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1999 – 2000 LEGISLATURE

LRB–0030/~~1~~2
DAK:kmg:~~lmh~~

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

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

Changes on p. 2, 7, 16, 17, 39, 40 + other pages.

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

Don't Gen. Cat.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

FAMILY CARE

Current law

Currently, home and community–based long–term care is provided to persons who are elderly, physically or developmentally disabled, chronically mentally ill or chemically dependent and to certain children as a benefit under one or more of several different programs under the department of health and family services (DHFS). These programs are funded by federal, state or, in some instances, county moneys, and each program has individualized eligibility criteria and benefit restrictions. For elderly and disabled persons, these programs include medical assistance (MA), the long–term support community options program (COP), three community integration programs (CIPs) and community aids. MA is a comprehensive jointly funded federal–state health program for persons with low income and few assets. COP provides assessments of functionality and home and community–based care to, among others, elderly and physically disabled persons as an alternative to institutionalized care; one part of COP is funded by state moneys and the other part is funded under a joint federal–state program under a waiver of federal medicaid laws. Under another joint federal–state program under a waiver of federal medical assistance laws, CIPs provide home and community–based

services and continuity of care for persons relocated from institutions, including state centers for the developmentally disabled, and persons who meet requirements for MA reimbursement in nursing homes.

Currently, DHFS is authorized to establish pilot projects under which DHFS contracts with a public or private entity to serve as a clearinghouse of information for individuals who are interested in home or community–based long–term support services or institutional long–term care services and to perform assessments to determine an individual's functional abilities, disabilities, personal preferences and need for home or community–based services or institutional services. DHFS is also authorized to contract with counties or federally recognized American Indian tribes or bands under a pilot project to demonstrate the ability of counties or tribes or bands to manage all long–term care programs under a long–term care management organization.

Currently, nursing homes are prohibited from admitting patients until a physician has completed a plan of care and the patient is assessed under COP or the long–term care pilot project or waives the assessment.

Creation of family care benefit, resource centers and care management organizations

The bill establishes a program of financial assistance for long–term care and support items, termed a "family care benefit", for persons who are eligible and are enrolled in a care management organization. The family care benefit is funded by general purpose revenues appropriated for MA, for COP and for community aids. DHFS must request from the federal secretary of health and human services any waivers of federal medicaid laws necessary to permit use of federal moneys to provide the family care benefit to recipients of MA; however, regardless of whether a waiver is approved, DHFS may implement the family care benefit. Persons are eligible for, but not necessarily entitled to, the family care benefit if they are at least 18 years of age, do not have a primary disabling condition of mental illness, substance abuse or developmental disability and meet functional and financial eligibility criteria. Functional eligibility criteria require functional capacity at either the comprehensive or intermediate level, as specified in the bill, or a condition that is expected to last at least 90 days or result in death within a year for a person who was a resident in a nursing home or was receiving long–term care services funded under COP, one of the CIP programs, the Alzheimer's family caregiver support program, community aids or county funding. ~~In general, financial eligibility criteria conform to the eligibility criteria for MA.~~ A person is entitled to the family care benefit and may enroll in a care management organization if he or she is financially eligible, meets cost–sharing requirements and meets any of several functional eligibility requirements or if he or she has a primary disabling condition of developmental disability and was a resident of a county or member of a tribe or band that operated a care management organization under a pilot project. Divestment prohibitions, prohibitions on treatment of certain trusts, provisions on protection of income and resources of a couple for maintenance of a spouse in the community, and estate recovery provisions, all of which correspond to similar prohibitions and provisions under MA, apply to enrollees, under rules that DHFS must promulgate. A client may

Persons are financially eligible if they are eligible for MA or if the cost of their care plan exceeds countable income and assets.

contest denial of eligibility, the determination of cost sharing, denial of entitlement, failure to provide timely services and support items in the plan of care, reduction of services or support items, development of an unacceptable plan of care and termination of the family care benefit, by filing a written request for a hearing within 45 days after receipt of notice of the contested matter. The hearing must be held under procedures that are prescribed by DHFS by rule.

