Kennedy, Debora

From: Lorraine Barniskis [BARNILO@dhfs.state.wi.us]
Sent: Friday, January 29, 1999 1:32 PM
To: Gretchen Fossum; Kennedy, Debora
Cc: Fredi-Ellen Bove; Shelley Malofsky; Charles Wilhelm
Subject: Follow-up comments

1-30cmt.doc

Here's what I've been able to come up with. Don't panic - this is several pages long only because I copied surrounding language so I could see the context as I worked.

I really struggled with the entitlement phase-in language, and am very open to better ideas. Please call if you want to discuss.

I do think we've cleaned up the county-only contracts part to be consistent with this. Let me know if you disagree.

THANK YOU!

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

(b) Within each county, the department shall initially contract to operate a care management organization with the county or a family care district 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. 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 agrees in writing that at least one additional care management organization is necessary or desirable.

~~2. Because the county does not elect to serve both older persons and persons with a physical disability or is unable to meet requirements for both of these client groups, an additional care management organization is necessary to serve the group that is not served by the county.~~ The county does not have the capacity to serve all county residents who are entitled to the family care benefit in the client group or groups that it serves, and cannot develop the needed capacity.

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).

~~(c) During the first 4 years in which a pilot county under par. (c) has a contract under which it accepts a per person per month payment for each enrollee in its care management organization, the department may not contract with another organization to operate a care management organization in the pilot county unless either of the conditions under par. (b) 1. or 3. applies.~~

(c) For contracts following the initial contracts specified in par. (b), the department shall, after consulting with the council on long–term care, prescribe criteria to determine the number of care management organizations that are necessary for operation in a county. Under these criteria, the department shall solicit applications, certify those applicants that meet the requirements specified in sub. (2) (a), select certified applicants for contract and contract with the selected applicants.

(d) Initial contracts with a care management organization under this subsection shall include a plan for phase-in of the capacity to serve entitled persons in the area served by the care management organization within two years of the date on which the care management organization accepts a per person per month payment for services under the family care benefit.

s. 46.286

(4) ENTITLEMENT. (a) Subject to par. (b) and (c), an eligible 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,~~ fulfills any required cost-sharing obligations, and meets any of the following criteria:

1. Is functionally eligible at the comprehensive level.

2. Is functionally eligible at the intermediate level and is eligible for medical assistance under sub. (1) (b) ~~2~~ 1.b.

3. Is functionally eligible at the intermediate level and determined by an agency under s. 46.90 (2) or ~~s. 55.05(1)~~ s. 55.01 (1t) to be in need of protective services under s. 55.05 or protective placement under s. 55.06.

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

~~(b) Under a phase-in plan approved by the department, enrollment in a care management organization of persons who are otherwise entitled to the family care benefit may be delayed for not longer than 1 year following the start date of the care management organization's initial contract under which the care management organization receives a per person per month payment. In counties with a population over 500,000, this period shall not be longer than 2 years.~~

See later material apply

(b) Within each county and for each client group, par. (a) shall first take effect on the effective date of a contract under which a care management organization accepts a per person per month payment to provide services under the family care benefit to eligible persons in that client group in the county. Within two years after this date, the department shall assure that sufficient capacity exists within one or more care management organizations to provide the family care benefit to all entitled persons in that client group in the county.

24 months

Each individual who is enrolled under that contract may not be disenrolled except as provided in

Note: What I'm trying to say above is that once a CMO is available for elderly people, for example, an elderly person is entitled, to the extent that capacity exists. Once in, the person remains entitled. Within 2 years, we have to assure sufficient capacity to serve all entitled elderly people. Please call if you think this language doesn't capture the intent.

(c) The department shall determine the date, which shall not be later than July 1, 2000, on which par. (a) shall first take effect for persons who are not eligible for medical assistance under ch. 49.

or

apply to

Issue of "non-financial eligibility requirements" under s. 46.286 (1):

No one can find a single reference to these non-financial requirements in ch. 49. The requirements themselves relate to such diverse topics as citizenship, alien status, fraud and abuse, people who are on strike, refusal to abide by certain rules, etc., etc.

Here's a proposed solution…

Instead of a separate paragraph (c) on non-financial requirements, we could revise par. (b) 1. a. to read something like the following:

The person would qualify for medical assistance except for financial criteria, and the projected cost of the person's care plan, as calculated by the department or its designee, exceeds his or her gross monthly income, ~~deductions and allowances permitted by rule by the department~~ plus one-twelfth of his or her ~~available~~ countable assets, less deductions and allowances permitted by rule by the department.

OCI exemption:

We were unable to reach OCI staff to review this. However I believe that the following language more accurately reflects our discussions with them:

SECTION 69. 600.01 (1) (b) 10. of the statutes is created to read:

600.01 (1) (b) 10. a. Except as provided in subd. b., long–term care services funded by the family care benefit, as defined in s. 46.2805 (4), that are provided by a care management organization that contracts with the department of health and family services under s. 46.284 and enrolls only individuals who are eligible under s. 46.286.

b. The exemption under this subd. does not apply if the services offered by the care management organization include hospital, physician or other acute health care services.

Cite for MA hearing rights:

I have not yet succeeded in reaching anyone who can help me with specifying cites in Chapter 49 related to hearing rights. Shelley Malofsky and Lou Dunlap (both of whom are DHFS attorneys) drafted the original federal cite.

~~Since I can't reach them~~, should we use a broad reference to ch. 49? Or fix this later in a technical amendment?

says 49.45(5) does not provide as much coverage as Federal cite

decision: use federal cite

Kennedy, Debora

From: Lorraine Barniskis [BARNILO@dhfs.state.wi.us]
Sent: Friday, January 29, 1999 3:30 PM
To: Kennedy, Debora
Subject: Entitlement round umpteen


entitle.doc

See what you think of this.

s. 46.286

(4) ENTITLEMENT. (a) Subject to par. (c) and (d), an eligible 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,~~ fulfills any required cost-sharing obligations, and meets any of the following criteria:

1. Is functionally eligible at the comprehensive level.

2. Is functionally eligible at the intermediate level and is eligible for medical assistance under sub. (1) (b) ~~2~~ 1.b.

3. Is functionally eligible at the intermediate level and determined by an agency under s. 46.90 (2) or ~~s. 55.05(1)~~ s. 55.01 (1t) to be in need of protective services under s. 55.05 or protective placement under s. 55.06.

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

(b) An entitled individual who is enrolled in a care management organization may not be involuntarily disenrolled except as follows:

1. For cause, subject to the requirements of s. 46.284 (3) (a).

2. The contract between the care management organization and the department is cancelled or not renewed. In this case, the department shall assure that enrollees continue to receive needed services through another care management organization or through the medical assistance fee-for-service system or any of the programs specified under sub. (1) (a) 2. a. to d. The department may transfer funds within or among appropriations for this purpose.

