State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–0030/P~~1~~2
DAK&TAY...:...:...

DOA:.....Fossum – Long–term care redesign

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

This IP2 revises Version 1C, which was sent to G. Fossum + Lorraine B. 12/18/98

1 AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided for a later version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

INSERT 1-1

2 **SECTION 1.** 15.07 (2) (k) of the statutes is created to read:

3 15.07 **(2)** (k) The chairperson of the council on long–term care shall be

4 designated ~~every 3 years~~ by the governor. SEC. RP; 15.07(2)(K)

5 **SECTION 2.** 15.197 (5) of the statutes is created to read:

6 15.197 **(5)** COUNCIL ON LONG–TERM CARE. (a) ~~*Creation.*~~ There is created in the

7 department of health and family services a council on long–term care which

8 ~~(b) *Membership.* The council~~ shall consist~~s~~ of ~~25~~ 15 members, ~~at least 13 of whom are~~

9 ~~persons who are aged 65 or older or who have physical or developmental disabilities~~

SECTION 2

The age or disability represented by these 13 members shall correspond to the proportion of members, as determined by the dept of h+f, of persons receiving long-term care in this state who are aged 65 or older or have phys or dev. dis.

or their family members, guardians or other advocates. Of those 13 members, at least 9 shall ~~correspond to the proportion of numbers, as determined by the department of health and family services, of~~ be persons receiving long–term care in this state who are aged 65 or older or have physical or developmental disabilities, and Up to 4 ~~of the 13 members~~ may be family members of or guardians or other advocates for these persons. The remaining membership consists of representatives of counties and of federally recognized American Indian tribes or bands; providers of long–term care services; representatives of resource centers under s. 46.283 and care management organizations under s. 46.284; ~~state officials, or community leaders~~ or other individuals with recognized ability and demonstrated interest in long-term care.

~~***NOTE: What is meant by the term "state official"?~~

(c) *Appointment.* The governor shall appoint members from nominations solicited by the secretary of health and family services under 1999 Wisconsin Act .... (this act), section 9123 (1) (b), and under s. 46.281 (3), except that the governor need not appoint the chairperson of the council on long–term care from the solicited nominations.

(d) *Terms.* The members appointed under par. (c) shall serve 3–year terms. No member may serve more than 2 consecutive terms.

*** I did not include "appointed by the governor", since s.15.09(1) grants that power.

SECTION 3. 16.009 (2) (b) 1. of the statutes is amended to read: SEC. RP; LRB 1997(5)

16.009 **(2)** (b) 1. Investigate complaints from any person concerning improper conditions or treatment of aged or disabled persons who receive care in a long–term care facility or concerning noncompliance with or improper administration of federal statutes or regulations or state statutes or rules related to long–term care ~~for the aged or disabled~~ facilities.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

SECTION 4. 16.009 (2) (b) 2. of the statutes is amended to read:

16.009 **(2)** (b) 2. Serve as mediator or advocate to resolve any problem or dispute relating to ~~long–term~~ care for the aged or disabled in long–term care facilities.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

~~****NOTE: Please see my change here from the language proposed. My understanding is that the BOALTC focuses on care, rather than on all aspects of a facility's operation, such as disputes with DHFS over MA reimbursement rates.~~

SECTION 5. 16.009 (2) (d) of the statutes is amended to read:

16.009 **(2)** (d) Promote public education, planning and voluntary acts to resolve problems and improve conditions involving ~~long–term~~ care for the aged or disabled in long–term care facilities.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

~~****NOTE: Same NOTE as for s. 16.009 (2) (b) 2. applies.~~

SECTION 6. 16.009 (2) (e) of the statutes is amended to read:

16.009 **(2)** (e) Monitor the development and implementation of federal, state and local laws, regulations, rules, ordinances and policies that relate to long–term care facilities ~~for the aged or disabled~~.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

~~**SECTION 7.** 16.009 (2) (em) of the statutes is repealed.~~

SECTION 8. 16.009 (2) (g) of the statutes is amended to read:

16.009 **(2)** (g) Stimulate resident, client and provider participation in the development of programs and procedures involving resident rights and long–term care facility responsibilities, by establishing resident councils and by other means.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

SECTION 9. 16.009 (2) (h) of the statutes is amended to read:

16.009 **(2)** (h) Conduct statewide hearings on issues of concern to aged or disabled persons who are receiving or who may receive care in a long–term care facility.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

SECTION 10. 16.009 (2) (i) of the statutes is amended to read:

16.009 **(2)** (i) Report annually ~~to the governor and the chief clerk of each house of the legislature for distribution to~~ the appropriate standing committees of the legislature under s. 13.172 (3) and to the governor. The report shall set forth the scope of the programs developed in the state for providing ~~long–term~~ care for the aged or disabled ~~developed in the state~~ in long–term care facilities, findings regarding the state's activities ~~in the field of~~ related to long–term care facilities for the aged and disabled, recommendations for a more effective and efficient total program and the actions taken by the agencies of the state to carry out the board's recommendations.

History: 1981 c. 20; 1983 a. 524; 1985 a. 29; 1987 a. 27; 1989 a. 31, 294; 1991 a. 39, 232; 1993 a. 16, 205; 1995 a. 27 s. 9126 (19); 1997 a. 131.

~~****NOTE: Please note my changes from the material proposed; I was concerned that "residential" long–term care, as a undefined term, would include both facility care and care in a person's residence, or home.~~

INSERT 4-9

SECTION 11. 20.435 (7) (bd) of the statutes is amended to read:

20.435 **(7)** (bd) *Community options program and long–term support pilot projects.* The amounts in the schedule for assessments, case planning, services ~~and~~, administration and risk reserve escrow accounts under s. 46.27 and for pilot projects under s. 46.271 (1), and the amounts carried forward under 1997 Wisconsin Act 27, section 9123 (2), for the pilot project under s. 46.271 (2m). If the department transfers funds to this appropriation from the appropriation account under sub. (5) (b), the amounts in the schedule for the fiscal year for which the transfer is made are increased by the amount of the transfer for the purposes specified in s. 49.45 (6v). Notwithstanding ss. 20.001 (3) (a) and 20.002 (1), the department may under this paragraph transfer moneys between fiscal years. Except for moneys authorized for transfer under this appropriation, under s. 46.27 (7) (fm) or (g) or under 1997 Wisconsin Act 27, section 9123 (2), all moneys under this appropriation that are allocated under s. 46.27 and are not spent or encumbered by counties or by the

department by December 31 of each year shall lapse to the general fund on the succeeding January 1 unless transferred to the next calendar year by the joint committee on finance.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

INSERT 5-4

SECTION 12. 46.27 (2) (k) of the statutes is created to read:

46.27 **(2)** (k) Review and approve or disapprove the terms of risk reserve escrow accounts created under sub. (7) (fr) and approve or disapprove disbursements for administrative or staff costs from the risk reserve escrow accounts.

SECTION 13. 46.27 (4) (a) (intro.) of the statutes is amended to read:

46.27 **(4)** (a) (intro.) ~~The~~ Except as provided in par. (am), the county board of supervisors shall select the county long–term support planning committee, which shall include at a minimum the following members:

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

SECTION 14. 46.27 (4) (am) of the statutes is created to read:

46.27 **(4)** (am) If a local long–term care council in a county assumes under s. 46.282 (2) (b) 2. the duties of the county long–term support planning committee under this subsection, the county long–term support planning committee for that county is dissolved.

SECTION 15. 46.27 (4) (c) (intro.) of the statutes is amended to read:

46.27 **(4)** (c) (intro.) The planning committee or, if a local long–term care council has under s. 46.282 (3) (b) 2. assumed the duties of the planning committee, the local

1 long–term care council shall develop a community options plan for participation in
2 the program. The plan shall include:

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

3 **SECTION 16.** 46.27 (4) (c) 5. of the statutes is amended to read:

4 46.27 **(4)** (c) 5. A description of the method to be used by the committee or, if
5 a local long–term care council has under s. 46.282 (3) (b) 2. assumed the duties of the
6 planning committee, the local long–term care council to monitor the implementation
7 of the program.

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

8 **SECTION 17.** 46.27 (7) (am) of the statutes is amended to read:

9 46.27 **(7)** (am) From the appropriation under s. 20.435 (7) (bd), the department
10 shall allocate funds to each county or private nonprofit agency with which the
11 department contracts to pay assessment and case plan costs under sub. (6) not
12 otherwise paid by fee or under s. 49.33 (2) or 49.45. The department shall reimburse
13 counties for the cost of assessing persons eligible for medical assistance under s.
14 49.46, 49.468 or 49.47 as part of the administrative services of medical assistance,
15 payable under s. 49.45 (3) (a). Counties may use unspent funds allocated under this
16 paragraph to pay the cost of long–term community support services and for a risk
17 reserve under par. (fr).

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

18 **SECTION 18.** 46.27 (7) (b) of the statutes is amended to read:

19 46.27 **(7)** (b) 1m. From the appropriations under s. 20.435 (7) (bd) and (im), the
20 department shall allocate funds to each county to pay the cost of providing long–term
21 community support services under sub. (5) (b) not otherwise paid under s. 49.45 to
22 persons eligible for medical assistance under s. 49.46 or 49.47 or to persons whom
23 the county department or aging unit administering the program finds likely to

1 become medically indigent within 6 months by spending excess income or assets for
2 medical or remedial care. The average per person reimbursement under this
3 paragraph may not exceed the state share of the average per person payment rate
4 the department expects under s. 49.45 (6m). The county department or aging unit
5 administering the program may spend funds received under this paragraph only in
6 accordance with the case plan and service contract created for each person receiving
7 long–term community support services. Counties may use unspent funds allocated
8 under this paragraph from the appropriation under s. 20.435 (7) (bd) for a risk
9 reserve under par. (fr).

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

10 **SECTION 19.** 46.27 (7) (fm) of the statutes is amended to read:

11 46.27 **(7)** (fm) The department shall, at the request of a county, carry forward
12 up to 10% of the amount allocated under this subsection to the county for a calendar
13 year if up to 10% of the amount so allocated has not been spent or encumbered by the
14 county by December 31 of that year, for use by the county in the following calendar
15 year, except that this amount shall be reduced by the amount of funds remaining in
16 the county's risk reserve escrow account under par. (fr) at the end of the calendar
17 year. The department may transfer funds within s. 20.435 (7) (bd) to accomplish this
18 purpose. An allocation under this paragraph does not affect a county's base
19 allocation under this subsection and shall lapse to the general fund unless expended
20 within the calendar year to which the funds are carried forward. A county may not
21 expend funds carried forward under this paragraph for administrative or staff costs,
22 except administrative or staff costs that are associated with implementation of the
23 waiver under sub. (11) and approved by the department.

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

The county shall notify the department of this decision and the amount to be placed in the risk reserve.

SECTION 20. 46.27 (7) (fr) of the statutes is created to read:

46.27 **(7)** (fr) 1. A county may ~~expend, for~~ decide to place in a risk reserve funds that are allocated under par. (am) or (b) or sub. (11) c. 3. and are not expended or encumbered for services under this subsection or sub. (11). The county shall maintain the risk reserve in an interest–bearing escrow account with a financial institution, as defined in s. 69.30 (1) (b), if the department has approved the terms of the escrow.

****NOTE: With respect to the requested words "The county may expend funds that are allocated under this section", how does this provision interact with other allocation language in COP? Please see my amendments of ss. 20.435 (7) (bd), 46.27 (7) (am), (b) and (g) and (11) (c) 7. The language seems to presume that the department distributes the allocated (earmarked??) moneys to counties only after counties indicate that they have expended it. Would it be more straightforward to have the department pay the county money for the risk reserve, rather than first allocating it and waiting to see if it is expended? Does this subdivision contemplate use of funds appropriated under s. 20.435 (5) (b) or (o) or (7) (im)?

****NOTE: Please note my use of "financial institution, as defined in s. 69.30 (1) (b)". This includes banks, savings and loans, credit unions, etc., which have either state or federal charters. Okay?

**** NOTE: Please see my change to wording proposed; it follows your explanation.

2. The annual amount of a county's expenditure for a risk reserve, as specified in subd. 1., may not exceed 10% of the county's most recent allocation under this paragraph or $750,000, whichever is greater. The total amount of the risk reserve, including interest, may not exceed 15% of the county's most recent allocation under this subsection.