The bill establishes requirements for a resource center, which, among other things, must provide under a contract with DHFS information and referral services, determinations of functional and financial eligibility for the family care benefit, assistance in enrolling in a care management organization if the person chooses to do so, and eligibility for certain other benefits, including MA. Within six months after the family care benefit is available to all eligible persons in the area of the resource center, the resource center must provide information about its services to all older persons and persons with a physical disability who reside in nursing homes, community–based residential facilities, adult family homes and residential care apartment complexes in the area of the resource center. A resource center must have a governing board that reflects the ethnic and economic diversity of the geographic area served by the resource center, and at least one–fourth of the governing board's members must be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates.

The bill establishes requirements for a care management organization, which must, under a contract with DHFS that provides payment on a capitated basis, accept enrollment of persons who are entitled to the family care benefit, as well as enrollment of persons who are eligible for the family care benefit and for whom funding is available. Under the contract, the care management organization must, among other things, conduct a comprehensive assessment for each enrollee, develop a comprehensive care plan for the enrollee and provide or contract for the provision of necessary services. DHFS may, by contract, impose solvency protections on a care management organization, including the requirement that a care management organization must segregate a risk reserve from other funds of the care management organization or its authorizing body and that the care management organization must maintain a risk reserve in an interest–bearing escrow account with a financial institution. A care management organization must have a governing board under requirements that are similar to those for the governing board of a resource center. The bill specifically exempts a care management organization from requirements for licensure as a home health agency.

Under the bill, DHFS must prescribe and implement a per person monthly rate structure for costs of the family care benefit. DHFS also must, among other duties, prescribe by rule and enforce performance standards for operation of resource centers and care management organizations, conduct ongoing evaluations of the system implementing the family care benefit and ensure that external organizations conduct reviews of the quality of management and service delivery of resource centers and care management organizations.

Family care district

The bill authorizes county boards of supervisors to create, on a single county or multicounty basis, special purpose districts that are termed family care districts. Under the bill, a family care district is a local unit of government, separate and distinct from the state and a county, for which the primary purpose is to operate a resource center or a care management organization, but not both. The jurisdiction of the family care district is the county or counties of the county board or boards of supervisors who created the district. The family care district's board is appointed for three–year terms by the county board of supervisors and must consist of 15 persons for a single county and, for a multicounty family care district, an additional member for each county in excess of two. Board members must be residents of the family care district's jurisdiction. At least one–fourth of the members must be representative of the client group or groups whom it is the family care district's primary propose to serve or those clients' family members, guardians or other advocates. No member may be an elected or appointed official or an employe of the county and no member may have a private financial interest in or profit from any contract or other business of the family care district.

The bill authorizes a family care district to carry out the provisions of the bill related to the family care benefit, resource centers and care management organizations. In addition, the bill grants to a family care district the powers to adopt and alter an official seal; adopt bylaws and policies and procedures to regulate its affairs; sue and be sued; negotiate and enter into leases and contracts; provide services related to services available under the family care benefit, to older persons and persons with disabilities, in addition to the services funded under the contract to operate a resource center or care management organization; acquire, construct, equip, maintain, improve or manage a resource center or a care management organization, but not both; employ agents, employes or special advisers, fix and regulate their compensation and provide employe benefits; mortgage, pledge or otherwise encumber the family care district's property or funds; buy, sell or lease property and maintain or dispose of it; create a risk reserve or special reserve, including as DHFS requires by contract; accept aid; and make instruments necessary to exercise its powers. In addition, the family care district may invest funds in an interest–bearing escrow account, in time deposits with a maturity of not more than two years and in federal bonds or securities. However, a family care district may neither issue bonds nor levy a tax or assessment.