(c) Within each county and for each client group, par. (a) shall first apply on the effective date of a contract under which a care management organization accepts a per person per month payment to provide services under the family care benefit to eligible persons in that client group in the county. Within two years after this date, the department shall assure that sufficient capacity exists within one or more care management organizations to provide the family care benefit to all entitled persons in that client group in the county.

(d) The department shall determine the date, which shall not be later than July 1, 2000, on which par. (a) shall first apply to persons who are not eligible for medical assistance under ch. 49.

Prefer my language for (1)(a) 1. a. – 9
put in levels in (1)(a) 1. (intro.)

Rules in (1)(a) 1. a. – rules reqmts for
nfacil. care + cop are different, are they not?
Confusing! Approp. place is in 46.298 (3) itself, not here.
Needs reparsing

Apply to COP only

COMBINED + PRIORITIZED COMMENTS 1/26/09

1. p.2 46.286(1)(c) – what, exactly, are "non-financial eligibility requirements for MA under ch. 49" (49.77(2)(a) is SSI) Why is this included if (b)1.b. is eligibility for MA? (Do treated as one program for both)

L.B. will get X ref.

2. p.2 46.286(1)(a) 1.a. – Rules requirements for nursing facil care + COP are different, are they not? Needs explaining

3. p.3 Divestment – Do they want both s. 49.453 + 49.454 (referred to in 49.453(1)(f))?

NOTE: Superseded by rules

DAK – remember to renumb. (4), etc. if want both
↳ See changes necessary, e.g. 49.453(2)(intro.)

4. p.4 Phase in + delayed effective date – please explain difference

tack 2 onto 46.286(4)

Separate provision? (12 months, rather than 1 yr?) (yes)

5. p.4 Do they want a reference to s. 46.286 (h+c-b services offered under) or (if provided) "under a waiver under s. 46.281(1)(c)? (is in effect? (a waiver) (4)

(yes)

Both provisions

6. p.5 Recovery of costs of care – Do they want the very same changes to MA estate recovery?

(yes)

Superseded by rules

L.B. will ask if lang. is same

Including both is messy bec. of organization of ch. 49

Separate lang = COP lang; why do they want?

p. 6 Hearing (2)(a) – Their lang. has no time limit
45 days
Do we have to say "mechanism" –
can't we refer to procedures prescribed
Yes
~~What is the~~
Why can't we use 49.45(5) + other lang refs
in 19 for MA recips instead of 42 CFR
LB will set
etc. – is clearer; what are these
references?

p. 37, l. 24 Cuts out choice of service provider – is that
intentional? No – put back in

Fixed Notice of . . . provision?

p. 7 Yes mechanisms? Can't we use procedures?

Clarify instructions – Does new lang ("After
Yes 7/1/2001") apply to what, in the draft, is
currently (e)?

Yes Are these provisions all they want
of what is currently 46.271 (2m)?

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

p. 8 add Services 7 =

p. 11 amdt. to 20.435 (7)(md) – is it necessary? (No)
(See (9)(md), ~~&~~ why is wrong) – can do
correction of (9) in (7), but need extra lang?
(Aid to organizations?)
DAK – check 46.283 (5)

No 20.435 (1)(bm) – title change (only MA?)
20.435 (1)(p) " " "
DAK – remember BUD NOTE if title change

p. 12 are these now the only approps. for 46.283 (5)? (yes)

yes 46.284(4)(a) — (5)(p) is meant?

yes Necessary to am. 20.435(5)(im) – is my amdt. correct? Title change?
GF:
1/29/99: From No

p. 13 46.27 (7)(fr) 2. what is meant (truly (am) or (b)? Are they all alternatives to $750,000?
No and

yes 46.281 (1)(g) 3. + 4. – GF: do you want this?

p. 14 (Yes) 46.289 (intro.) ok w/ GF ?

Delete ✓ 46.2805 (8) – and duties under 46.283(4)
Why are these separate, anyhow ?
Is this def. necessary substantively ?

p. 15 46.283 (2)(b) 2. – this isn't broad enough, is it?
Never mind What if they fail to meet standards while holding a K?

p. 16 46.283 (5) – "for performance of the duties" – correct?

p. 17 46.284 (1)(c) – 48 mo.?

What is Attachment 2?

46.284 (4)(d) – "without limitation" unnecessary because of "may include"

**** NOTE p. 28 of draft

p. 18 – See proposed lang changes

p. 20 46.284 (3) (m) ?

Never mind

46.284 (4) (b) and (c) – What does proposed language mean? Purpose?

Never mind

Delete w/ all of 49.89 (9) "Rights" language – don't understand; doesn't jibe Subrogation rights

p. 21 46.27 (3) or (1) (bm) ? (On LOK reference?)

Yes

LB to call F. Nepple

p. 22 600.01 (1) (b) 10. – add back in?

p. 50 NOTE – is this addressed elsewhere?

?

Kennedy, Debora

From: Lorraine Barniskis [stitcher@itis.com]
Sent: Monday, January 25, 1999 7:36 PM
To: Kennedy, Debora; Fossum, Gretchen
Cc: bovefe@dhfs.state.wi.us; malofsf@dhfs.state.wi.us; barnilo@dhfs.state.wi.us
Subject: Consolidated comments

1-25cmts.doc

As promised, here are all our comments of the past few days, consolidated and prioritized. I'm sorry to say that most of them are pretty important. But at least they should be easier to follow.

Please call if you have questions (7-5267) or if I can help in any other way. Thanks.

p.s. - I'm sending this via my personal e-mail account, so don't just hit "reply" if you want to respond.

Combined and prioritized comments - Family Care legislation[1] 1/26/99

Very high priority

(Politically volatile, needed to correct critical areas like eligibility, appropriations, etc., or that respond to holes left in draft due to unanswered questions)

S. 46.286 - Eligibility, entitlement, & related

(1) ELIGIBILITY. ~~A~~ Except as provided in par. (d), a person is eligible for, but not necessarily entitled to, the family care benefit if the person is at least 18 years of age, does not have a primary disabling condition of mental illness, substance abuse or developmental disability, 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:

> [Response to drafter's note: Adding the word "primary" was a change we were going to suggest. I would leave the term "condition" unmodified in par. (a) 1. a. and b.; it's not exactly the same.]

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

a. ~~The~~ 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. Rules promulgated by the department under s. 46.~~287~~ 288 (3) (4) shall ensure that criteria for functional eligibility at the comprehensive level shall be substantially similar to eligibility criteria for receipt of medical assistance for nursing facility care and for the long term support community options program under s. 46.27.

b. ~~The~~ 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 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.

[1] I've shortened or eliminated some explanatory notes and left out responses to Gretchen's questions. LB

2. The person has a condition that is expected to last at least 90 days or result in death within one year of the date of application and, on the date that the family care benefit became available in the person's county of residence, the person was a resident in a nursing home or was receiving long-term care services, as specified by the department, funded under any of the following:

a. 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.~~ Home and community-based waiver programs under 42 USC 1396n (c).

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

d. Community aids under s. 46.40 if documented by the county through a method prescribed by the department.

e. County funding if documented by the county through a method prescribed by the department.