****NOTE: I have used "not expended or encumbered" rather than "not needed". With the numbers of waiting lists in counties for services, is it realistic to assume that $750,000 (or more) would be available for this account annually in a county?

****NOTE: Your requested language was for an interest–bearing escrow account, which would yield only interest; therefore, I have not drafted requested language referring to "other gains accruing from investment of the funds".

3. A county may expend funds maintained in a risk reserve, as specified in subd. 1., for any of the following purposes:

a. To defray costs of long–term community support services under this section.

b. To meet requirements under any contract the county has with the department to operate a care management organization under s. 46.284.

c. If approved by a resolution of the county's board of supervisors, to transfer funds to a quasi–governmental county authority created under *****.

c. If approved by the department, for administrative or staff costs under this section.

4. A county that maintains a risk reserve, as specified in subd. 1., shall annually, on a form prescribed by the department, submit to the department a record of the status of the risk reserve, including revenues and disbursements.

SECTION 21. 46.27 (7) (g) (intro.) of the statutes is amended to read:

46.27 **(7)** (g) (intro.) The department may carry forward to the next state fiscal year ~~up to $500,000 of~~ funds allocated under this subsection and not encumbered by counties by December 31 ~~or,~~ carried forward under par. (fm) ~~or expended for a risk reserve under par. (fr)~~. The department may transfer moneys within s. 20.435 (7) (bd) to accomplish this purpose. An allocation under this paragraph shall not affect a county's base allocation for the program. The department may allocate these transferred moneys during the next fiscal year to counties <u>for planning and implementation of aging resource centers under s. 46.283 or care management organizations under s. 46.284 and</u> for the improvement or expansion of long–term community support services for clients whose cost of care significantly exceeds the average cost of care provided under this section, including any of the following:

SECTION 22. 46.28 of the statutes is renumbered 46.291.

SECTION 23. 46.28 of the statutes is created to read:

INSERT 9-21

46.28 Definitions; long–term care. In sections 46.28 to 46.~~287~~ 288: **(1)** "Care management organization" means an entity that is certified as a care management organization under s. 46.284 (2) and that has a contract under s. 46.284 (1).

INSERT 10-3

(2) "Eligible person" means a person who meets the criteria for functional eligibility under s. 46.285 (1) (a) and for financial eligibility under s. 46.285 (1) (b).

(3) "Enrollee" means a person who is enrolled in a care management organization.

(4). "Family care benefit" means financial assistance for long–term care and support items for a person who meets functional and financial criteria and is enrolled in a care management organization.

~~****NOTE: Is "support items" correct? "Supports", by itself, is unclear.~~

~~**(5)** "Local long–term care council" means a long–term care council that is appointed under s. 46.282 (2) (a).~~

~~**(6)**~~ 5 "Long–term care system" means ***** the organizations and programs that provide the family care benefit or other publicly-funded long-term care benefits or that provide information about and access to those organizations and programs.

~~****NOTE: Would you have language for this definition?~~

NOTE: I changed "services" to "organizations and programs" bec. I was unsure of the antecedent. If this does not meet the standards for operation, I will do a search of the draft for this term later. I will then see if the def. works.

~~**(7)**~~ 6 "Nonprofit organization" has the meaning given in s. 108.02 (19).

~~**(8)**~~ 7 "Older person" means a person who is aged at least 65.

~~**(9)**~~ 8 "Resource center" means an entity that ~~is established as a resource center~~ meets the standards for operation under s. 46.283 (~~1~~ 3).

~~**(10)**~~ 9 "Tribe or band" means a federally recognized American Indian tribe or band.

This term is now used in ss. 46.281 (1) (g) 3. and 4., 46.282 (1) and (3), 46.283 (2) (a) and 46.289 (intro.). Are the uses correct

SECTION 24. 46.281 of the statutes is created to read:

46.281 Powers and duties of the secretary and the department; long–term care. **(1)** DUTIES OF THE DEPARTMENT. The department shall do all of the following:

or, if under contract to provide a portion of the services specified under s. 46.283 (3), meets the standards for operation with respect to those services

**** Does this lang. do what you want?

(a) Provide training to members of the council on long–term care who ~~receive long–term care services~~, to enable these members to participate in the council's duties. are aged 65 or older or who have physical or developmental disabilities or their family members, guardians or other advocates

****NOTE: I did not add to this provision the requested requirement that DHFS pay reasonable expenses of consumer council members, because s. 15.09 (6) provides for "actual and necessary expenses" reimbursement. Also, I changed "consumer of long–term care services" to persons "who receive" the services, because not every enrollee will be a "consumer" (buyer) of the services.

(b) Provide information to the council on long–term care, ~~including copies of reports submitted to the department by local long–term care councils~~, and seek recommendations of the council. If the department's final decision differs from the recommendations of the council made under s. 46.282 (1) (c), the department shall provide, in writing, an explanation of the reasons for the difference.

(c) Request from the secretary of the federal department of health and human services any waivers of federal medicaid laws necessary to permit the use of federal moneys to ~~fund the long–term care system and~~ provide the family care benefit to recipients of medical assistance. The department shall implement any waiver that is approved. Regardless of whether a waiver is approved, the department may implement ~~the long–term care system~~. operation of resource centers, care management organizations and the family care benefit

****NOTE: ~~What federal laws are the waiver requests to? Is "fund the long–term care system" too broad?~~

(d) Implement the operation of resource centers ~~and~~ care management organizations (and the family care benefit) statewide, on a phased–in basis, by December 31, 2004.

~~(1)~~ Contract with ~~all of the following:~~ as meeting requirements

~~1. If the local long–term care council for the applicable area has developed the initial plan under s. 46.282 (3) (a) 1.,~~ ~~an entity~~ one or more entities certified under s. 46.284 (2) for services of the entity as a care management organization and ~~an entity certified under ***** for services of the entity as a resource center.~~ one or more entities for services specified under s. 46.283 (2)

~~****NOTE: See my **** NOTE re certification of resource centers under s. 46.283 (2).~~

2. An organization that is not a resource center or a care management organization, to provide external advocacy services for clients of the long–term care system.

****NOTE: How does the role of BOALTC fit in with this subdivision? Definition of "external advocacy" is crucial.

(g) Prescribe and implement a per person monthly rate structure for costs of the family care benefit.

****NOTE: Needs exception from rule–making requirements of ch. 227?

(h) Prescribe standards for operation of management information systems.

****NOTE: What are these? Needs exception from rule–making requirements of ch. 227? See also par. (i) 1. below.

(i) In order to maintain continuous quality assurance and quality improvement ~~in the long–term care system~~ for resource centers and care management organizations, do all of the following:

DAK: check renumbering Do search

1. Prescribe by rule and by contract and enforce performance standards for operation of resource centers and care management organizations.

2. Use performance expectations that are related to outcomes for persons receiving long–term care services in contracting with care management organizations and resource centers.

~~****NOTE: I did not draft all of this instruction because it was vague.~~

3. Conduct ongoing evaluations of the long–term care system.

4. Require that quality assurance and quality improvement efforts are included throughout the long–term care system.

5. Ensure that reviews of the quality of management and service delivery of resource centers and care management organizations are conducted by external organizations ~~that are external to the long–term care system~~ and make information about specific review results available to the public.

restore

~~***NOTE: Does this language convey your intent adequately?~~

(h) After consulting with the council on long–term care, prescribe criteria for evaluations and determinations under s. 46.282 (3) (a) 2.

(j) Include in each contract with a resource center or a care management organization requirements for the protection of the rights specified in s. 46.286.

(2) POWERS OF THE DEPARTMENT. The department may develop risk–sharing arrangements in contracts with care management organizations, in accordance with applicable state laws and federal statutes and regulations.

(3) DUTIES OF THE SECRETARY. (a) As vacancies arise in the membership of the council on long–term care, the secretary shall solicit nominations for membership from all of the following:

1. Persons aged 65 or older and persons with physical or developmental disabilities.

2. Family members and guardians of and advocates for persons under par. (a).

3. Organizations of providers of long–term care services.

4. Counties.

5. Federally recognized American Indian tribes or bands.

6. Other persons with knowledge of and interest in ~~the~~ long–term care ~~system~~ services.

(b) The secretary shall provide a list of nominees from the nominations solicited under par. (a) to the governor for appointment as members of the council on long–term care.

**** NOTE: I deleted all of sub. (3) (duties of the secy.) rather than just par. (b), par. (a) seems unnecessary if the secy no longer (under par (b)) provides a list to the gov. from nominations solicited.

INSERT 13-20

SECTION 25. 46.282 of the statutes is created to read:

46.282 Council~~s~~ on long–term care. (1) ~~COUNCIL ON LONG–TERM CARE; DUTIES.~~ The council on long–term care appointed under s. 15.197 (5) shall do all of the following:

(f) Prescribe criteria to assign priority equitably on any necessary waiting lists for persons who are eligible for the family care benefit but who do not meet the criteria under s. 46.285 (3).

EC. RP; 6.281(1)(a)

(a) Assist the department in developing broad policy issues related to long–term care services and the long–term care system.

(b) Assist the department in developing, implementing, coordinating and guiding the long–term care system, including by reviewing and making non-binding recommendations to the department on all of the following:

(a) 1. The department's standard contract provisions for resource centers and care management organizations.

(b) 2. The family care benefit, including the per person rate structure for the benefit.

(c) 3. The long–term support community options program under s. 46.27.

(d) 4. The community integration programs under ss. 46.275, 46.277 and 46.278.

(e) 5. Programs other than those under subd. 3. and 4. that provide home and community–based services.

(f) 6. The provision of medical assistance services under a fee–for–service system.

(c) At the request of a county, tribe, local long–term care council, care management organization or applicant for a contract to operate a care management organization, review, under guidelines established by the council, a preliminary decision of the department concerning the number of care management organizations that may operate in a geographic area, the awarding of a contract for operation of a care management organization and the termination of specific contracts. The long–term care council shall make recommendations to the department for the department's final decision.

(3) Monitor patterns of complaints or grievances and appeals regarding the long–term care system in order to identify issues of statewide importance.

(4) Monitor the numbers of persons on waiting lists.

(5) ~~(f)~~ Review patterns of utilization of various types of services by care management organizations.

(6) ~~(g)~~ Monitor the pattern of care management organization enrollments and disenrollments throughout the state.

(7) ~~(h)~~ ~~Review annual reports submitted by local long–term care councils and other information and~~ report annually to the legislature in the manner provided under s. 13.172 (2) and to the governor on the status, significant achievements and problems of ~~the long–term care system~~, including all of the following:

(a) ~~1.~~ Numbers of persons served. family care benefit

(b) ~~2.~~ Costs of long–term care provided under the ~~long–term care system~~ resource centers, care management organizations and the family care benefit.

(c) ~~3.~~ The number and service areas of resource centers and care management organizations.

****NOTE: I kept just the term "resource center" because it is such a mouthful and because it is defined in s. 46.81.

(d) ~~4.~~ Waiting list information.

(e) ~~5.~~ Results of reviews of quality of ~~long–term care~~ services provided ~~under the long–term care system~~ resource centers and care management organizations.

~~This section does not apply after July 1, 2004.~~

~~(2)~~ LOCAL LONG–TERM CARE COUNCILS; APPOINTMENT; MEMBERSHIP; TERMS; COMPENSATION AND TRAINING; OFFICERS. (a) *Appointment.* 1. The county board of supervisors of a county shall appoint a local long–term care council or the county boards of supervisors of 2 or more contiguous counties shall appoint a local long–term care council, except as follows:

a. In a county with a county executive or a county administrator, the county executive or county administrator shall appoint the local long–term care council,

other than as provided in subd. 1. b., subject to confirmation by the county board of supervisors.

b. If the lands of any federally recognized American Indian tribe or band are located in the county or contiguous counties to be served by a local long–term care council, each tribe or band with these lands shall appoint at least one member of the local long–term care council.

2. A county board of supervisors or, in a county with a county executive or a county administrator, the county executive or county administrator shall appoint members of the local long–term care council who are required to be older persons or persons with physical or developmental disabilities or their immediate family members of or guardians or other advocates for these persons from nominations that are submitted to the county board of supervisors or the county executive or county administrator by older persons or persons with physical or developmental disabilities or their family members or guardians and by local organizations that represent older persons or persons with physical or developmental disabilities.

