the Wisconsin Department of Workforce Development by §§49.132(2)(b), (2r)(d), (4)(d) and (e)2 and (5)(e), and 49.155(5), Stats., the department proposes an order to renumber subchapter VII of HSS 55 and to create DWD 56.08, relating to the administration of child care funds and required parent copayments.

Analysis

The Department is authorized by s. 49.132(2)(b), (2r)(d), (4)(d) and (e)2 and (5)(e), Stats., to create a rule interpreting s. 49.155(5), Stats.

This rule contains a schedule of required copayments for parents who receive state child care funds. Under the schedule, a parent who receives a child care subsidy will not be required to pay more than 16% of gross income as a copayment. The copayments for licensed child care are 30% more than the copayments for certified child care.

The rule also provides that the schedule may be adjusted in the future to reflect changes in costs or other economic factors. Adjustments to the schedule will be published in the Wisconsin Administrative Register. A new rule will be promulgated to make adjustments to the schedule involving an increase in copayments of 15% or more, and advance public notice of at least one month will be given before an emergency rule involving an increase of 15% or more is adopted.

PROPOSED ORDER

Pursuant to the authority vested in the Wisconsin Department of Workforce Development by ss. 49.132(2)(b), (2r)(d), (4)(d) and (e)2 and (5)(e), and 49.155(5), Stats., the department proposes an order to renumber subchapter VII of HSS 55 and to create DWD 56.08, relating to the administration of child care funds and required parent copayments.

SECTION 1. Subchapter VII of HSS 55 is renumbered ch. DWD 56.

SECTION 2. DWD 56.08 is created to read:

DWD 56.08 Parent copayments. (1) SCHEDULE. The department shall set a schedule for parent copayment responsibilities which meets the following criteria:

(a) All families will have a copayment responsibility.

(b) Copayment amounts will be based on family size, family gross income, the number of children in a given family in child care, and the type of child care selected.

(c) The initial schedule is Table DWD 56.08(1)(c).

Note: Table DWD 56.08(1)(c) is reproduced at the end of this document.

(2) APPLICATION. (a) The copayment schedule applies to the following parents:

1. Parents who receive low-income child care funds under s. 49.132(3) and (4), Stats.

2. Parents who receive at-risk child care funds under s. 49.132(2m) and (2r), Stats.

3. Parents who receive child care funds as former AFDC recipients under s. 49.191(2), Stats.

4. Parents who receive child care funds as participants in the food stamp employment and training program under s. 49.124, Stats., to the extent permitted by federal statutes and rules.

(b) This subsection applies to all parents who receive child care financial assistance under s. 49.141(2)(b), Stats.

(c) This subsection applies before the sunset of s. 49.132, Stats., takes effect in accordance with ss. 49.132(6), Stats.

(3) ADJUSTMENTS. (a) The department may adjust the amounts in the schedule to reflect the following factors:

1. A change in child care prices or in the rates paid by county or tribal agencies.

2. A change in the amount of funds available for child care assistance.

3. A change in costs due to a change in the consumer price index.

4. A change in the federal poverty level.

5. A change in economic factors affecting the cost of child care to the state, such as an increase in the demand for child care financial assistance under s. 49.141(2)(b), Stats.

(b) The department shall publish adjustments to the copayment schedule in the Wisconsin administrative register.

(c) If the department proposes to make adjustments to the copayment schedule that would increase parental copayments by 15% or more, the department shall promulgate an administrative rule to make such adjustments, and the department shall not issue an emergency rule to implement such adjustments before providing advance public notice of at least one month.

[Table DWD 56.08(1)(c) appears here.]

(End)

DWD Table 56.08(1)(c)

Child Care Co-Payment Schedule for Licensed and Certified Care

Look down the column of the appropriate family size until you find the gross family monthly income level at or just less than the family income. Look to the right to find the appropriate co-payment by family and type of care.