[Response to drafter's note: No, it is not appropriate to include personal care or other MA fee-for-services here.]

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

1. As determined by the department or its designee, either of the following applies:

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

b. He or she is eligible for medical assistance under ch. 49.

2. The person accepts medical assistance if eligible under ch. 49 unless exempted by the department by rule.

(c) Non-financial eligibility criteria. The person meets non-financial eligibility requirements for medical assistance under ch. 49. The department or its designee may grant an exception to this requirement for persons functionally eligible under subd. par. (a) 2.

Lorraine to get X ref.

(d) A person whose primary disabling condition is developmental disability is eligible if the person is a resident of a county or is a member of a tribe operating a care management organization under s. 46.281 (1) (e) and meets all other eligibility criteria under this subsection.

(2) COST SHARING. (a) Persons who are determined to be financially eligible under sub. (1) (b) shall contribute to 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 from the person's gross monthly income plus one-twelfth of countable assets.

(b) Funds received under par. (a) shall be used by a care management organization to pay for ~~long-term care~~ services under the family care benefit.

(c) A person who is required to contribute toward the cost of his or her care but who does not make required contributions is no longer eligible for the family care benefit unless exempted in accordance with rules promulgated by the department.

[Response to drafter's notes: Yes, cost sharing applies to all of sub. (1) (b). The "sliding scale" will be set so that very low-income people will not have a cost-share, but some MA recipients will contribute to the cost of their care. The CMO will collect and use the money; capitation payments will reflect the average client contribution anticipated.]

(3) DIVESTMENT. (a) The department or its designee shall require all persons applying for or receiving the family care benefit to report all resource transfers to the department or its designee.

Note: **Please delete** everything in the draft after the above sentence. Instead, we want the applicable provisions of s. 49.453 to apply to all recipients of the family care benefit, whether MA-eligible or not. Can we simply cross-reference it? If not, please repeat necessary language in the family care sections.

NOTE: 1/28, 1/29. These provisions shall be by rule

(3)

~~(4)~~ ENTITLEMENT. (a) Except as provided in par. (b), an eligible 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,~~ fulfills any required cost-sharing obligations, and meets any of the following criteria:

1. Is functionally eligible at the comprehensive level.

2. Is functionally eligible at the intermediate level and is eligible for medical assistance under sub. (1) (b) ~~2~~ 1.b. *[or just refer to ch. 49 again, which would be clearer.]*

3. Is functionally eligible at the intermediate level and determined by an agency under s. 46.90 (2) or ~~s. 55.05(1)~~ s. 55.01 (1t) to be in need of protective services under s. 55.05 or protective placement under s. 55.06. *[This change is a better reference to the county protective services agency.]*

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

(b) Under a phase-in plan approved by the department, enrollment in a care management organization of persons who are otherwise entitled to the family care benefit may be delayed for not longer than ~~1 year~~ following the start date of the care management organization's initial contract under which the care management organization receives a per person per month payment. In counties with a population over 500,000, this period shall not be longer than 2 years.

Note: The Department needs time to develop the system capacity to provide the Family Care benefit as an entitlement to people who are not Medicaid-eligible. Please allow for a delayed effective date for this group. We suggest something like the following:

"The department shall determine the date, which shall not be later than July 1, 2000, on which s. 46.285 (4) shall apply to persons who are not eligible for medical assistance under ch. 49."

Please amend s. 49.46 (2) (b) 8. to add a reference to the new waiver granted under s. 46.281 (1) (c).

Please also amend s. 49.47 (4) (as) 1. and 3. to add persons who are eligible for medical assistance coverage of the family care benefit under a waiver granted under s. 46.281 (1) (c).

Explanation:
These amendments will (1) clarify that benefits under the new waiver are covered, and (2) clarify that people will access Medicaid card coverage, along with Family Care, if they meet the same income and asset tests as for our current HCB waivers. It's possible that other sections of ch. 49 need to be amended. If so, we'll have to do it in a technical amendment.

Regarding the drafter's notes on spousal impoverishment:
The term "institutionalized spouse," oddly enough, includes a spouse who receives services under the home and community based waivers such as COP-W and CIP. (Federal drafters seem not as sensible as state drafters, and we use the federal term.) Our sensible state drafter is correct that current Medicaid provisions would cover a Medicaid-eligible person receiving Family Care.

However, we also want to apply the same protections in figuring financial eligibility and cost-sharing for Family Care for non-MA people, as we do now in COP. And we would like it clear in the Family Care legislation that spousal impoverishment protections will apply. Please let me know if you need more information or help with this.

s. 46.288 (3) (j): Change "available assets" to "countable assets."

Revisions to sections on recovery of costs of care

(Please note, for purposes of coordination, that Medicaid estate recovery provisions have been requested to be amended under the Department's budget request and under a Revisor's Bill.)

The references under **s. 46.286 (5)** should include s. 49.497 and s. 867.035.

We want estate recovery provisions to be identical for Medicaid and non-Medicaid clients of Family Care. Is there is a way to simply include non-MA clients in the Medicaid provisions?

If separate language remains for non-MA clients, please make the following changes:
In sub. (6) (b) 1., delete the phrase "or against the estate of the surviving spouse of a client"; also clarify that the claim is for the actual cost of services paid for by the Family Care benefit.

The phrase "after the client attained 55 years of age" should **not** be deleted.

In sub. (6) (b), add a subd. 8. to exempt from recovery the lump sum asset exemption of $12,000 allowed in calculating cost share. Please see pp. 77-78 of the Department's July 31, 1998 proposal.

In the first sentence of sub. (6) (c), please add, after "in each county," the following: "and each care management organization". Also, please clarify here also that what can be recovered is actual costs of Family Care funded services. Later in this paragraph, the appropriation reference should be to s. 20.435 (5) (im) and (7) (im).

In sub. (6) (e), both dates in question should be the effective date of the Act.

S. 49.496 (3) (a) should be amended to list the Family Care benefit as a recoverable service.

Cross-references to the Family Care benefit should be included in the following notice provisions related to estate recovery:
s. 859.07 (2), s. 867.01 (3) (d), s. 867.02 (2), s. 867.03 (1) (c) and (1m) (a) and (b).

A cross-reference to s. 46.286 should also be included in s. 700.24.

s. 46.287 - Rights, hearings

Revise the draft for s. 46.287 to read something like the following:

(1) DEFINITION. In this section, "client" means a person applying for eligibility for the family care benefit, an eligible person or an enrollee.