3. If a tribe or band or the Great Lakes inter–tribal council, inc., intends to apply for ~~certification as~~ a contract to operate a resource center or for certification of a care management organization, the tribe or band or the Great Lakes inter–tribal council, inc., shall as a condition of the application for the certification appoint a local long–term care council.

(b) *Membership.* 1. A local long–term care council that serves a single–county area shall consist of 21 members, at least 11 of whom are older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates. Of those 11 members, at least 8 shall ~~correspond to the proportion of numbers, as determined by the department, of~~ be persons receiving long–term care in this state who are aged 65 or older or have physical or developmental disabilities,

The age or disability represented by these 11 members shall correspond to the proportion of members, as determined by the dept, of persons receiving long-term care in this state who are aged 65 or older or have physical or dd.

1 and up to 3 may be family members of or guardians or other advocates for these
2 persons. The remaining membership shall consist of providers of long–term care
3 services, persons residing in the county with recognized ability and demonstrated
4 interest in long–term care and up to 3 members of the county board of supervisors
5 or other elected officials.

6 2. A local long–term care council that serves an area of 2 or more contiguous
7 counties shall consist of 25 members, at least 13 of whom are older persons or persons
8 with physical or developmental disabilities or their family members, guardians or
9 other advocates. Of those 13 members, at least 9 shall correspond to the proportion
10 of numbers, as determined by the department, of persons receiving long–term care
11 in this state who are aged 65 or older or have physical or developmental disabilities,
12 and up to 4 may be family members of or guardians or other advocates for these
13 persons. The remaining membership shall consist of providers of long–term care
14 services, persons residing in the county with recognized ability and demonstrated
15 interest in long–term care and either up to 4 members of the county boards of
16 supervisors or other elected officials or, for a council that serves an area of more than
17 4 contiguous counties, up to one member of the county board of supervisors of each
18 county or up to one other elected official in each county area.

19 3. A local long–term care council that is appointed by a tribe or band or by the
20 Great Lakes inter–tribal council, inc., shall consist of 21 members, at least 11 of
21 whom are older persons or persons with physical or developmental disabilities or
22 their family members, guardians or other advocates. Of those 11 members, at least
23 8 shall correspond to the proportion of numbers, as determined by the department,
24 of persons receiving long–term care in this state who are aged at 65 or older or who
25 have physical or developmental disabilities, and up to 3 may be family members of

1 or guardians or other advocates for these persons. The remaining membership shall
2 consist of providers of long–term care services, persons residing in the county with
3 recognized ability and demonstrated interest in long–term care and up to 3 members
4 of the governing board of the tribe or band or the Great Lakes inter–tribal council,
5 inc., that appoints the local long–term care council.

6 4. Vacancies in membership in a local long–term care council shall be filled for
7 the residue of the unexpired term in the manner that the original appointments are
8 made. A local long–term care council member may be removed from office for the
9 following reasons:

10 a. For cause, by a two–thirds vote of each county board of supervisors or
11 governing body of the tribe or band or of the Great Lakes inter–tribal council, inc.,
12 participating in the appointment, on due notice in writing and hearing of the charges
13 against the member.

14 b. If the member when appointed was a member of the county board of
15 supervisors or was another elected official and was not reelected to that office, on due
16 notice in writing.

17 (c) *Terms.* The members of the local long–term council appointed under par.
18 (a) shall serve 3–year terms. No member may serve more than 2 consecutive terms.
19 Of the members first appointed under par. (b) 1. or 3., 7 shall be appointed for 3 years;
20 7 shall be appointed for 4 years; and 7 shall be appointed for 5 years. Of the members
21 first appointed under par. (b) 2., 9 shall be appointed for 3 years; 8 shall be appointed
22 for 4 years; and 8 shall be appointed for 5 years.

23 (d) *Compensation and training.* Members of the local long–term care council
24 who are older persons, persons with physical or developmental disabilities or the
25 family members or guardians of these persons shall receive compensation for

reasonable expenses associated with membership participation. The county board of supervisors or, in the case of a local long–term care council appointed by a tribe or band or the Great Lakes inter–tribal council, inc., under par. (b) 3., the tribe or band or the Great Lakes inter–tribal council, inc., shall provide training to these members to enable them to participate effectively.

(e) *Officers.* At the the first meeting of a long–term care council, members shall elect from their number a chairperson, a secretary and other officers as necessary. Vacancies in these offices shall be filled for the unexpired terms. The chairperson shall preside at all meetings when present and countersign all actions taken by the long–term care council. In case of the absence of the chairperson for any meeting the members present shall choose a temporary chairperson.

resource centers and care management organizations

(3) LOCAL LONG–TERM CARE COUNCILS; POWERS AND DUTIES. (a) A local long–term care council shall do all of the following within the council's area:

1. Develop the initial plan for the structure of the county, multicounty or tribal ~~long–term care system~~, including formulating recommendations on all of the following: INS 19-15

~~****NOTE: Recommendations to whom? Who (what) should receive or act on these recommendations?~~

a. Whether or not the county, counties, tribe or band or Great Lakes inter–tribal council, inc., should exercise its right of first election under s. 46.283 (1) (a) to operate an aging or disability resource center or a care management organization and how the operation should proceed.

b. Whether local, private ~~nonprofit~~ organizations other than the county should serve as alternatives or in addition to county–operated entities to operate an aging or disability resource center or a care management organization and, if so, which organizations should be considered.

c. If applicable, how county–operated functions should interact with an aging or disability resource center or care management organization that is operated by a federally recognized American Indian tribe or band or by the Great Lakes inter–tribal council, inc.

2. Under criteria ~~prescribed by~~ that the department, after consulting with the council on long–term care, prescribes, evaluate and determine whether additional care management organizations are needed in the area and, if so, recommend this to the department.

**** NOTE: We do not draft "in consultation with" because it is then unclear which party has the duty to act. I chose here to leave reference to the council in, rather than delete it.

3. a. Within 60 days after receipt of a request by an applicant seeking certification or renewal of certification as ~~a resource center or~~ a care management organization in the area of the local long–term care council, provide comments and recommendations to the applicant for inclusion in the application, as specified in ~~s.~~ ~~**** and~~ 46.284 (2) (a). ~~For a care management organization,~~ the comments shall address the applicant's qualifications and expertise; the extent to which the applicant meets the requirements of s. 46.284 (2) (b); the extent of interaction between the applicant and local providers of long–term care services, volunteer agencies and community institutions; and, if the applicant is operating a care management organization, client experience with its services.

~~****NOTE: In answer to your request, because of the "shall" in s. 46.282 (3) (a) (intro.), this subdivision already requires action by the local long–term care council.~~

~~****NOTE: TO DAK: ADD X–REFERENCE (AND DUTY OF RESOURCE CENTER).~~

**** NOTE: Is this language now correct?

b. Advise the department regarding applications for initial certification or certification renewal of a ~~resource center or~~ care management organization in the area of the local long–term care council and assist the department in reviewing and evaluating the applications.

**** NOTE: Is this language now correct?

~~****NOTE: To DAK: draft in s. 46.283 requirement that applying organizations attach copies of council's recommendations to applications.~~

4. Receive information about and monitor complaints from persons served by any care management organization in the area concerning whether the numbers of providers of long–term care services used by the care management organization are sufficient to ensure convenient and desirable choice for enrollees and provide recommendations to the care management organization under subd. 3. a. and advice to the department under subd. 3. b. about this issue.

~~****NOTE: Do these language changes achieve the result you intended?~~

5. Review initial plans and existing provider networks of any care management organization in the area to assist the care management organization in developing a network of service providers that includes a sufficient number of accessible, convenient and desirable services.

6. Advise care management organizations about whether to offer optional acute and primary health care services and, if so, how these benefits should be offered.

7. Review the utilization of various types of long–term care services by care management organizations in the area.

8. Monitor the pattern of enrollments and disenrollments in local care management organizations.

9. Identify gaps in services, living arrangements and community resources and develop strategies to build local capacity to serve older persons and persons with physical or developmental disabilities, especially those with long–term care needs.

10. Perform long–range planning on policy for older persons and persons with physical or developmental disabilities.

11. Annually review interagency agreements between the resource center and care management organizations and make recommendations, as appropriate, on the interaction between the resource center and the care management organizations to assure a ~~coordinated long–term care system~~. coordination among them

****NOTE: Since "resource center" is now a defined term, I have used that term in this language change.

12. Annually review the number and types of complaints and grievances about the long–term care system by person who receive or may receive care under the system, to determine if a need exists for system changes, and recommend system or other changes if appropriate.

13. Identify potential new sources of community resources and funding for needed services for older persons and persons with physical or developmental disabilities.

14. Monitor and evaluate the resource center and care management organizations.

DAK check renumbering

15. Support long–term care system improvements to improve services to older persons and persons with physical or developmental disabilities and their families.

16. Annually report to the department and to the long–term care council concerning significant achievements and problems in the local long–term care system.

(b) A local long–term care council may ~~do all of the following within the local long–term care council's area:~~

1. Review and act on grievances from enrollees or potential enrollees of a care management organization.

****NOTE: This provision needs work, unless a specific grievance, review and appeal procedure is specified elsewhere. Informal complaint mediation must have statutory authority. Because the benefit is an entitlement, due process requirements must be met.

I have used the term "enrollees or potential enrollees," rather than "consumers", accurate?

2. Assume the duties of the county long–term community support planning committee under s. 46.27 (4).

SEC. RP; 46.282

APPLICATION FOR CONTRACT

SECTION 26. 46.283 of the statutes is created to read:

46.283 Resource centers. (1) ~~ESTABLISHMENT~~. (a) Except as provided in pars. (b) and (c), within ~~36~~ 54 months after the effective date of this paragraph [revisor inserts date] or within ~~36~~ 54 months after the approval by the secretary of the federal department of health and human services of all waivers of federal medicaid laws that are necessary to implement the long–term care system, as determined by the department, whichever is later, any of the following may take place:

1. A county board of supervisors may elect to ~~establish~~ apply to the department for a K to operate a resource center that is operated by a county department under s. 46.21, 46.215, 46.22, 46.23, 51.42 or 51.437 or is operated by a quasi–governmental authority ***** created by the county board of supervisors.

apply to the department for a K to operate

****NOTE: Is this accurate? If so, the above–referenced statutes should also be amended to provide for this.

2. The governing body of a tribe or band or of the Great Lakes inter–tribal council, inc., may elect to ~~establish~~ apply to the department for a K to operate a resource center for tribal members within the boundaries of a county.

3. A county board may elect to ~~establish~~ apply to the department for a K to operate a multiple county resource center in conjunction with the county board or boards of one or more other counties or may ~~establish~~ elect to apply to the department ~~to~~ for a K to operate a county–tribal resource center in conjunction with the governing body of a tribe or band.

****NOTE: Or in conjunction with GLITC?

apply to the department to

1 4. The governing body of a tribe or band may elect to establish a resource center
2 in conjunction with the governing body or governing bodies of one or more other
3 tribes or bands.

****NOTE: Or in conjunction with GLITC?

4 (b) In lieu of ~~election to~~ establish a resource center as specified in par. (a), the
5 department may contract with an applying nonprofit organization that meets the
6 standards specified in sub. (3) to serve as a resource center if any of the following
7 occurs:

apply for a K to operate

8 1. A county or tribe or band declines at any time to ~~establish~~ a resource center.
9 2. The county or tribe or band fails to ~~elect~~ to ~~establish~~ a resource center within
10 the time period specified in par. (a).

apply

~~****NOTE: What if the county board or tribal governing body elects to establish but fails to actually carry it out?~~

11 3. The county board or governing body of a tribe or band fails to meet the
12 standards specified in sub. (3).

13 (c) If receipt of approval by the secretary of the federal department of health
14 and human services of all waivers of federal medicaid laws that are necessary to
15 implement the long–term care system so requires, the department may contract with
16 a nonprofit organization to provide certain functions that a resource center is
17 required to provide.

****NOTE: What functions, specifically? I did not draft the "non–county agency" language requested because it is as yet unclear what this "non–county agency" will be or whether it will be authorized in this bill.

18 (d) A resource center established under par. (a), (b), or (c) may serve older
19 persons exclusively, may serve persons with physical or developmental disabilities
20 exclusively or may serve all these persons.