	[----------Gross Monthly Family Income----------]									WEEKLY LICENSED CARE CO-PAY AMOUNT					WEEKLY CERTIFIED CARE CO-PAY AMOUNT				
	FAMILY SIZE:									KIDS IN SUBSIDIZED CARE:					KIDS IN SUBSIDIZED CARE:				
	2	3	4	5	6	7	8	9	10 or more	1	2	3	4	5 or more	1	2	3	4	5 or more
70% FPL	$ 619	$ 778	$ 937	$1,095	$1,254	$1,413	$1,571	$1,730	$ 1,889	$5	$9	$14	$18	$23	$3	$6	$10	$13	$16
75% FPL	$ 663	$ 833	$1,004	$1,173	$1,343	$1,514	$1,683	$1,853	$ 2,024	$5	$11	$16	$21	$26	$4	$7	$11	$15	$18
80% FPL	$ 707	$ 889	$1,070	$1,251	$1,433	$1,614	$1,795	$1,977	$ 2,158	$8	$13	$18	$24	$29	$6	$9	$13	$17	$20
85% FPL	$ 751	$ 944	$1,137	$1,329	$1,522	$1,715	$1,907	$2,100	$ 2,293	$11	$16	$21	$26	$32	$7	$11	$15	$18	$22
90% FPL	$ 796	$ 1,000	$1,204	$1,408	$1,612	$1,816	$2,020	$2,224	$ 2,428	$13	$20	$26	$33	$39	$9	$14	$18	$23	$28
95% FPL	$ 840	$ 1,055	$1,271	$1,486	$1,701	$1,917	$2,132	$2,347	$ 2,563	$16	$24	$32	$39	$48	$11	$17	$22	$28	$33
100% FPL	$ 884	$ 1,111	$1,338	$1,564	$1,791	$2,018	$2,244	$2,471	$ 2,698	$18	$26	$34	$42	$50	$13	$18	$24	$30	$35
105% FPL	$ 928	$ 1,167	$1,405	$1,642	$1,881	$2,119	$2,356	$2,595	$ 2,833	$21	$29	$37	$45	$53	$15	$20	$26	$31	$37
110% FPL	$ 972	$ 1,222	$1,472	$1,720	$1,970	$2,220	$2,468	$2,718	$ 2,968	$24	$32	$39	$48	$55	$17	$22	$28	$33	$39
115% FPL	$ 1,017	$ 1,278	$1,539	$1,799	$2,060	$2,321	$2,581	$2,842	$ 3,103	$26	$34	$42	$50	$58	$18	$24	$30	$35	$41
120% FPL	$ 1,061	$ 1,333	$1,606	$1,877	$2,149	$2,422	$2,693	$2,965	$ 3,238	$29	$37	$45	$53	$61	$20	$26	$31	$37	$42
125% FPL	$ 1,105	$ 1,389	$1,673	$1,955	$2,239	$2,523	$2,805	$3,089	$ 3,373	$32	$39	$48	$55	$63	$22	$28	$33	$39	$44
130% FPL	$ 1,149	$ 1,444	$1,739	$2,033	$2,328	$2,623	$2,917	$3,212	$ 3,507	$34	$44	$53	$62	$71	$24	$30	$37	$43	$50
135% FPL	$ 1,193	$ 1,500	$1,806	$2,111	$2,418	$2,724	$3,029	$3,336	$ 3,642	$37	$48	$58	$69	$79	$26	$33	$41	$48	$55
140% FPL	$ 1,238	$ 1,555	$1,873	$2,190	$2,507	$2,825	$3,142	$3,459	$ 3,777	$39	$50	$61	$71	$82	$28	$35	$42	$50	$57
145% FPL	$ 1,282	$ 1,611	$1,940	$2,268	$2,597	$2,926	$3,254	$3,583	$ 3,912	$42	$53	$63	$74	$84	$30	$37	$44	$52	$59
150% FPL	$ 1,326	$ 1,667	$2,007	$2,346	$2,687	$3,027	$3,366	$3,707	$ 4,047	$45	$55	$66	$76	$87	$31	$39	$46	$54	$61
155% FPL	$ 1,370	$ 1,722	$2,074	$2,424	$2,776	$3,128	$3,478	$3,830	$ 4,182	$48	$58	$69	$79	$90	$33	$41	$48	$55	$63
160% FPL	$ 1,414	$ 1,778	$2,141	$2,502	$2,866	$3,229	$3,590	$3,954	$ 4,317	$50	$61	$71	$82	$92	$35	$42	$50	$57	$65
165% FPL	$ 1,459	$ 1,833	$2,208	$2,581	$2,955	$3,330	$3,703	$4,077	$ 4,452	$51	$63	$74	$84	$95	$36	$44	$52	$59	$66
	^^^----------165% of the Federal Poverty Level----------^^^																		
170% FPL	$ 1,503	$ 1,889	$2,275	$2,659	$3,045	$3,431	$3,815	$4,201	$ 4,587	$53	$66	$76	$87	$98	$37	$46	$54	$61	$68
175% FPL	$ 1,547	$ 1,944	$2,342	$2,737	$3,134	$3,532	$3,927	$4,324	$ 4,722	$54	$68	$79	$90	$100	$38	$48	$55	$63	$70
180% FPL	$ 1,591	$ 2,000	$2,408	$2,815	$3,224	$3,632	$4,039	$4,448	$ 4,856	$56	$70	$82	$92	$103	$39	$50	$57	$65	$72
185% FPL	$ 1,635	$ 2,055	$2,475	$2,893	$3,313	$3,733	$4,151	$4,571	$ 4,991	$58	$72	$84	$95	$105	$40	$52	$59	$66	$74
190% FPL	$ 1,680	$ 2,111	$2,542	$2,972	$3,403	$3,834	$4,264	$4,695	$ 5,126	$59	$74	$87	$98	$108	$42	$54	$61	$68	$76
195% FPL	$ 1,724	$ 2,166	$2,609	$3,050	$3,492	$3,935	$4,376	$4,818	$ 5,261	$61	$76	$90	$100	$111	$43	$55	$63	$70	$78
199% FPL	$ 1,759	$ 2,211	$2,663	$3,112	$3,564	$4,016	$4,466	$4,917	$ 5,369	$63	$78	$92	$103	$113	$44	$57	$65	$72	$79
	<<<----------200% of the Federal Poverty Level---------->>>																		
204% FPL	$ 1,803	$ 2,266	$2,730	$3,191	$3,654	$4,117	$4,578	$5,041	$ 5,504	$ 64	$ 84	$ 95	$ 105	$ 116	$ 45	$ 59	$ 66	$ 74	$ 81
209% FPL	$ 1,848	$ 2,322	$2,796	$3,269	$3,743	$4,218	$4,690	$5,164	$ 5,639	$ 66	$ 86	$ 97	$ 107	$ 118	$ 46	$ 60	$ 68	$ 75	$ 83
214% FPL	$ 1,892	$ 2,378	$2,863	$3,347	$3,833	$4,319	$4,802	$5,288	$ 5,774	$ 68	$ 88	$ 99	$ 110	$ 121	$ 47	$ 62	$ 69	$ 77	$ 84
217% FPL	$ 1,918	$ 2,411	$2,903	$3,394	$3,886	$4,379	$4,869	$5,362	$ 5,855	$ 69	$ 91	$ 101	$ 112	$ 123	$ 48	$ 63	$ 71	$ 79	$ 86