(2) HEARING. (a) A client may contest any of the following by filing a written request for a hearing under a mechanism for hearing the dispute that is prescribed by the department by rule, except that a medical assistance applicant or recipient may not have a hearing right for the same action under both this section and 42 CFR 431.200 ~~et. seq.~~:

1. Denial of eligibility under s. 46.286 (1).

2. Denial of entitlement under s. 46.286 (~~4~~ 3).

3. Determination of cost-sharing under s. 46.286 (2).

4. Failure to provide timely services and support items that are included in the plan of care.

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

6. Development of a 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 is unacceptable to the enrollee.

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

7. Termination of the family care benefit.

(b) An enrollee may contest a decision of a care management organization regarding the type, amount or quality of the client's services under the family care benefit other than those specified in par. (a) 4. to 6. In this case, the client shall first send a written request for review by the unit of the department that monitors care management organization contracts. This unit shall review and attempt to resolve the dispute. If the dispute is not resolved to the satisfaction of the enrollee, he or she may request a hearing under the mechanism specified in par. (a) (intro.).

(c) Notice of adverse actions taken, appeal rights and provision of information regarding availability of advocacy services shall be provided by the resource center or care management organization in a form and manner prescribed by the department by rule.

Add a prohibition against reprisal, or the overt or implied threat of reprisal for registering complaints or grievances or for requesting a hearing under s. 46.287 (a).

Since the enumeration of rights is being deleted, **s. 46.281 (h) should be changed** to read something like the following:

"Require by contract that resource centers and care management organizations establish mechanisms through which individuals who are applying for or receiving the family care benefit may register complaints and grievances and mechanisms for resolving complaints and grievances."

[It is particularly important to add back applicants to the definition of "client", and to specify a right to a hearing to contest findings regarding "entitlement" (or some equivalent language). Without the latter, we haven't covered situations where an error is made that finds a person eligible at the intermediate level (not necessarily entitled) vs. at the comprehensive level (entitled).

Authorizing pilots; transition from old requirements for COP assessments to new requirements for functional/financial screen; new provider penalties

1. Move the authorization for the Department to operate CMO pilots from non-statutory provisions to the statutes. We agree with the drafter's notes that this is a better approach, since the pilots will be funded for the whole biennium (from the same appropriations as those listed in s. 46.284 (4)).

   It would seem logical to combine the CMO pilot language with current statutory provisions authorizing limited Resource Center pilots under s. 46.271 (2m). Both of these need to be updated to allow full pilots and allow demonstration of the full program. We could amend the existing s. 46.271 (2m) to accomplish this, but it would be easier to follow if we renumbered that section into the new Family Care legislation—perhaps under s. 46.281. I suggest the following:

   Delete s. 46.281 (1) (d), renumber (e) to (d) and add to the beginning of the new (d): "After July 1, 2001,".

   Renumber and amend s. 46.271 (2m) as s. 46.281 (1) ~~(e)~~ (d) to read:

   (e) 1. *County and Tribal Resource Center Pilots.* Prior to July 1, 2001, the department shall establish, in geographic areas determined by the department, a pilot project under which the department may contract with a county, a **** district, a tribe or the Great Lakes inter-

tribal council, inc., or any under a joint application of two or more of any of these entities, to operate a resource center.

2. *County and Tribal Care Management Organization Pilots.* Prior to July 1, 2001, the department shall contract with counties or tribes under a pilot project to demonstrate the ability of counties or tribes to manage all long–term care programs and administer the family care benefit as care management organizations.

2. Change s. 46.281 (3) to read:

(3) DUTY OF THE SECRETARY. The secretary shall certify to each county, nursing home, ~~and~~ community–based residential facility, adult family home and residential care apartment complex the date on which a resource center that serves the area of the county, nursing home, ~~or~~ community–based residential facility, adult family home or residential care apartment complex is first available to provide a functional and financial screen under s. 46.283 (3) (b) and (e). To facilitate phase-in of resource centers, the secretary may certify that the resource center is available for specified groups of eligible individuals or for specified facilities in the county.

Explanation: The phase-in provision is needed to accommodate situations like Milwaukee, where the Resource Center pilot is only for elderly people, and where phase-in of pre-admission screening is likely across type of facility and/or geographic area within the county (e.g., by zip code).

3. With respect to current statutory provisions related to requirements for the COP assessment, the department should grant exemptions or waivers of all the requirements on counties under Chapter 46. To cover a few that I missed originally, we should **add to s. 46.289 the following cites: 46.27 (5) (e), 46.27 (7) (cj), and 46.277 (5) 1n.**

~~**Sections 25 through 28, 31, 35 and 36 of the bill could then be deleted.**~~

4. **Section 52 of the bill** should be amended as follows:

50.02 (2) (d) The department shall promulgate rules that prescribe the time periods and the methods of providing information specified in ss. 50.033 (2r) and (2s), 50.034 (5m) and (5n), 50.035 (4m) and (4n) and 50.04 (2g) (a) and (2h) (a).

5. The new requirements for facilities look generally good. Several changes should be made in each section:

- The term "an assessment" should be changed to "a functional and financial screen"

- The requirements for providing information and for referring should be subject to the Secretary's having certified the availability of a resource center for the facility and for the target group(s) for whom the resource center is available. (See note under 2. above.)

- Please add to the first sentence of each section related to forfeitures: "... required to forfeit not more than $500 for each violation."

- In the forfeiture provisions for CBRFs and for hospitals, the second sentence of the provision includes the phrase "or for failure to correct it." This phrase is not used for other facility types. Please **delete** this phrase; it's hard to see how a facility that had not informed a prospective resident or referred a new admission within the required time frame could later correct it.

- There is no forfeiture provision for Adult Family Homes, but this is okay. People enter these facilities only when placed by a county.

6. The following additional changes to existing statutes should be made. (Cross references used in the following assume that the changes in 1. above have been made.)

S. 50.035 (8), which prohibits admissions of residents in Resource Center pilot areas without required screens (termed assessment in this language) probably should be **repealed**. The new language requiring provision of information and referral to the Resource Center will kick in instead, when the Secretary certifies that the Resource Center is available.

Amend s. 50.04 (2m) to read:

50.04 (2m) PLAN OF CARE AND ASSESSMENT REQUIRED. 1. ~~No~~ Except as provided in subd. 2, no nursing home may admit any patient until a physician has completed a plan of care for the patient and the patient is assessed or the patient is exempt from or waives assessment under s. 46.27 (6) (a) ~~or 46.271 (2m) (a) 2~~. Failure to comply with this subsection is a class "C" violation under sub. (4) (b) 3.

2. Subd. 1. does not apply to those residents for whom the secretary has certified that a resource center is available ~~under s. 46.281 (3).~~ under 46.281 (3)

Rather than as proposed in the draft, amend s. 50.06 (7) as follows:

50.06 (7) An individual who consents to an admission under this section may request that an assessment be conducted for the incapacitated individual under the long–term support community options program under s. 46.27 (6) or, if the secretary has certified that a resource center is available for the individual, a functional and financial screen to determine eligibility for the family care benefit under s. 46.286 (1).

Amend s. 49.45 (6m) (c) to read:

49.45 (6m) (c) 5. Admit only patients assessed or who waive or are exempt from the requirement of assessment under s. 46.27 (6) (a) or, if required under s. 50.035 (4n) or s. 50.04 (2h), who have been referred to a resource center.