INSERT 24-20

21 (2) CERTIFICATION.

send entire draft for X refs

~~****NOTE: How does this work? Is it similar to the provisions for a CMO?~~

(3) STANDARDS FOR OPERATION. The department shall assure that at least all of the following are available to a person who contacts a resource center for service:

(a) Information and referral services and other assistance at hours that are convenient for the public.

(b) The availability of functional screening and response, on an emergency basis, 24 hours per day.

****NOTE: What is meant by "response"?

(c) Prevention and intervention services.

(d) Counseling concerning ~~state and federal~~ public and private benefits programs ~~and financial planning services~~.

(e) A determination of functional eligibility for the family care benefit.

(f) A determination of the maximum amount of cost sharing required for a person who is seeking long–term care services, under standards prescribed by the department.

(g) Assistance to a person who is eligible for the family care benefit with respect to the person's choice of whether or not to enroll in a care management organization and, if so, which available care management organization would best meet his or her needs.

(h) Assistance in enrolling in a care management organization for persons who choose to enroll.

(i) Equitable assignment of priority on any necessary waiting lists, consistent with criteria prescribed by the department, for persons who are eligible for the family care benefit but who do not meet the criteria under s. 46.285 (3).

****NOTE: It was unclear to me what "management" meant in the language proposed for this paragraph. Is my language accurate?

(j) Assessment of risk for each person who is on a waiting list, as described in par. (i), development with the person of an interim plan of care and assistance to the person in arranging for services.

(k) Transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system.

(L) Services under s. 46.90 and ch. 55, if a person is eligible for the services ~~and the resource center is a county agency~~.

~~***NOTE: What if the resource center is an authority? I don't understand the distinction here. What if an authority is considered to be a county agency?~~

(m) A determination of eligibility for state supplemental payments under s. 49.77, medical assistance under s. 49.46, 49.47 or 49.468 or the federal food stamp program under 7 USC 2011 to 2029 ~~if the resource center is a county agency~~.

~~***NOTE: Same question as for par. (L).~~

(4) RESOURCE CENTER; DUTIES. A resource center shall do all of the following:

(a) Provide services within the entire minimum geographic area prescribed for the resource center by the department.

(b) Submit to the department all reports and data required or requested by the department.

(c) Implement internal quality improvement and quality assurance processes that meet standards prescribed by the department.

(d) Cooperate with any review by an external advocacy organization, as specified under s. 46.28 (1) (f) 2.

(5) FUNDING. ~~(a)~~ From the appropriation under s. 20.435 (*****) (*****), the department shall contract with organizations that meet standards under ***** and shall distribute funds for services provided by resource centers.

~~(b) ***** County matching funds *****~~

board

1 **(6)** GOVERNING BOARD; MEMBERSHIP; DUTIES. (a) A resource center shall have a
2 governing ~~body~~ that is distinct from the membership of the care management
3 organization, as follows:
4 1. If the resource center is a county department under s. 46.21, 46.215, 46.22,
5 46.23, 51.42 or 51.437, the board for that county department shall serve as the
6 governing board for the resource center.
7 2. If the resource center is a quasi–governmental county authority *****, the
8 membership of the governing board shall be appointed by the county board of
9 supervisors or, in a county with a county executive or a county administrator, by the
10 county executive or county administrator, subject to confirmation by the county
11 board of supervisors.
12 3. If the resource center is operated by a tribe or band or by the Great Lakes
13 inter–tribal council, inc., the membership of the governing board shall be appointed
14 by the governing body of the tribe or band or of the Great Lakes inter–tribal council,
15 inc.
16 (b) 1. The membership of the governing board required under par. (a) shall
17 reflects the ethnic and economic diversity of the geographic area served by the
18 resource center. ~~The governing board shall be comprised of an uneven number of~~
19 ~~members~~, at least one–fourth of ~~whom~~ the members of the governing board shall be older persons or persons with physical
20 or developmental disabilities or their family members, guardians or other advocates.
21 Of those members, at least two–thirds shall correspond to the proportion of numbers,
22 as determined by the department, of persons receiving long–term care from the care
23 management organization who are older persons or persons with physical or
24 developmental disabilities.

****NOTE: This language is now identical to that for the governing body of a care management organization (see. 46.284 (5) (a) and (b). Please review. Lengths of terms should be specified. Note that subds. 2. and 3. below are not included in the CMO language.

1 2. If the resource center is a county agency or is operated by a tribe or band or
2 by the Great Lakes inter–tribal council, inc., at least one–third but not more than
3 two–thirds of the members of the board shall be elected county or tribal officials.

****NOTE: What does "county agency" mean? Should this language stay in?

4 3. The remainder of the board's membership shall be comprised of residents of
5 any county or members of any tribe or band that the resource center serves. Members
6 appointed under par. (a) may not be associated with providers of services within the
7 purview of the resource center.

****NOTE: Should this language stay in?

8 (c) The governing board of a resource center shall do all of the following:
9 1. Develop a mission statement for the resource center that is consistent with
10 the goals of the long–term care system.

****NOTE: Where are these goals specified?

11 2. Determine the structure, policies and procedures of the resource center
12 consistent with rules promulgated by the department and guidelines ***** of the
13 local long–term care council.

****NOTE: To DAK: Where are these guidelines set forth? Right term?

14 3. Oversee the implementation and operation of the resource center to ensure
15 compliance with contract requirements and statutes and rules.
16 4. Ensure that the care management organization has a viable plan for
17 implementation and operation that addresses contractual requirements and
18 applicable statutory and rule requirements.

****NOTE: I did not include the specific issues listed on p. 92 of the proposal (Appendix 5) concerning the details of a viable plan, because I was unsure if they overlapped with specified rules or statutes or specific contractual requirements. They also appear to be overly specific for inclusion in the statutes. Please review.

1 5. Identify unmet needs and prepare plans to meet those needs.

****NOTE: Needs of whom? The enrollees? The CMO?

2 6. In the case of a resource center that is operated by a county with a county
3 executive or county administrator, do all of the following:
4 a. Advise the county executive or county administrator on the appointment of
5 the director of the organization.
6 b. Recommend program priorities.
7 c. Prepare a proposed budget for submission to the county executive or county
8 administrator.
9 d. Approve the final budget for submission to the department.
10 e. Advise the director of the organization on purchasing and providing services.
11 7. In the case of a resource center that is operated in a county that is not
12 described in subd. 5., do all of the following:
13 a. Govern the resource center.
14 b. Appoint the director of the organization, subject to confirmation of the county
15 board.
16 c. Prepare a proposed budget for submission to the county board.
17 d. Determine whether services are to be provided by the resource center or
18 purchased by the resource center.
19 8. In the case of a resource center that is not described in subd. 5. or 6., do all
20 of the following:
21 a. Govern the resource center.
22 b. Appoint the director of the resource center.
23 c. Prepare and monitor the resource center's budget.
24 **SECTION 27.** 46.284 of the statutes is created to read:

46.284 Care management organizations. (1) CONTRACTS. (a) The department may contract for operation of a care management organization only with ~~a care management organization~~ an entity that is certified under sub. (2) No entity may operate as a care management organization under the requirements of this section unless certified and under contract with the department.

****NOTE: Please note that I have revised and reorganized s. 46.284 (1) and (2). Section 46.284 (2) (a) contains material previously positioned in s. 46.284 (1) (a).

(b) Within each county, the department shall initially contract to operate a care management organization with the county or a quasi–governmental organization established by the county under s. ***** if the county elects to operate a care management organization and the care management organization meets the requirements of sub. (2) and performance standards prescribed by the department. A county that contracts under this paragraph may operate the care management organization for all of the target groups or for a selected group or groups. The initial contracts shall be for 2 years ~~and shall permit the county to be the exclusive operator of a care management organization in that county for the target groups that the county elects to serve~~. During the first 2 years in which the county has a contract under which it accepts a per person per month payment for each enrollee in the care management organization, the department may not contract with another organization to operate a care management organization in the county unless any of the following applies:

1. The county ~~and the local long–term care council~~ agree in writing that at least one additional care management organization is necessary or desirable.

2. Because the county does not elect to serve ~~all target groups~~ both older persons and persons with a physical disability or is unable to meet requirements for ~~all target~~ both these client groups, an additional care management

organization is necessary to serve ~~those target~~ the groups that ~~are~~ is not served by the county.

3. The governing body of a tribe or band or the Great Lakes inter–tribal council, inc., elects to operate a care management organization within the area and is certified under sub. (2).

INSERT 31-5

****NOTE: Please read s. 46.284 (2) in conjunction with the definition of a CMO under s. 46.28 (1). I believe that PACE and Partnership programs are excluded by the two statutes.

****NOTE: What is a "target group"? It should be defined. I did not draft "by rule and under contract requirements", since I am separately drafting authority for DHFS to establish performance standards by rule and by contract.

****NOTE: To DAK: Delete "quasi–governmental organization" if not established.

(2) CERTIFICATION; REQUIREMENTS. (a) ~~The department shall certify as a care management organization~~ If an entity ~~that~~ meets the requirements under par. (b) and applicable rules of the department and ~~that~~ submits to the department an application for initial certification or certification renewal, the department shall certify that the entity meets the requirements for a CMO for certification under par. (a). ~~An application shall include comments about the applicant and recommendations about the application that are provided by the appropriate local long–term care council, as specified under s. 46.282 (3) (a) 3.~~

(b) ~~To be certified as a care management organization,~~ An applicant shall demonstrate or ensure all of the following:

1. Adequate availability of providers with the expertise and ability to provide services that are responsive to the disabilities or conditions of all of the applicant's proposed enrollees and sufficient representation of programmatic philosophies and cultural orientations to accommodate a variety of enrollee preferences and needs.

2. Adequate availability of providers that can meet the preferences and needs of its proposed service recipients for services at various times, including evenings, weekends and, when applicable, on a 24–hour basis.

1 3. Adequate availability of providers that are able and willing to perform all
2 the tasks that are identified in proposed enrollees' service and care plans.
3 4. Adequate availability of residential and day services that are geographically
4 accessible to proposed enrollees' homes, families or friends.
5 5. Adequate supported living arrangements of the types and sizes that meet
6 proposed enrollees' preference and needs.
7 6. Expertise in determining and meeting the needs of every target population
8 that the applicant proposes to serve and connections to the appropriate service
9 providers.
10 7. Thorough knowledge of local long–term care and other community resources.
11 8. The ability to manage and deliver, either directly or through subcontracts
12 or partnerships with other organizations, the full range of benefits to be included in
13 the monthly payment amount.
14 9. Thorough knowledge of methods for maximizing informal caregivers and
15 community resources and integrating them into a service or care plan.
16 10. Coverage for a geographic area specified by the department.
17 11. The ability to develop strong linkages with systems and services that are
18 not directly within the scope of the applicant's responsibility but that are important
19 to the target group that it proposes to serve, including primary and acute health care
20 services.
21 12. Adequate and competent staffing by qualified personnel to perform all of
22 the functions that the applicant proposes to undertake.
23 (c) In addition to the requirements specified under par. (b), to maintain
24 certification a care management organization shall do all of the following:

****NOTE: What does "maintain certification" mean here? Some of the requirements would seem to apply only to a CMO that has a contract to operate. Also, once a decision is made on this language, the language of sub. (2) (a) should be reviewed to see if it needs change.

(g) ~~1.~~ Meet all performance standards required by the federal government and promulgated by the department by rule. ***** NOTE: I did not draft "or by contract" as requested, because it is unnecessary; if the CMO fails to meet these standards, it is a breach of contract.

(h) ~~2.~~ Submit in the manner prescribed by the department by rule any information or reports required by the department.

~~****NOTE: I did not include "or by contract" here; it seems superfluous to the contract itself.~~

***** NOTE: Please see note under (g).

(i) ~~3.~~ Implement internal quality improvement and assurance processes that meet standards prescribed by the department by rule.

(j) ~~4.~~ Cooperate with external quality assurance reviews.

(k) ~~5.~~ Meet departmental requirements for protection of solvency.

(l) ~~6.~~ Annually submit to the department a financial audit that meets the requirements 42 CFR ?

Move to be part of (3)

(3) DUTIES OF THE CARE MANAGEMENT ORGANIZATION. A care management organization that is under contract with the department shall do all of the following: ****

***** NOTE: The CFR cite is incorrect; most likely it is 42 CFR ?

(a) Accept requested enrollment of any person who is eligible for the family care benefit. No care management organization may disenroll any enrollee, except under circumstances specified by the department by contract. No care management organization may encourage any enrollee to disenroll in order to obtain long–term care services under the medical assistance fee–for–service system. No involuntary disenrollment is effective unless the department has reviewed and approved it.