7. **Add** a definition of "functional and financial screen" in the new **s. 46.2805** to mean: "A screen prescribed by the department, used to determine functional eligibility under s. 46.286 (1) (a) and financial eligibility under s. 46.286 (1) (b)."

   (Note: this definition could also be used in Ch. 50 as a shorthand term to reduce verbiage there.)

8. (See also changes recommended for s. 46.283 (4) below)

Amend s. 46.27 (4) to add the following responsibilities for existing Long-Term Support Planning Committees:

- Advise the county board of supervisors and, if applicable, the county administrator or county executive, on whether to apply to the department and whether to create a ***** district to apply to the department for a contract to operate a resource center or a care management organization.
- 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.
- Advise care management organizations about whether to offer optional acute and primary health care services and, if so, how these benefits should be offered.

GF: this language is old

s. 16.009 (2) (p) - BOALTC advocacy contracts:

(at end of intro)... Advocacy services for potential or actual recipients of the family care benefit required under this paragraph shall include all of the following:

GF: delete sections 6-12 of draft

1. Providing information, technical assistance and training ~~for consumers of long-term care services~~ about how to obtain ~~the~~ needed services or support items.

2. Providing advice and assistance in preparing and filing complaints, grievances and appeals of complaints or grievances.

3. Providing negotiation and mediation on behalf of ~~consumers of long-term care services~~ these recipients or potential recipients.

4. ~~Assuring the availability of and consulting with legal backup services for~~ Providing individual case advocacy assistance regarding the appropriate interpretation of statutes, rules or regulations.

5. Providing ~~representation for consumers of long-term care services~~ individual case advocacy services in administrative hearings and legal representation for judicial proceedings regarding family care services or benefits.

Note: While attorneys are required to represent people in judicial proceedings, individual advocacy services may be provided by either attorneys or non-attorneys in administrative proceedings. We have tried to make this more generic to as not to suggest that attorneys' services would always be required.

Appropriations:

The wording of the amendment to **s. 20.435 (5) (b)** should be similar to that under the Community Aids and COP appropriations: "to fund services provided by resource centers under s. 46.283 and for **services under the family care benefit under s. 46.284 (4).**"

Section 17 of the Bill should be deleted. The appropriation under s. 20.435 (5) (p) is federal funding for Badger Care and will not be used to fund Family Care.

Some MA administration funds (GPR and FED) will be used to fund some Resource Center activities. The appropriations under **s. 20.435 (1) (bm) and (p) and (7) (md)** should therefore be amended, by inserting at the end of the first sentence: "and for services of resource centers under s. 46.283".

DAK ensure that 46.283 has these funds

Some COP funds will be used to fund some of the functional screening activities of the Resource Center. The following phrase therefore needs to be added to the amendment of **s. 20.435 (7) (bd)**: "for services of resource centers under s. 46.283".

Please **delete** the creation of a new appropriation under **s. 20.435 (7) (ip)**. Instead, please **amend s. 20.435 (7) (im)** to read:

20.435 (7) (im) *Community options program and family care benefit: recovery of costs of care.* [current language] In addition, all moneys received from the recovery of costs of care under ss. 46.286 (6) and 867.035 for payments to care management organizations for provision of the family care benefit under s. 46.284 (4).

s. 46.283 (5): Change the appropriation references to the following: s. 20.435 (1) (bm) and (p) and (7) (b), (bd) and (md).

s. 46.284 (4) (a): Delete the reference to (6) (p).

s. 46.286 (6) (c) and (d): Change the appropriation reference to s. 20.435 (5) (im) and (7) (im).

GF: No longer do

DAK: do search & end

S. 20.435 (5) (im) is the federal counterpart to s. 20.435 (7) (im). It is the appropriation from which we pay the federal government its share of recoveries. If (7) (im) is mentioned anywhere beside the paragraphs I caught above, please add (5) (im)

Sections 21, 22 and 51 of the draft:

We agree that these changes to the powers and duties of county departments and aging units should also include the authority to operate a CMO. They should also include authority for the county department to create a risk reserve if it operates a CMO. — No - is by K - unnecessary

Are County Human Service Departments under s. 46.23 not included because they have all the powers of a Social Service Department? Similar changes should be made for 51 agencies, to accommodate the pilots. Yes. 51.42(3)(ar) 17. 51.437(4m)(n)

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s. 46.27 (7) (fm) - Amendment should read:

"except that the amount carried forward shall be reduced by the amount of funds that the county has notified the department that it wishes to place in a risk reserve under par. (fr)."

---

s. 46.27 (7) (fr): Please revise to read:

1. ~~A~~ Notwithstanding s. 46.036 (3) and (5m), a county may 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 notify the department of this decision and of the amount to be placed in the risk reserve. 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.~~ , subject to department approval of the terms of the escrow. All interest from the principle shall be reinvested in the escrow account. ✓

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~~ par. (am) ~~or~~ and (b) and sub. (11) (c) 3. or $750,000, whichever is ~~greater~~ less. The total amount of the risk reserve, including interest, may not exceed 15% of the county's most recent allocation under this subsection.

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s. 46.2805; definitions

Citation for Partnership: Please change to read:

"A demonstration program known as the Wisconsin partnership program under a federal waiver authorized under 42 USC 1315." ✓

"Eligible person": Note that above recommendations for changes to the eligibility provisions add a paragraph for non-financial eligibility to s. 46.286 (1). Wouldn't it be simplest to define this term as "a person who meets all eligibility criteria under s. 46.286 (1)"? ✓

Defining the term **"Long-term care system,"** seems to be creating confusion rather than clarifying. I suggest that we delete this definition and replace this term (or "long-term care services") as now used in the draft as follows: ✓

s. 46.281 (1) (g) 2.: Delete "long-term care services". ✓

s. 46.281 (1) (g) 3. and 4.: replace with "the long-term care system specified in ss. 46.2805 to 46.2895" ✓

s. 46.282 (1): Delete the phrase ✓

s. 46.282 (2): replace with "long-term care services and systems" ✓

s. 46.282 (3): revise to read, "Monitor patterns of long-term care related complaints, grievances and appeals in order to identify issues of statewide importance."

s. 46.283 (2) (a): replace with "the long-term care system specified in ss. 46.2805 to 46.2895"

s. 46.289 (intro): leave as is

unnecc; deleted

The definition for **"Resource Center"** seems to work, except shouldn't the standards for operation refer to 46.283 (3) **and (4)**?

No

S. 46.281: Powers and duties of the department and the secretary

sub. (1) (c): Amend, by adding at the end of the second sentence: "...that is approved that is consistent with ss. 46.2805 to 46.2895.

Delete sub. (1) (d), which does not fit with our pilot approach.

check repo.

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s. 46.282: (7): The reference to local LTC councils should be deleted. Just start the first sentence with "Report annually..."

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s. 46.283 - Resource Centers:

(1) (b): Please **delete** the phrase "within the boundaries of a county."