(b) Conduct a comprehensive assessment for each enrollee, including an in–person interview with the enrollee, using a standard format developed by the department.

(c) With the enrollee and the enrollee's family or guardian, if appropriate, develop a comprehensive care plan that reflects the enrollee's values and preferences.

(d) Provide or contract for the provision of necessary services and monitor the provided or contracted services.

(e) Provide, within guidelines established by the department, a mechanism by which an enrollee may arrange for, manage and monitor his or her family care benefit directly or with the assistance of another person chosen by the enrollee. The care management organization shall monitor the enrollee's use of a fixed budget for purchase or services or support items from any qualified provider, monitor the health and safety of the enrollee and provide supportive services uniquely tailored to meet needs of these enrollees.

(f) Provide, on a fee–for–service basis, case management services to persons who are functionally eligible but not financially eligible for the family care benefit.

~~***NOTE: Have I captured your intent with respect to pars. (d) to (f)?~~

Fill in here ~~pl33 S#11~~ NOTE: Paragraphs (g) to (L) were formerly located in sub. (2)(c).

(4) FUNDING AND RISK–SHARING. ~~~~ INSERT 34-12

(5) GOVERNING BOARD~~, MEMBERSHIP, DUTIES~~. (a) A care management organization shall have a governing board that is distinct from the membership of the governing board of the resource center, as follows:

1. If the care management organization is a county department under s. 46.21, 46.215, 46.22, 46.23, 51.42 or 51.437, the board for that county department shall serve as the governing board for the care management organization.

2. If the care management organization is a quasi–governmental county authority, the membership of the governing board shall be appointed by the county board of supervisors or, in a county with a county executive or a county administrator, by the county executive or county administrator, subject to confirmation by the county board of supervisors.

1 3. If the care management organization is operated by a tribe or band or by the
2 Great Lakes inter–tribal council, inc., the membership of the governing board shall
3 be appointed by the governing body of the tribe or band or of the Great Lakes
4 inter–tribal council, inc.

5 (b) The membership of the governing board required under par. (a) shall reflect
6 the ethnic and economic diversity of the geographic area served by the care
7 management organization. ~~The governing board shall be comprised of an uneven~~
8 ~~number of members,~~ at least one–fourth of ~~whom~~ the members of the governing board shall be older persons or persons
9 with physical or developmental disabilities or their family members, guardians or
10 other advocates. Of those members, at least two–thirds shall correspond to the
11 proportion of numbers, as determined by the department, of persons receiving
12 long–term care from the care management organization who are older persons or
13 persons with physical or developmental disabilities.

****NOTE: Do pars. (a) and (b) now reflect your intent? Lengths of terms should be specified.

14 (c) The governing board of a care management organization shall do all of the
15 following:

16 1. Develop a mission statement for the care management organization that is
17 consistent with the goals of the long–term care system.

****NOTE: Where are these goals specified?

18 2. Determine the structure, policies and procedures of the care management
19 organization consistent with rules promulgated by the department and guidelines
20 ***** of the local long–term care council.

****NOTE: To DAK: Where are these guidelines set forth? Right term?

1 3. Oversee the implementation and operation of the care management
2 organization to ensure compliance with contract requirements and statutes and
3 rules.

4 4. Ensure that the care management organization has a viable plan for
5 implementation and operation that addresses contractual requirements and
6 applicable statutory and rule requirements.

****NOTE: I did not include the specific issues listed on p. 92 of the proposal (Appendix 5) concerning the details of a viable plan, because I was unsure if they overlapped with specified rules or statutes or specific contractual requirements. They also appear to be overly specific for inclusion in the statutes. Please review.

7 5. Identify unmet needs and prepare plans to meet those needs.

****NOTE: Needs of whom? The enrollees? The CMO?

8 6. In the case of a care management organization that is operated by a county
9 with a county executive or county administrator, do all of the following:

10 a. Advise the county executive or county administrator on the appointment of
11 the director of the organization.

12 b. Recommend program priorities.

13 c. Prepare a proposed budget for submission to the county executive or county
14 administrator.

15 d. Approve the final budget for submission to the department.

16 e. Advise the director of the organization on purchasing and providing services.

17 7. In the case of a care management organization that is operated in a county
18 that is not described in subd. 6., do all of the following:

19 a. Govern the care management organization.

20 b. Appoint the director of the organization, subject to confirmation of the county
21 board.

22 c. Prepare a proposed budget for submission to the county board.

1 d. Determine whether services are to be provided by the care management
2 organization or purchased by the care management organization.
3 8. In the case of a care management organization that is not described in subd.
4 6. or 7., do all of the following:
5 a. Govern the care management organization.
6 b. Appoint the director of the care management organization.
7 c. Prepare and monitor the care management organization's budget.

8 **(6)** LICENSURE AS A HOME HEALTH AGENCY. Regardless of whether a care
9 management organization provides services that are similar to services provided by
10 a home health agency, as defined in s. 50.49 (1) (a), the care management
11 organization need not obtain licensure under s. 50.49 to provide the services.

****NOTE: I did not draft similar language to this, as requested, for the PACE/Partnership Programs, or for Medicaid Prepaid Health Programs and Managed Care Programs. Probably, for those programs, a specific exception to s. 50.49, stats., should be made. The definition language for PACE and Partnership is insufficient (I need the full federal citation). Where are the other programs statutorily mentioned?

12 **SECTION 28.** 46.285 of the statutes is created to read:

13 **46.285 Family care benefit. (1)** ELIGIBILITY. A person who is aged at least
14 18, whose primary disabling condition is not mental illness and who meets all of the
15 following criteria is eligible for, but not entitled to, the family care benefit:
16 (a) *Functional eligibility.* A person is functionally eligible if his or her
17 functional capacity is at one of the following levels:
18 1. At the comprehensive level, the person:
19 a. Has a long–term, irreversible condition.
20 b. Requires ongoing care or assistance, which may include a wide range of
21 services, from others to meet his or her needs.

**** Note that I deleted sub. (6); please see 50.49(6m)
SECTION . AM; 46.284 (1)(c) - delete consult w/ council 7/1/01

1 c. Is in serious jeopardy of losing his or her health and safety in the absence of
2 the care or assistance.

3 2. At the intermediate level, the person:

4 a. Has a condition that is long term or is potentially long term.

5 b. Is at risk of losing his o her independence or is at risk of encountering a
6 serious decline in his or her functional capacity.

7 c. Needs periodic assistance from others to meet his or her needs, but needs or
8 is likely to need a minimum number or amount of services.

9 d. May or may not need ongoing case management.

10 (b) *Financial eligibility.* A person is financially eligible if he or she is eligible
11 for medical assistance under s. 49.46 (1) or 49.47 (4).

****NOTE: *Has been determined* eligible? The instructions conflict with the proposal, i.e., the proposal requires financial eligibility for Medicaid, whereas the instructions refer to persons who are "categorically eligible"; I have included eligibility under both categorically and medically needy; what about ss. 49.465 and 49.468, stats.? Please review.

12 **(2)** COST SHARING.

****NOTE: Do you want me to use current language under s. 46.27 (6u) for this subsection? If so, are there any changes in that language that you want?

13 **(3)** ENTITLEMENT. A person is entitled to and may receive the family care benefit
14 if he or she participates in cost sharing, if applicable, is enrolled in a care
15 management organization and meets all of the following criteria:

16 (a) Is functionally eligible at the comprehensive level.

17 (b) Is functionally eligible at the intermediate level and is financially eligible.

18 (c) Is functionally eligible at the intermediate level and, following an
19 investigation under s. 46.90 (5) of alleged abuse, material abuse or neglect by another
20 person or of alleged self–neglect is determined under s. 46.90 (5m) (a) be in need of
21 services under ch. 55.

****NOTE: Does this language capture your intent? If not, under the 12/08/98 revised instructions, it will be necessary to clarify who substantiates the need for adult protective services; if the investigative powers under s. 46.90 (5) are not used, it will also be necessary to clarify how the need is substantiated.

(d) Is receiving services under s. 46.27, 46.275, 46.277 or 46.278 on the effective date of this paragraph [revisor inserts date].

****NOTE: Is s. 46.275, stats., properly included here?

SECTION 29. 46.286 of the statutes is created to read:

46.286 Rights of persons, eligible persons and enrollees. (1) DEFINITIONS.

(a) *Title.* 1. 'Title.'

INSERT 39-5

SECTION 30. 46.286 of the statutes is created to read:

46.286 Rights of clients, eligible persons and enrollees. (1) DEFINITION. In this section, "client" means an older person or a person who has a physical or developmental disability who has contact with a resource center or a care management organization and includes an eligible person and an enrollee.

****NOTE: Is the definition accurate in including eligibles and enrollees, i.e., are they entitled to all of the rights specified in sub. (2)? What about advocates and guardians for and family members of these persons who have contact with the RC or CMO? I did not draft a definition of "person", because it is very confusing to have numerous references to "person" outside this section with a different meaning than would exist inside this section.

(2) RIGHTS OF CLIENTS. A client has the right to all of the following:

(a) Receipt of complete and accurate information that is provided in an understandable and culturally appropriate manner and that will enable the client to make informed choices about possible receipt of long–term care services under the family care benefit or under other benefit programs.

NOTE **** Provided by what (whom)?

****NOTE: It is a problem to refer to "other long–term care service systems", because "long–term care system" will be a defined term. Is "other benefit programs" accurate?

(b) Receipt of a prompt determination as to whether he or she is an eligible person.

(c) Accuracy of information about the client that is collected by a resource center, a care management organization or a contractor with a resource center or a care management organization and treatment of that information in a confidential manner.

(d) Access to all information about the client that is maintained by a resource center, a care management organization or a contractor with a resource center or a care management organization.

(e) Treatment that is respectful, fair and free of discrimination.

(f) Assistance in understanding his or her rights under this section and in resolving any dispute that he or she may have concerning his or her contact with a resource center or a care management organization.

(g) Fair and equitable procedures for resolving complaints or disputes.

(h) Freedom from reprisal or the overt or implied threat of reprisal for registering complaints or grievances or participating in procedures under par. (g).

(3) RIGHTS OF ELIGIBLE PERSONS. An eligible person shall have the right to all of the following:

(a) Choice as to whether or not to enroll in a care management organization for receipt of the family care benefit.

(b) Choice as to whether to disenroll from a care management organization for any reason.

****NOTE: It was unclear to me what the proposed language for this subsection meant: can one receive the family care benefit if one is not enrolled? Should par. (a) be "enroll in a care management organization and receive the family care benefit or . . . "?

(4) RIGHTS OF ENROLLEES. An enrollee shall have the right to all of the following:

(a) Full participation in planning and evaluating the treatment and services he or she receives.

does all of the following: 1.

(b) Development of a plan of care that is tailored to meet his or her unique needs and circumstances as indicated by performance of an individualized assessment.

(INSERT 41-2)

(c) Prompt receipt ~~from providers~~ of services and support items that are adequate and that are adequate and appropriate in meeting the enrollee's individual needs. included in the plan of care

~~****NOTE: What is a "qualified" provider? I did not draft all the language proposed, because I do not understand how either providers or services and support items (it is unclear which) can "as much as possible preserve the enrollee's health, safety and well being and keep the enrollee free from abuse and neglect".~~

(d) Choice as to whether to disenroll from a care management organization for any reason.

(INSERT 41-4)

SECTION 31. 46.287 of the statutes is created to read:

46.287 Rule–making. The department shall promulgate as rules all of the following: **(1)** Standards for performance by resource centers and care management organizations, including requirements for maintaining quality assurance and quality improvement.

(2) Requirements for the provision of services by advocacy organizations contracting with the department under s. 46.281 (1) (f) 2.

(3) Rights of clients, eligible persons and enrollees that are specified in s. 46.286.