> [We will not limit the boundaries of a tribal Resource Center, and reservations cross county lines. A tribal Resource Center would still be "for tribal members." I understand that separation of jurisdictions is necessary for functions like eligibility determination, but the intro to s. 46.283 (3) does not require that a Resource Center *provide* the listed functions, only that we assure that all of them are available to somebody who contacts a Resource Center. We can handle jurisdictional issues through our contracting requirements, for example by arrangements among agencies for co-location, telephone connections, or other mechanisms.]

(2): Only if the county declines or can't meet standards would we contract with a non-profit to operate a Resource Center. Given our pilot approach for this biennium, this can be simplified and clarified to read as:

(2) EXCLUSIVE CONTRACT. (a) Prior to July 1, 2001, the department may contract only with a county, a ********district, the governing body of a tribe or band or the Great Lakes inter–

tribal council, inc., or under a joint application of two or more of any of these entities, to operate a resource center.

(b) After July 1, 2001, the department may contract with a private nonprofit organization to operate a resource center if the department determines that the organization has no significant connection to an entity that operates a care management organization and if any of the following applies:

1. A county board of supervisors declines in writing to apply for a contract to operate a resource center.

2. A county agency or a ****** district applies for a contract but fails to meet the standards specified in sub. (3).

(3) (b): Amend to read: "A determination of functional eligibility for the family care benefit~~, including the availability of functional screening and a determination of eligibility, on an emergency basis, 24 hours per day~~."

Add a paragraph under **s. 46.282 (4)** to require that the Resource Center "Assure that emergency calls to the resource center are responded to promptly, 24 hours per day."

(3) (c): Amend to read: "Within the limits of available funding, prevention and intervention services."

(3) (e): Amend to read:
"A determination of financial eligibility and the maximum amount of cost sharing required for a person who is seeking ~~long-term care services~~ the family care benefit, under standards prescribed by the department."

(3) (k): **Delete** (This is important.)

check X refs

(4)

(e) Within 6 months after the family care benefit is available to all eligible persons in the area of the resource center, provide information about the services of the resource center, including the services specified in sub. (3) (d), about assessments under s. 46.284 (3) (b) and care plans under 46.284 (3) (c), and about the family care benefit to all ~~current~~ older persons and all persons with a physical disability who are residents of nursing homes, community–based residential facilities, adult family homes and ~~resident~~ residential care apartment complexes in the area of the resource center.

check assessment

(f) Provide a functional and financial screen to any resident, as specified in par. (e), who requests a screen and assist any resident who is eligible and chooses to enroll in a care management organization to do so.

(g) Provide a functional and financial screen to any person seeking admission to a nursing home, community-based residential facility, residential care apartment complex, or adult family home, if the secretary has certified that the resource center is available to the person and the facility.

Is this in secy's duties?

(h) Provide access to services under s. 46.90 and ch. 55 to a person who is eligible for the services, through close cooperation with the county agency or agencies that provide the services.

(5): Add, after "under sub. (3)", "and perform duties under sub. (4)".

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s. 46.284 - Care management organizations

We want to allow a longer period of exclusive rights to be a CMO to our pilot counties. They are the real pioneers in this effort and will work with us to develop this new way of delivering services. Consequently, it will take them longer than CMOs that start in future years to develop full capacity to be competitive. In addition, we need to give guarantees to these counties that during this developmental phase we will not find them out of compliance with standards and give the contract to another organization. (Instead, we would simply go back to the current system, using funds supporting current enrollees to provide COP/Waiver services.) To accomplish this, we request the following:

Amend s. 46.284 (1) (b) by:
- adding at the beginning, "Except as provided in par. (c),"
- deleting the sentence: "The initial contracts shall be for 2 years."

Renumber the current par. (c) to (d).

DAK: This is connected to

Add a new par. (c):

(c) During the first 4 years in which a pilot county under ...[see Attachment 2] has a contract under which it accepts a per person per month payment for each enrollee in its care management organization, the department may not contract with another organization to operate a care management organization in the pilot county unless either of the conditions under par. (b) 1. or 3. applies.

Drafter's note: I agree that addition of a provision similar to s. 46.283 (1) would be appropriate. And that language related to operation of a CMO should be added to the amendments to current statutes related to county department duties (along with authority to create a risk reserve for this purpose). Again, is there a reason why HSDs under s. 46.23 were not included? Also, a couple of our CMO demonstration sites involve 51 agencies. Should we not include them too?

(3) (a): Please change the first sentence of this paragraph to read:

"Accept requested enrollment of any person who is entitled to the family care benefit and of any person who is eligible for the family care benefit and for whom funding is available."

(3) (L): Change to read: Annually submit to the department ~~a~~ an independent financial audit that meets ~~the~~ federal requirements ~~of 42 CFR ****~~.

(4) (g): Delete (now redundant).

(4) (a): The exemption from s. 46.036 can be restricted to subs. (3) and (5m).

(4) (d) and (e):

At the end of the intro to **(d)**, please add: "without limitation"

Add to **(d)**, subd. 3:

3. Limitations on the distribution of funds from the risk reserve.

Renumber (e) to (d) 4. and change the opening phrase to read:

4. ~~A county may~~ The requirement that a care management organization place funds...

[We probably do need to authorize counties to create risk reserves, but that authorization is better placed in the sections of the statutes that describe the powers of county departments; see recommendations above. All of this provision should be stated as a solvency protection for all CMOs, whether counties or not.]

Any of the following apply to operation by both a rc and a cmo

s. 46.285 - Joint operation of resource center and care management organization

This section needs to be revised; a county can't authorize "a county agency" to apply to be both the Resource Center and the CMO. In addition, further information from HCFA indicates that the last option in the draft is not acceptable due to the requirement that eligibility be done only by public employees. It also occurs to me that we need to make it clear that the requirement for separation applies to any kind of entity, not just counties. Does this work?

46.285 Operation of resource center and care management organization. In order to meet federal requirements and assure federal financial participation in funding of the family care benefit, an entity may not directly operate both a resource center and a care management organization.

a county, a tribe, ~~or~~ an organization or a corporation

(1) COUNTY OPERATION. (a) If a county board of supervisors, and, if applicable, a county executive or a county administrator, elect to apply to the department for a contract to operate a resource center, the county board of supervisors may create a ***** district to apply to the department for a contract to operate a care management organization.

(b) If a county board of supervisors, and, if applicable, a county executive or a county administrator, elect to apply to the department for a contract to operate a care management organization, the county board of supervisors may create a ***** district to apply to the department to operate a resource center.

Not withstanding 46.2895(2)

(2) TRIBAL OPERATION. (a) If the governing body of a tribe or band elects to apply to the department for a contract directly to operate a resource center, tribal members may form a separate corporation to apply to the department for a contract to operate a care management organization. ~~Not more than 25% of the~~ members of the governing board of the corporation may be members of the tribal governing body.

No

Not withstanding 46.2895(2)

(b) If the governing body of a tribe or band elects to apply to the department for a contract to operate a care management organization, tribal members may form a separate corporation to apply to the department for a contract to operate a resource center. ~~Not more than 25% of the~~ members of the governing board of the corporation may be members of the tribal governing body.

No

FCD

(3) JOINT COUNTY AND TRIBAL OPERATION. Any county or fcd that seeks to operate jointly with a tribe or tribal corporation a cmo or rc shall submit jointly with the tribe or tribal corporation an application to the department to operate the cmo or rc.

[If you think it inappropriate to include the material on tribes here, maybe it should be done as a directive to the Department about how to treat tribal applications. Tribal members could, of course, form a corporation without any special statutory authority.]

Moderately High Priority

(Important, so please try to do if at all possible, but the world will not end if we wait for technical amendment.)

s. 46.284 (3) (e): Please change lines 20-21 to read:
"and safety of the enrollee and provide ~~supportive services uniquely tailored to meet needs of these enrollees~~ assistance in management of the enrollee's budget and services at a level tailored to the enrollee's need and desire for such assistance."

s. 46.284 (3) (g): For clarity, please change the "and" to "or."
[As drafted, this could be read to mean that standards had to be covered by both state and federal requirements.]

s. 46.284 (3) (h): Please either delete or change to be the same as s. 46.283 (4) (b).

s. 46.284 (3): Please add par. ~~(m)~~ to read:
(m) Meet all other requirements imposed by the department by contract.
[Our attorneys are concerned that we could get pressure to restrict our contract provisions to those following from statutory provisions, especially when we are being fairly specific in statute about these requirements.]

s. 46.284 (4) (b) and (c): Please add, in each of these paragraphs, after the second reference to par. (a), the phrase "as determined by the department by contract".

s. 46.284 (5) (a): Please add, at the end of this paragraph, "representative of the care management's enrollees".

Somewhere, we should add the following:
A care management organization shall have rights under s. 49.89 (9) to recover costs of providing services to any enrollee, whether or not the enrollee is eligible for medical assistance under ch. 49.

Miscellaneous clean-up

(If necessary, could be included in technical amendment.)

p. 13, definition of PACE:

I have just become aware of the fact that there is a definition of PACE already in the statutes in s. 46.27 (3) (bm). I like the one we developed better, but they should probably be consistent. I suggest changing the old one to match the new one.

s. 46.284 (4) (a): Please delete the word "minimum".

s. 46.283 (6): This title could be shortened to simply "Governing Board," as was done for CMOs.

s. 46.284 (2) (b)3: Amend to read: Adequate availability of providers that are able and willing to perform all of the tasks that are likely to be identified in proposed enrollees' service and care plans.

G. Foosum –

p. 28, l. 12 – delete "or other gains"

p. 28, l. 16 – add – T bonds, etc. language from family care district

hcb means "home + community-based"

Responses to drafter's notes not covered above

p. 11, note following line 21: "Not expended or encumbered" is a better phrase. Keep the $750,000, it will limit the carryover in Milwaukee (now that we've changed the "greater" to "less"). Referring only to "interest" is fine.

p. 15, drafter's note following line 23: Why would we need an exception to ch. 227 to set rates? Under Medicaid, we already operate a number of managed care programs in which we pay capitated rates for a set of services. Would it be different for payments for enrollees who are not MA-eligible?

never mind; exception exists in 227.01 (13)(n)

Drafter's note under s. 46.283 (3) (h): This language is a good translation of our shorthand term of "managing" waiting lists and accurately reflects our intent.

p. 29; drafter's note: The exemption from home health agency licensing is better placed under chapter 50; good change.

s. 46.288 (3) Rule-making on eligibility and entitlement: The changes to our instructions are fine. Thanks to the drafter for catching the discrepancies.

Note re: facility penalties: It's fine to include penalties in statute; I just ran out of time to figure out what they should be. Administratively imposed forfeitures are fine.

SHOBO: If were to include

Note on s. 600.01 (1) (b) 10.: The requested language regarding "long-term care services" was meant to exclude from this exemption a CMO that decided to include primary and acute services in its benefit package and whose capitation included funding for those services. OCI does want to review any such case, probably as part of an OCI exemption process.
I will have asked OCI staff to review the draft, but got no response.

Note on p. 50 - non-statutory language on CMO Pilots: There are no tribes among our original CMO demos or alternates; on the other hand, it does no harm to leave them in.

Questions for Gretchen:

yes ① Add s. 46.23 (3)(e)? – goes to open record exception – {CMO same / rec same} power – may exchange w/ each other + w/ service providers + w/ co. depts.
create in each

See Lorraine ② Joint family care district with a tribe –
1) establish by K under 66.30?
no 2) K to specify no. of members on gov. bd from tribe?
3) Should same limitation on co./fcd re no tribal gov. body officials or employees?

6-2907 BONNIE

notwith 46.2895(9),

Kennedy, Debora

From: Fossum, Gretchen
Sent: Wednesday, January 27, 1999 4:42 PM
To: Kennedy, Debora
Subject: Lorraine's Changes

I talked to Lorraine. On the eligibility - she said that the had several meetings with the MA eligibility staff and had a couple of their attorneys look over the draft.

The critical piece at the top of page under (1) Eligibility where she adds that people with a primary disabling condition of MI, AODA or DD are not eligible. On the piece regarding promulgation of rules - the reference to s. 46.287(4) is incorrect. The section that deals with eligibility should be referenced. The department feels strongly that this sentence should be put in.

On page 8, at the bottom - what Lorraine meant to say was that if the cites of 46,(5)(e) ..... 46.277(5)1n are added to the draft, then sections 25 through 28, 31, 35 of the draft can be deleted.

Hope this helps. Will most likely talk to you tomorrow.

1999–2000 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB .....
99-0030/rac:cw

Editors & WPD's DO NOT USE THIS

Analysis insert:

Under the bill, if a county board adopts a resolution establishing a family care district, the board must do all of the following:

1. If the district offers employment to any individual who was previously employed by the county and who while employed by the county performed duties relating to the XXXX function and whose wages, hours and conditions of employment were established in a collective bargaining agreement with the county which is in effect on the date the individual commences employment with the district, require the district to abide by the terms of the collective bargaining agreement concerning the individual's compensation and benefits until the time of the expiration of that collective bargaining agreement or adoption of a collective bargaining agreement with the district covering the individual as an employe of the district, whichever occurs first.

2. If the district offers employment to any individual who was previously employed by the county and who while employed by the county performed duties relating to the XXXX function, but whose wages, hours and conditions of employment were not established in a collective bargaining agreement with the county that is in effect on the date the individual commenced employment with the district, require the district to initially provide that individual the same compensation and benefits that he or she received while employed by the county.

3. If the district offers employment to any individual who was previously employed by the county and who while employed by the county performed duties relating to the XXXX function, require the district to recognize all years of service with the county for any benefit provided or program operated by the district for which an employe's years of service may affect the provision of the benefit or the operation of the program.

4. If the county has not established its own retirement system for county employes, require the district to adopt a resolution to be included under the Wisconsin retirement system. If the county has established its own retirement system for county employes, provide that district employes are eligible to participate in the county retirement system.