(INSERT 41-13)

SECTION 32. 234.03 (13) of the statutes is amended to read:

234.03 **(13)** To purchase and enter into commitments for the purchase of mortgages and securities if the authority shall first determine that the proceeds of the sale of such mortgages and securities to the authority will be utilized for the purpose of residential housing for occupancy by persons or families of low and moderate income and to enter into agreements with sponsors of residential facilities, as defined in s. ~~46.28~~ 46.291 (1) (d) and (e), and with eligible sponsors, mortgagors or issuers of securities for the purpose of regulating the planning, development and

1 management of housing projects financed in whole or in part by the proceeds of the
2 mortgages or securities purchased by the authority.

History: History: 1971 c. 287; 1973 c. 208, 333; 1975 c. 221; 1977 c. 418; 1981 c. 349 ss. 12, 32; 1983 a. 27 ss. 1622e to 1622m, 2202 (20); 1983 a. 81; 1983 a. 83 ss. 7, 8, 22; 1983 a. 192; 1985 a. 29 ss. 2242, 3200 (28); 1985 a. 334; 1987 a. 27, 399; 1993 a. 16, 112, 437; 1997 a. 27.

3 **SECTION 33.** 234.03 (15) of the statutes is amended to read:

4 234.03 **(15)** To acquire or contract to acquire from any person by grant,
5 purchase or otherwise, leaseholds, real or personal property or any interest therein,
6 only when the authority finds that ~~low–~~ low–income or moderate–income housing
7 cannot be developed privately without an acquisition by the authority, or when the
8 authority acquires property by reason of default by a sponsor of a residential facility,
9 as defined in s. ~~46.28~~ 46.291 (1) (d) and (e), or by an eligible sponsor; to own, hold,
10 clear, improve and rehabilitate and to sell, assign, exchange, transfer, convey, lease,
11 mortgage or otherwise dispose of or encumber the same. Nothing in this chapter
12 shall be deemed to impede the operation and effect of local zoning, building and
13 housing ordinances or ordinances relating to subdivision control, land development,
14 fire prevention or other ordinances having to do with housing or housing
15 development.

History: History: 1971 c. 287; 1973 c. 208, 333; 1975 c. 221; 1977 c. 418; 1981 c. 349 ss. 12, 32; 1983 a. 27 ss. 1622e to 1622m, 2202 (20); 1983 a. 81; 1983 a. 83 ss. 7, 8, 22; 1983 a. 192; 1985 a. 29 ss. 2242, 3200 (28); 1985 a. 334; 1987 a. 27, 399; 1993 a. 16, 112, 437; 1997 a. 27.

16 **SECTION 34.** 234.61 (1) of the statutes is amended to read:

17 234.61 **(1)** Upon the authorization of the department of health and family
18 services, the authority may issue bonds or notes and make loans for the financing of
19 housing projects which are residential facilities as defined in s. ~~46.28~~ 46.291 (1) (d)
20 and the development costs of those housing projects, if the department of health and
21 family services has approved the residential facilities for financing under s. ~~46.28~~
22 46.291 (2). The limitations in ss. 234.18 (1), 234.40, 234.50, 234.60, 234.65 and

234.66 do not apply to bonds or notes issued under this section. The definition of "nonprofit corporation" in s. 234.01 (9) does not apply to this section.

History: History: 1983 a. 27; 1983 a. 81 s. 13; 1983 a. 83 s. 22; 1983 a. 192; 1985 a. 29, 334; 1993 a. 437; 1995 a. 27 s. 9126 (19); 1997 a. 27 s. 3355c; Stats. 1997 s. 234.61.

SECTION 35. 234.61 (2) (b) of the statutes is amended to read:

234.61 **(2)** (b) Of the amount specified in par. (a), $30,000,000 may only be used to finance residential facilities serving 15 or fewer persons who are chronically disabled, as defined in s. ~~46.28~~ 46.291 (1) (b).

History: History: 1983 a. 27; 1983 a. 81 s. 13; 1983 a. 83 s. 22; 1983 a. 192; 1985 a. 29, 334; 1993 a. 437; 1995 a. 27 s. 9126 (19); 1997 a. 27 s. 3355c; Stats. 1997 s. 234.61.

SECTION 36. 234.61 (2) (c) 1. of the statutes is amended to read:

234.61 **(2)** (c) 1. Of the amount specified in par. (a), $48,580,000 may only be used to finance residential facilities with 100 or fewer units for elderly persons, as defined in s. ~~46.28~~ 46.291 (1) (c) or to finance additional residential facilities serving 15 or fewer persons who are chronically disabled.

History: History: 1983 a. 27; 1983 a. 81 s. 13; 1983 a. 83 s. 22; 1983 a. 192; 1985 a. 29, 334; 1993 a. 437; 1995 a. 27 s. 9126 (19); 1997 a. 27 s. 3355c; Stats. 1997 s. 234.61.

SECTION 37. 234.61 (2) (c) 2. of the statutes is amended to read:

234.61 **(2)** (c) 2. The remainder of the amount specified in par. (a) may only be used to finance residential facilities with 50 or fewer units for elderly persons, as defined in s. ~~46.28~~ 46.291 (1) (c), or to finance additional residential facilities serving 15 or fewer persons who are chronically disabled.

INSERT 43-16

History: History: 1983 a. 27; 1983 a. 81 s. 13; 1983 a. 83 s. 22; 1983 a. 192; 1985 a. 29, 334; 1993 a. 437; 1995 a. 27 s. 9126 (19); 1997 a. 27 s. 3355c; Stats. 1997 s. 234.61.

SECTION 9123. Nonstatutory provisions; health and family services.

(1) COUNCIL ON LONG–TERM CARE. (a) *Initial terms.* Notwithstanding the length of terms specified for the members of the council on long–term care appointed under section 15.197 (5) of the statutes, as created by this act, the initial members of the council shall be appointed under that subsection for the following terms:

1. Nine of the members, for terms expiring on July 1, 2002.

2. Eight of the members, for terms expiring on July 1, 2003.

1 3. Eight of the members, for terms expiring on July 1, 2004.

2 (a) *Nominations.* Not later than 90 days after the effective date of this
3 paragraph, the secretary of health and family services shall provide to the governor
4 a list of nominations for appointment as initial members of the council on long–term
5 care under section 15.197 (5) of the statutes, as created by this act. The secretary
6 shall solicit the nominations from persons aged 65 or older and persons with physical
7 or developmental disabilities; immediate family members and guardians of and
8 advocates for these persons; organizations of providers of long–term care services;
9 counties; federally recognized American Indian tribes or bands; and other persons
10 with knowledge of and interest in the long–term care system, as defined in section
11 46.28 (4) of the statutes, as created by this act.

12 (END)

~~(2)~~ (2) LENGTH OF INITIAL TERMS OF MEMBERS OF BOARD ON AGING AND LONG-TERM CARE. Notwithstanding sec 15.105 (10) ots, as affd by this act,

the length of terms specified for members of the BOALTC appointed under

1 one of the ~~two~~ 2 additional initial members appointed under that subsection shall be appointed for a term expiring on May 1, 2005 and the other of the 2 additional initial members appointed under that subsection shall be appointed for a term expiring on May 1, 2006.

(2) RULES FOR FAMILY CARE BENEFIT.

p. 121 D-MAN → DWD

section 46.287 (1) to ~~(4)~~ (5)

INSERT 1-1

Reference	Comments
p. 11, note following line 14	The requests to HCFA would be to waive portions of s. 1902 of Title 19 of the Social Security Act related to statewideness, comparability and freedom of choice. Yes, I think "fund the long-term care system" in line 11 is too broad. I would take it out, leaving "...the use of federal moneys to provide the family care benefit..." We will be able to get some federal funds to support Resource Center functions, but don't need waivers to do so. In line 14, please change "long-term care system" to "operation of resource centers, care management organizations and the family care benefit."
p. 11, line 16	Please add "and the family care benefit"
p. 11, lines 18-21 and note following	See later notes regarding Resource Center provisions. I would change the portion of this subd. related to Resource Centers to read: "...and one or more entities for services specified under s. 46.283 (3).
p. 12, lines 1-3 and note following	Please delete this responsibility from DHFS purview. Instead, the Board on Aging and LTC will assume this responsibility. Amend s. 15.105 (10) to read: There is created a board on aging and long-term care, attached to the department of administration under s. 15.03. The board shall consist of ~~7~~ 9 members appointed for staggered 5-year terms. Members shall have demonstrated a continuing interest in the problems of providing long-term care for the aged or disabled. At least ~~4~~ 6 members shall be public members with no interest in or affiliation with any nursing home. At least 5 members shall be persons aged 65 or older or persons with physical or developmental disabilities or their family members, guardians or other advocates. See INSERT 4-9 The changes to s. 16.009 (2) can stay as drafted; these relate to BOALTC's role as the ombudsman for residents of LTC facilities. CR; 16.009 (2)(p) Add to the general responsibilities of BOALTC: "~~Long-term care advocacy. The board shall~~ contract with one or more organizations to provide advocacy services to potential or actual recipients of the family care benefit as defined under s. 46.28 (4) or their families or guardians. The board and contract organizations under this ~~subsection~~ paragraph shall assist these persons in protecting their rights under all applicable federal or state laws and regulations. An organization with which the board contracts for these services may not be a provider, nor an affiliate ~~thereof~~ of a provider, of long-term care services, a resource center under s. 46.283 or a care management organization under s. 46.284. Advocacy services include, ~~but are not limited to~~ all the following: (1) providing information, technical assistance and training for consumers about how to obtain services or supports, (2) providing advice and assistance in preparing and filing complaints, grievances and appeals, (3) providing negotiation and mediation on behalf of items.

Reference	Comments
	individuals, ~~and~~ assuring the availability of, and consulting with legal backup for appropriate interpretation of law or regulation, and providing representation in administrative hearings and judicial proceedings." NOTE **** ~~what~~ I do not understand **
p. 12, line 6 and following note	I suggest deleting this. Paragraph (i) seems to cover it.
p. 12, lines 8, 14 and 16	Please change the term "the long-term care system" to "resource centers and care management organizations"
p. 12, note following line 13	This provision is fine as drafted.
p. 12, lines 17-20 and note following	I suggest changing the phrase "the long-term care system" to "these organizations" — or just drop the phrase and move "external" ahead of "reviews." These reviews just have to be external to the organization being reviewed.
p. 13, line 17	Please change the term "the long-term care system" to "long-term care services"
p. 14, line 5	To avoid the possibility of any future misunderstanding, please add "non-binding" before the word "recommendations."
p. 14, lines 15-22	Please drop this paragraph. See Attachment 1.
p. 15, line 8	Please change the term "the long-term care system" to "resource centers, care management organizations and the family care benefit"
p. 15, line 10	Please change the term "the long-term care system" to "the family care benefit"
p. 15, line 14	Please change this to read "...quality of services provided by resource centers and care management organizations"
pp. 16-17	See first comment above regarding proportionality requirement. The same concern applies to local councils
p. 19, line 15	Please change the term "the long-term care system" to "resource centers and care management organizations"
p. 19, note following line 15	These recommendations are to the county board(s) of supervisors and county executive/administrator if applicable, or tribal governing board, who must consider them in deciding: - whether to authorize one or more existing county/tribal agencies to apply to the department for a contract to operate a resource center or CMO, and if so, which agencies and for which target groups - if a county, whether to create a quasi-governmental authority (or district) to apply to the department for a contract to operate a resource center or CMO

INSERT 4-9

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608–266–3561)

867.035
701.065(1)(b)1.
859.02(2)(a)
705.04(29)
20.435(1)(in)

CR; 20.435(7)(ip)

20.435(7)(ip) Family care benefit; ~~cost sharing~~ ~~and~~ recovery of costs of care. ~~From the~~ ~~All~~ All moneys received ~~from the~~ ~~and~~ from the recovery of costs of care under ss. 46.285(6) and 867.035, for payments ~~for~~ ~~to~~ ~~****~~ to ~~****~~ for ~~the~~ provision of the family care benefit as provided in 46.285(6)(d)

**** NOTE: The wording of this appropriation is dependent on decisions relating to s. 46.285(6)(c) and (d) — please see s. 20.435(7)(im), stats., which I used as a model.

INSERT 5-4

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608-266-3561)

CR; 46.215 (1)(r)

46.215 (1)(r) If authorized under s. 46.283 (1)(a) 1., to apply to the department to operate a resource center under s. 46.283 and, if the department contracts with the county under s. 46.283 (2), to operate the resource center.

Same provision

CR; 46.22 (1)(b) 1.j.

Same provision

CR; 46.82 (3)(a) 19. (Eliminate "to" bec. of intro.)