5. Provide that district employes are eligible to receive health care coverage under any county health insurance plan that is offered to county employes.

6. Provide that district employes are eligible to participate in any deferred compensation or other benefit plan offered by the county to county employes, including disability and long–term care insurance coverage and income continuation insurance coverage.

The bill also provides that a family care district is an employer for all purposes of the municipal employment relations act; as such, employes of the district may organize and seek to establish all terms of wages, hours and conditions of employment through collective bargaining.

SECTION 1. 40.02 (28) of the statutes is amended to read:

40.02 **(28)** "Employer" means the state, including each state agency, any county, city, village, town, school district, other governmental unit or instrumentality of 2 or more units of government now existing or hereafter created within the state and any federated public library system established under s. 43.19 whose territory lies within a single county with a population of 500,000 or more, except as provided under ss. 40.51 (7) and 40.61 (3), ~~or~~ a local exposition district created under subch. II of ch. 229 or a family care district created under XXXX. Each employer shall be a separate legal jurisdiction for OASDHI purposes.

History: 1981 c. 96, 187, 250, 274, 386; 1983 a. 9, 27; 1983 a. 81 s. 11; 1983 a. 83 s. 20; 1983 a. 106, 140; 1983 a. 141 ss. 1 to 3, 20; 1983 a. 191 ss. 1, 6; 1983 a. 192 s. 304; 1983 a. 255 s. 6; 1983 a. 275, 290, 368; 1983 a. 435 s. 7; 1985 a. 29, 225; 1985 a. 332 ss. 52, 251 (1); 1987 a. 27, 62, 83, 107, 309, 340, 356, 363, 372, 399; 1987 a. 403 ss. 43 to 45, 256; 1989 a. 13, 14, 31; 1989 a. 56 s. 259; 1989 a. 166, 182, 189, 218, 230, 240, 323, 327, 336, 355, 357, 359; 1991 a. 32, 39, 113, 152, 229, 269, 315; 1993 a. 16, 263, 383, 490, 491; 1995 a. 27, ss. 1946 to 1953, 9130 (4); 1995 a. 81, 88, 89, 216, 240, 302, 381, 417; 1997 a. 3, 27, 39, 69, 110, 162, 237, 238.

SECTION 2. 40.02 (36) of the statutes is amended to read:

40.02 **(36)** "Governing body" means the legislature or the head of each state agency with respect to employes of that agency for the state, the common council in cities, the village board in villages, the town board in towns, the county board in counties, the school board in school districts, or the board, commission or other governing body having the final authority for any other unit of government, for any agency or instrumentality of 2 or more units of government, for any federated public library system established under s. 43.19 whose territory lies within a single county with a population of 500,000 or more ~~or~~, for a local exposition district created under subch. II of ch. 229 or a family care district created under XXXX.

History: 1981 c. 96, 187, 250, 274, 386; 1983 a. 9, 27; 1983 a. 81 s. 11; 1983 a. 83 s. 20; 1983 a. 106, 140; 1983 a. 141 ss. 1 to 3, 20; 1983 a. 191 ss. 1, 6; 1983 a. 192 s. 304; 1983 a. 255 s. 6; 1983 a. 275, 290, 368; 1983 a. 435 s. 7; 1985 a. 29, 225; 1985 a. 332 ss. 52, 251 (1); 1987 a. 27, 62, 83, 107, 309, 340, 356, 363, 372, 399; 1987 a. 403 ss. 43 to 45, 256; 1989 a. 13, 14, 31; 1989 a. 56 s. 259; 1989 a. 166, 182, 189, 218, 230, 240, 323, 327, 336, 355, 357, 359; 1991 a. 32, 39, 113, 152, 229, 269, 315; 1993 a. 16, 263, 383, 490, 491; 1995 a. 27, ss. 1946 to 1953, 9130 (4); 1995 a. 81, 88, 89, 216, 240, 302, 381, 417; 1997 a. 3, 27, 39, 69, 110, 162, 237, 238.

SECTION 3. 46.2895 (6) of the statutes is created to read:

46.2895 **(6)** EMPLOYMENT AND EMPLOYE BENEFITS. If a county board adopts a resolution establishing a family care district, the board shall do all of the following:

(a) If the district offers employment to any individual who was previously employed by the county and who while employed by the county performed duties relating to the XXXX function and whose wages, hours and conditions of employment were established in a collective bargaining agreement with the county under subch. IV of ch. 111 which is in effect on the date the individual commences employment with the district, require the district, with respect to that individual, to abide by the terms of the collective bargaining agreement concerning the individual's compensation and benefits until the time of the expiration of that collective bargaining agreement or adoption of a collective bargaining agreement with the district under subch. IV of ch. 111 covering the individual as an employe of the district, whichever occurs first.

(b) If the district offers employment to any individual who was previously employed by the county and who while employed by the county performed duties relating to the XXXX function, but whose wages, hours and conditions of employment were not established in a collective bargaining agreement with the county under subch. IV of ch. 111 that is in effect on the date the individual commenced employment with the district, require the district, with respect to that individual, to initially provide that individual the same compensation and benefits that he or she received while employed by the county.

(c) If the district offers employment to any individual who was previously employed by the county and who while employed by the county performed duties relating to the XXXX function, require the district, with respect to that individual, to recognize all years of service with the county for any benefit provided or program operated by the district for which an employe's years of service may affect the provision of the benefit or the operation of the program.

(d) 1. If the county has not established its own retirement system for county employes, require the district to adopt a resolution to be included within the provisions of the Wisconsin retirement system under s. 40.21 (1). In this resolution, the district shall agree to recognize 100% of the prior creditable service of its employes earned by the employes while employed by the district.

2. If the county has established its own retirement system for county employes, provide that district employes are eligible to participate in the county retirement system.

(f) Provide that, subject to the terms of any applicable collective bargaining agreement as provided in par. (a), district employes are eligible to receive health care coverage under any county health insurance plan that is offered to county employes.

(g) Provide that, subject to the terms of any applicable collective bargaining agreement as provided in par. (a), district employes are eligible to participate in any deferred compensation or other benefit plan offered by the county to county employes, including disability and long–term care insurance coverage and income continuation insurance coverage.

SECTION 4. 111.70 (1) (j) of the statutes is amended to read:

111.70 **(1)** (j) "Municipal employer" means any city, county, village, town, metropolitan sewerage district, school district, family care district created under XXXX or any other political subdivision of the state which engages the services of an employe and includes any person acting on behalf of a municipal employer within the scope of the person's authority, express or implied.

History: 1971 c. 124, 246, 247, 307, 336; 1973 c. 64, 65; 1977 c. 178, 186, 272, 442, 449; 1979 c. 32 s. 92 (15); 1981 c. 20, 112, 187; 1983 a. 189, 192; 1985 a. 29; 1985 a. 182 s. 57; 1985 a. 318; 1987 a. 153, 399; 1991 a. 136; 1993 a. 16, 429, 492; 1995 a. 27, 225, 289; 1997 a. 27, 237.