(INSERT 9-21)

STATE OF WISCONSIN – ~~LEGISLATIVE REFERENCE BUREAU~~ – LEGAL SECTION
(608–266–3561)

✓ 46.27 (5) (am) – Do not amend

~~AM 46.27 (6)(a) 1. 2, unless the person is~~

RN 46.27 (5) (e) → 1. After the date specified in s.46.281(3),
CR 2. Subd. 1 does not apply to persons who are aged or are 65 or older ~~or are elderly or temporarily~~ disabled ~~persons~~ and who is residing in the area that is served by a resource center to which s.46.281(3) applies.

RN ~~46.27 (6)(a) 1. – a.~~ Please see note under s.46.277(5)(d) 1n.b.
~~CR b.~~

CR 46.27 (6)(a) 2.i ↑

RN 46.27 (6) (a) 3. → a.
CR b.

CR ~~AM~~ 46.27 (7) (cj) 3. ~~a~~ ab. After Subd. 3.a. does not apply

CR 46.27 (11) (c) 5n. ab. ↑ 5n. a. ...

CR 46.277(5) (d) 1n. a.b. ↑ 1n. a. ...

RN 50.06 (7) → (a)
CR (b) ↑ par. (a) ...

NOTE: The amendments to s.46.27 and 46.277 conflict with some ~~do not jibe with~~ of the ~~exceptions~~ limited waivers or exemptions in s.46.289. Please decide which treatment you prefer.

Numerous provisions should be looked at to determine if they should be amended to provide for functional screening as well as COP assessment, including s. 49.45 (6m) (c) 5.
46.277 (5)(d) 1n.,
50.04(2m)

INS 10-3

not "CMO" does not mean ~~any of the following~~ an entity that Ks w/the dept to operate (a) ~~An entity that contracts w/the dept to operate~~ A any of the following program of all-inclusive care for persons aged 65 or older authorized under 42 USC 1395 to 1395ggg.

(b) ~~An entity that Ks with the~~ A demonst program known as the Wis partnership program under a waiver of ~~ss~~ sections 1813, 1814, 1833, 1886 and 1902 of the federal social security act.

**** NOTE: Can you possibly obtain citations to the U.S. Code for these provisions? We are reluctant to cite in this manner.

(INSERT 13-20)

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608–266–3561)

46.281 (3)

(3) DUTIES OF THE SECRETARY. The secretary shall certify to each ~~the applicable county's~~ ~~nursing home and cbrf~~ county, nh + cbrf the date on which a resource center ~~becomes~~ is first available ~~who for which~~ to provide a functional screen under s. 46.283 (~~7~~) (b) and (e).

~~resource center~~

that ~~which~~ serves the area of the county, nh or cbrf

INS 19-15

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608–266–3561)

to the county bd of supervisors and, in a
co w/a co exec or a co admin, to the co exec
or co admin, to the governing body of the
tribe or band or of the GLITC inter-tribal council,
in c., if applicable, and to the department

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(a) ~~After considering recommendations of the local long-term care council under s. 46.282 (a) 1.,~~ a county board of supervisors and, in a county with a co exec or a co admin, the co exec or co. admin, ~~or the governing body of a tribe or band or of the Great Lakes Inter-tribal council, inc.,~~ may decide all of the following:

1. Whether to authorize one or more county departments under s. 46.21, 46.215, 46.22 or 46.23 or an aging unit under s. 46.82 to apply to the department for a contract to operate a resource center, and, if so, which ~~county dept. to do~~ to authorize.

~~2. If a decision is made to authorize under subd. 1. which county department and what client group would be served.~~

2. Whether to create a ~~quasi governmental~~ ***** district to apply to the dept for a K to operate a res. center.

(b) After considering recommendations of the local long-term care council under s. 46.282 (a) 1., the governing body of a tribe or band or of the GL i-t council, inc., may decide whether to authorize a tribal agency to apply to the department for a K to operate a resource center for tribal members within the boundaries of a county and, if so, what client group would be served.

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(c) A county bd of sup ~~and, in a county w/ a county exec or adm, the co mgr~~, may decide under the requirements of par. (a) to apply to the department for a contract to operate a multiple county resource center ~~under par. (a)~~ in conjun w/ the co bd or boards of one or more other cos or a county-tribal resource center in conj w/ the gov body of a tribe or band or the GLTC

(d) The gov body of a tribe or band may ~~do~~ decide under the requirements of par. (b) to apply to the dept for a K to operate a resource center in conj. with the gov body or gov bodies of one or more other tribes or bands or the G-L-Art council, inc.) or with a county board of supervisors.

(2) Exclusive K. (a) Except as provided in ~~par.~~ subd. 2. (b), during the first 54 months, the department may contract only with a county, a district ~~****~~, the governing body of a tribe or band or the GLTC, inc., or under a joint application of any of these, to operate a resource center

~~(b)~~ 2. The dept may contract with a private nonprof org that ~~has no~~ is entirely separate from any entity that operates a CMO if: co decides to apply contribs fares to meet standards

(b) After the first 54 months, dept may contract w/ counties, districts, tribes, under jt. applicn w/ a private nonprof that is entirely separate...

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46.284(1)

(c) ~~After 24 months the first 24 months after~~ After consulting with the council on long-term care, prescribe criteria to determine the number of CMAs that should operate in a county. Under these criteria, the department shall solicit applications ~~and select~~, certify those applicants that meet the requirements specified in s. 46.284 (2)(a), select certified applicants for contract and contract with the selected organizations.

(c) For contracts following the initial contracts specified in par. (b) ~~After an initial 2 year contract period as provided in par. (b)~~, the department shall

(INSERT 34-12)

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(4) FUNDING AND RISK-SHARING. (a) From the approp accounts under 20.435(5)(b) and (o) and ( )( ), the department shall provide funding ~~for payment~~ (for the provision of services ~~under~~ on a capitated payment basis) under this section. Notwithstanding s. 46.036, a care management o that is under K w/ the dept may expend the funds, consistent with this section, including providing payment, on a capitated basis, to providers of services under the tc benefit.

*** Note: Do you really want to w/withst. all of s. 46.036?

(b) If the expenditures by a cmo under par. (a) exceed payments received from the dept under par. (a), ~~all of the following apply:~~ the department may share the loss with the cmo, w/in the limits ~~that the dept~~ prescribed ~~establishes~~ under the K with the ~~dept~~.

~~(c) 2. The cmo may~~

~~(c)~~ ~~If the expenditures~~ If the payments received from the dept under par. (a) exceed the expenditures by a cmo under par. (a), the cmo may retain a portion of the savings, ~~and shall return a portion to the department~~, within the limits prescribed under the K w/ the dept, and shall return the remainder to the dept.

~~(b)~~ (d) The department may, by contract, impose solvency protections that the department determines are reasonable and necessary to retain federal financial participation. These protections may include ~~requirements~~ all of the fol. requirements that a cmo segregate

a risk reserve from other funds of the CMO or the authorizing body, including the county, ~~&~~ for the CMO

2. Requirements that interest or other gains accruing to the ~~fund~~ risk reserve remain in the ~~fund~~ risk reserve account.

(e) A county may ~~establish~~ place funds in a risk reserve ~~&~~ and maintain the risk reserve in an interest-bearing escrow account with a financial institution, as defined in s. 69.30 (1)(b). ~~Funds~~ Moneys in the risk reserve may be expended only for the provision of services under this section. If a CMO ceases participation under this section, the funds in the risk reserve, minus any contribution of ~~funds~~ moneys other than those specified in par. (a), shall ~~revert~~ be returned to the department. The department shall expend the moneys for the payment of outstanding debts to providers of ~~services~~ family care benefit services and for the continuation of family care benefit services to enrollees.

*** NOTE I did not know how to characterize "non-Family Care funds"; please review to see if my characterization is accurate.

(f) ~~1.~~ A CMO (subject to subd. 2.) may enter into contracts with providers of family care benefit services ~~under~~ and may ~~determine~~ ~~interest or not to~~ limit profits of the providers under the contracts. 2. The department ~~may~~ shall ~~(a)~~ review the contracts in subd. 1. including rates for the provision of service, ~~specified~~ to ensure that the contract terms protect access to services by enrollees and financial viability of the CMO, and may require contract revisions.

~~(5) A CMO may enter into contracts with providers~~

(g) ~~The department shall annually~~
~~and~~ A CMO shall annually be subject to an independent financial audit that the department shall obtain.

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46.285 Joint operation of rc + cmo. If a co bd of supers and, in a co w/ a ce or a ca, the ce or ca, decides ~~both~~ to authorize a county agency to apply to the department for ~~a~~ both a contract to operate a resource center and a contract ~~to apply to the department for certification~~ to operate a cmo, the county board of supervisors and, ~~in a ce~~ if applicable, the ce or ca, may do one of the foll: ~~directly~~ operate the cmo and

(1) create a ~~xxxx~~ district to operate the rc, ~~and~~

(2) ~~directly~~ operate the rc and create a * —— district to operate the cmo.

(3) Create a * —— district to operate both the rc and the cmo.

(4) Directly operate both the rc and the cmo, ~~for the~~ except with respect to determinations of eligibility, as specified in s. 46.286 (1) and w/respect to development of enrollees' plans of care, as specified in s. 46.287 (2) (b).

INSERT 39-5

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SECTION 28. 46.28~~5~~6 of the statutes is created to read:

46.285 Family care benefit. (1) ELIGIBILITY. A person is eligible for, but not entitled to, the family care benefit if the person is at least 18 years of age and meets all of the following criteria:

(a) Functional eligibility. A person is functionally eligible if, due to a primary disabling condition other than mental illness, substance abuse, or developmental disability, any of the following applies, as determined by the department or its designee:

1. The person's functional capacity is at either of the following ~~levels~~:

a. ~~Comprehensive level. A person's functional capacity is~~ At the comprehensive level if the person has a long–term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance or supervision.

b. ~~Intermediate level. A person's functional capacity is~~ At the intermediate level, if the person has a condition that is expected to last at least 90 days or result in death within one year ~~of~~ after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

2. The person ~~was a resident in a nursing home or~~ was receiving long-term care services funded under any of the following or was a res in a nh on the date that the family care benefit became available in the person's county of residence:

a. The Long-term support community options program under s. 46.27 (7) or (11).

b. A Community integration program under s. 46.275, 46.277 or 46.278.

c. The Alzheimer's family caregiver support program under s. 46.87.

d. Community aids under s. 46.40.

e. County funding. ***** NOTE: What abt. personal care under MA?

(b) Financial eligibility. A person is financially eligible if either of the following, as determined by the department or its designee, applies:

1. The projected cost of the person's care plan, as calculated by the department or its designee, exceeds ~~his or her~~ the person's gross monthly income, deductions and allowances ~~permitted~~ specified by rule by the department, plus ~~1/12~~ one-twelfth of his or her available assets.

2. ~~He or she~~ The person is eligible for medical assistance under s. ~~49.472, 49.46 (1) (a) 4 or 6m, 49.47 (4) (a) 3 or 4~~, 46.27 (11), 46.275, 46.277 ~~or~~, 46.278 or any program of assistance operated under a waiver granted under 42 USC 1396n (c). , 49.46 (1)(a) 4. or 6m.; 49.47 (4)(a) 3. or 4. or 49.472

NOTE: I added "primary" to "disabling condition", since your instructions include a whole term. Is this accurate? Another problem: the condition referred to in par. (a) 1. a and b. the same as the primary disabling condition? If so, it should be termed that.

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~~Note: 49.472 is the new eligibility under the Pathways program (to be created by this budget).~~

**** NOTE: If LRB 99-0206 (the Pathways to Independence draft) is not included in the budget bill, the reference to s. 49.472 in par. (b)2. must be eliminated.

(2) COST SHARING. (a) Persons determined to be financially eligible under sub. (1) (b) shall ~~be required to~~ contribute toward the cost of their care an amount calculated by the department or its designee, after subtracting from the person's gross income the deductions and allowances permitted by the department by rule. ~~**** NOTE: This is incorrect. Shouldn't the reference be to sub. (1)(b) 2.~~ is it?

(b) Funds received under par. (a) shall be used to pay for long-term care services.

(3) DIVESTMENT. (a) The department or its designee shall require all persons applying for the family care benefit and, annually, all persons receiving the benefit to provide a declaration of assets, on a form prescribed by the department. The declaration shall include all of the following: 1. All ~~any~~ assets that the person ~~applying for or receiving the services~~, or his or her spouse ~~has~~ transferred to another for less than fair market value at any time within the 36-month period immediately before the date of the declaration, ~~or with respect to~~ 2. All payments made from a trust or portions of a trust that would be treated as assets transferred by an individual under s. 49.454 (2) (c) or (3) (b), established by the person or his or her spouse, within the 60-month period immediately before the date of the declaration.

**** NOTE: How is this intended to work? Who uses the money? The CMO? Orders the department credit it to the main appropriation?

(b) In determining financial eligibility under sub. (1) (a) and in calculating the amount under par. (a), the department or its designee shall include as the assets for any person, except those persons who are eligible for medical assistance under s. 49.46, 49.468 or 49.47, any portion of assets that the person or the person's spouse has transferred to another as specified in par. (a), unless one of the following applies:

1. The transferred asset has no current value.

2. The department or its designee determines that undue hardship would result to the person or to his or her family from a denial of financial eligibility or from including all or a portion of a transferred asset in the calculation of the amount of cost sharing required.

(4) ENTITLEMENT. A person is entitled to and may receive the family care benefit through enrollment in a care management organization if he or she is financially eligible, participates in cost sharing, if applicable, and meets any of the following criteria:

(a) Is functionally eligible at the comprehensive level.

(b) Is functionally eligible at the intermediate level and is financially eligible under sub. (1) (b) 2.

**** NOTE: Note my changes to the lang. proposed. Is the draft accurate?

(c) Is functionally eligible at the intermediate level and is determined by an agency under s. 46.90 (2) or s. 55.05(1) to be in need of protective services or placement ~~under~~ under s. 55.05 protective under s. 55.06 ~~ch. 55. The need for protective services or placement shall be established in accordance with applicable provisions under s. 55.05 and s. 55.06~~.

(d) Is functionally eligible under sub. (1) (a) 2.

Notes: We do want the same ***spousal impoverishment*** *protections and* ***estate recovery*** *provisions to apply to Family Care that currently apply to COP-Waiver*

; MEDICAL ASSISTANCE ELIGIBILITY

(5) RECOVERY OF COSTS OF CARE; For a person who ~~is~~ receive the family care benefit and eligible for medical assistance under s. 49.46, 49.468 or 49.472 and receive the family care benefit, ~~the provisions of~~ s. 49.496 applies.

(b) ~~For~~ A person other than a person specified in par. (a) is deemed to be a client ~~under~~ s. 46.27(7g) ~~in par. (a) 1., and s. 46.27(7g) applies for the purpose~~ ~~s. 46.27(7g) applies to the person~~

~~(b) For a person who is other than a person~~

~~1. In this paragraph~~

(6) RECOVERY OF COSTS OF CARE; OTHER ELIGIBILITY.

Copy 46.27(7g) here - adapt

NOTE: I do not understand the instructions about spousal impoverishment. If a person is eligible under medical assistance, ~~the spouse~~ s. 49.455 applies. But for persons on ~~short~~ long-term care, is this ~~the rule~~ relevant? ~~If a community spouse~~ "Spousal impoverishment" is supposed to protect the community spouse when the other spouse is institutionalized. I'm having difficulty figuring out how the concept works with respect to community long-term care.

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2. As much as possible enables the enrollee to preserve his or her health, safety and well being.

3. As much as possible enables the enrollee to be free from abuse or neglect

(INSERT 41-4)

(5) HEARING. (a) A client may contest any of the following, by sending within 10 days after receipt of notice of any of the following, a written request for hearing under ~~s. 227.44 to the division of hearings and appeals created under s. 15.103(1):~~ a mechanism for hearing that is prescribed by the dept by rule:

1. Denial of eligibility under s. 46.285(1)
2. Denial of timely services

**** Note: What is meant here? Both services under the family care benefit and administrative services? What is meant by denial & untimely delivery? Failure to provide timely services + support items that are included in the plan of care

3. Reduction of services under the family care benefit. or support items

4. Termination of the family care benefit.
5. Development of a ~~unacceptable~~ plan of care that is unacceptable for any of the following reasons:

a. The plan of care requires the enrollee to live in a place that, to the enrollee, ~~does not [illegible]~~ is unacceptable.

b. The plan of care provides care, treatment or support items that are in suff. to meet the enrollee's needs, are unnecessarily restrictive or are unwanted by the enrollee.

(b) A client may contest ~~any of the following as grievance~~ the type, amount or quality of service under the family care benefit or may contest the choice of service provider under the procedure specified in par. (a) (intro.) only if ~~after the client's grievance is first reviewed~~ the contract monitoring unit of the Department has first reviewed and attempted to resolve the ~~issue~~ dispute.

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**** NOTE: What event triggers the client's right to ~~write~~ request a s.227.44, stats., hearing under this subsection? Note that I have included language about resolving the issue. Should the contract monitoring unit be required to issue a written response to the client's complaint?

~~(3)(a)~~ **** NOTE: I am told by the civil procedures drafter, Bob Nelson, that the proposal to require that the hearing under s.227.44 be a de novo review is unnecessary.

~~(d) Upon receipt of a ~~request~~ written request for hearing as specified in par. (a) or (b), the division of hearings and appeals created under s.15.103(1) shall notify the contract monitoring unit of the department, which shall conduct a concurrent grievance review and attempt to resolve the dispute prior to the date of the hearing.~~

(c) Whenever an action that is specified under par. (a) 1. to 4. is taken or a dispute under par. (b) arises, ~~* * *~~ shall provide the client, in writing, with ~~written~~ notice of appeal procedures available, an explanation of how the procedures operate and a recommendation about the most appropriate procedure for the client to pursue.

*** NOTE: Who (what) is to provide the client with this information? What if the ~~[illegible]~~ recommendation is misleading, inaccurate, etc.?

~~(4) RIGHT OF ACTION~~

~~(6) CIVIL LIABILITY. Any client who incurs damages to his or her health or well being or to his or her property as the result of a violation of sub. (2) (a) to (h), and ~~[illegible]~~ eligible person who is~~

**** NOTE: It is clear that, because receipt of the family care benefit is an entitlement, certain procedural due process requirements must be met. Please review to determine if this changed section now comports w/ your intent.

~~** NOTE: I am not at all sure that I have captured your intent here. Please review.~~

895.488 Civil liability for insurance fraud. (1) Any person who incurs damages to his or her business or property as the result of a violation of s. 943.395 (1) or expenses related to the investigation of a violation of s. 943.395 (1) may bring a civil action against the person who committed the violation.

(2) The party bringing an action under sub. (1) has the burden of proving by clear and convincing evidence that a violation occurred under s. 943.395 (1). A conviction under s. 943.395 (1) is not a condition precedent to bringing an action, obtaining a judgment or collecting a judgment under this section.

(3) Notwithstanding the limitations under s. 799.25 or 814.04, if the person who incurs the damages or expenses prevails, the court shall grant the prevailing party actual damages and costs and disbursements, including reasonable attorney fees and the expenses incurred in investigating the violation of s. 943.395 (1).

(4) Any recovery under this section shall be reduced by the amount recovered as restitution for the same act under ss. 800.093 and 973.20.

(5) A person is not criminally liable under s. 943.30 for any civil action brought in good faith under this section.

(END)

(4) Criteria and processes for determining functional eligibility under s. 46.285 (1)(a), financial eligibility under s. 46.285(1)(b) and entitlement under s. 46.285(4), including definition of the following terms applicable to s. 46.285:

(a) "Primary disabling condition."

(b) "Mental illness".

(c) "Substance abuse"

(d) "Long-term or irreversible" ~~condition~~

(e) "Requires ongoing care, assistance or supervision"

(f) "Condition that is expected to last at least 90 days or result in death within one year"

* NOTE: This term differs from that proposed; it follows the December 22 language creating s. 46.285.

(g) "At risk of losing independence or functional capacity".

~~(h) "Public~~

*** NOTE: I did not draft "publicly-funded long-term care services"; where is this term used?

(h) "Gross monthly income"

(i) Deductions and allowances

(j) "Available assets".

(5) ~~Standards for pro~~ Procedures and standards for procedures for s. 46.286(5).

(6) Standards for determining undue hardship under s. 46.285 (6)(f).

SEC. CR; 46.288 TRANSITION. POWER TO WAIVE OR EXEMPT ~~(1) DEPARTMENT~~,
POWER TO WAIVE. (1) The department may waive, on a county-specific basis and within the limits of applicable federal statutes and regulations all rules promulgated under s. 46.27 and 46.277 ~~and~~.

In order to effectuate the transition to provision ~~services~~ to the ~~benefit~~ ~~the family~~

In order to facilitate the transition to the long-term care system specified in ss. 46.28 to 46.287, ~~(1)~~ all of the following ~~may be~~ may take place:

~~(1) The dept may~~

(1) If the secretary finds it necessary, he or she may ~~waive the funds~~

(2) ~~The secretary may~~ grant a county limited waivers to or exemptions from ss. 46.27 (3)(e) (intro.), 1. and 2. and (f), (5)(d), (6)(a) 1., 2. and 3., (b) (intro.), 1. and 2., (6r)(c), (7)(b) and (cm) and (11) (c) 5m. (intro.) and 6. and 46.277 (3)(a), (4)(a) and (5)(d) 1m. and 2.

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CR; 50.04 (2g) PROVISION of info required. (a) A nh shall, inform the prospective resident of the services of a resource center under s. 46.283, the family care benefit under s. 46.286 and the availability of an assessment ~~under~~ to determine the prospective resident's eligibility for the family care benefit under s. 46.286(1) (1) ~~[illegible]~~

within the time period after inquiry by a prospective resident that is prescribed by the department by rule,

(b) Failure to comply with this subsection is a class "C" violation under sub. (4)(b) 3.

50.04 (2h) REQUIRED REFERRAL. (a) A nh shall, refer to a resource center under s. 46.283 ~~[illegible]~~ a person who is seeking admission and who is at least 65 years of age, has ~~a physical or~~ developmental disability or has a physical disability or condition that is expected to last at least 90 days, unless any of the following applies:

1. ~~(b)~~ The person has received an assessment of functional eligibility under s. 46.286(1)(a) within the previous 6 months.

2. ~~(b)~~ The person is entering the nh only for respite care.

3. ~~(b)~~ The person is an enrollee of a care management organization.

(b) Failure to comply with this subsection is a class "C" violation under sub. (4)(b) 3.

~~****NOTE: Should s. 50.04 (2m) be amended, in light of the proposed cor. Do How? Do you want it to be inapplicable if this applies?~~

50.02 (2) (d) The department shall promulgate rules that prescribe the time periods specified in s. 50.04 (2g)(a) and (2h)(a).

Also for CBRFs, AFHs, RCACs, hospitals

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SEC. CR; 600.01 (1)(b) 10.

600.01 (1)(b) 10. long-term care services funded by the family care benefit, as defined under s. 46.286(4), that are provided by a care management organization that contracts with the dept of h + fs under s. 46.284 and enrolls only individuals who are eligible under s. 46.285,

NOTE: I reworded this language to fit more grammatically within s. 600.01 (1)(b). Note that I omitted "for long-term care services"; I did not understand its meaning

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AM; 701.065 (1)(b)1. - add 46.285 (6)

AM 705.04 (2g) - or an amount equal to the family care benefit under s. 46.285 that is recoverable under s. 46.285 (6)(b)1. and that was paid on behalf of the decedent or the decedent's spouse

AM 859.02 (2)(a) - add 46.285 (6)

AM 867.035 (1)(a) (intro.)

CR; 867.035 (4n) - delete (4m)

*** Note: As yet, there is not a provision in s. 46.285 that corresponds to s. 46.27 (7); the number of that provision should be inserted in this subsection.

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1997 Wisconsin Act 237, section 9122 (4) is ~~renumbered~~ repealed and recreated to read

~~(c) Notwithstanding section 46.285 of the statutes, as created by this act~~

(4)(a) in section 46.286(1)(a)(intro.) ots, as created by this act,

(b) Notwithstanding the exclusion from functional eligibility of a person whose primary disabling condition is developmental disability, ~~as specified~~ such a person is ~~eligi~~ functionally eligible for the family care benefit if the person is a resident of a county or is a member of a tribe operating a care management organization under this subsection.