Under the bill, a family care district must appoint a director, who must manage the family care district's property, business and employes. The family care district must also develop and implement a personnel structure and other employment policies. However, with respect to the hiring of employes who formerly were county employes to perform the same or substantially similar functions that they previously performed, the family care district must do the following:

1. For an employe whose wages, hours and conditions of employment were established in a collective bargaining agreement with the county that is in effect on the date on which the individual commences employment with the district, abide by the terms of the collective bargaining agreement concerning the individual's

compensation and benefits until 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. For an employe 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 on which the individual commenced employment with the district, initially provide that individual the same compensation and benefits that he or she received while employed by the county.

3. 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, adopt a resolution to be included under the Wisconsin retirement system (WRS).

If the county has established its own retirement system for county employes, the county must do all the following:

1. Provide that family care district employes are eligible to participate in the county retirement system.

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

3. Provide that family care 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.

Numerous laws that apply to special purpose districts and local units of government apply to the family care district, including, among others:

1. The members of the family care district governing board and the director of the family care district are subject to the code of ethics for local government officials.

2. The family care district is exempt from the sales and use taxes.

3. The family care district is subject to public employe occupational safety and health laws.

4. The family care district is governed by unemployment compensation laws.

5. The family care district may participate in the local governmental property insurance fund.

6. The family care district is governed by municipal administrative procedures concerning constitutionally protected rights.

7. The family care district is subject to laws restricting employers from testing employes and prospective employes for human immunodeficiency virus (HIV) or an antibody to HIV.

8. The family care district is exempt from treble damages in any suit brought for its operation as a monopoly.

9. Persons attempting to sue the family care district are subject to limitations on actions that may be brought against it and limitations as to the filing of the notice of the injury and recoverable damages.

The bill provides that a family care district:

1. Must adhere to the open records laws, except that the family care district may exchange confidential information about a client, without the client's informed consent, with a county department of social services, human services, developmental disabilities services or community programs or with a resource center or a care management organization, if the county department, resource center or care management organization is in the jurisdiction of the family care district and the exchange is necessary to enable performance of duties or coordinate service delivery to the client.

2. Must adhere to the open meetings laws.

3. Is subject to auditing by the legislative audit bureau and review of its performance by the joint legislative audit committee.

4. Is an employer for all purposes of the municipal employment relations laws; as such, employes of the district may organize and seek to establish all terms of wages, hours and conditions of employment through collective bargaining.

5. Is subject to prohibitions on public funding for abortions and for abortion–related activities.

6. May participate in the local government pooled–investment fund.

7. May contract with other municipalities and with federally recognized American Indian tribes and bands in this state for the receipt or furnishing of services or the joint exercise of required or authorized powers or duties.

8. Is exempt from local property tax and income tax.

9. Is subject to laws regulating buildings and safety.

10. Is governed by state minimum wage and hour and family and medical leave laws and is subject to worker's compensation laws.

11. May participate in programs of state retirement, health and long–term care benefits, disability benefits and survivor benefits, deferred compensation plans, employe–funded reimbursement accounts and health insurance premium credits and be included as a coverage group under social security.

12. Is an "employer" for the purposes of coverage for group and individual health benefits and for small employer health insurance.

13. Is a "municipality" for the purposes of laws relating to the publication of legal notices.

Under the bill, obligations and debts of a family care district are not the obligations or debts of the county that created the family care district. A family care district may be dissolved by joint action of the family care district board and the county board or boards of supervisors that created the district, subject to performance of its contractual obligations and if first approved by the secretary of health and family services. If the family care district was created by more than one county, the county boards of supervisors must agree on the apportioning of the district's property before dissolution takes place.

Expansion of pilot projects

The bill authorizes DHFS to continue contracting with counties or tribes or bands under the current pilot projects until July 1, 2001. After that date, DHFS may contract with one or more entities certified as meeting requirements for a resource center and for services of an entity as a care management organization. During the

first 24 months in which a county has a contract with DHFS under which the county accepts a per person per month payment for each enrollee in the county's care management organization, DHFS may not contract with another organization to operate a care maintenance organization in that county unless the county agrees in writing that at least one additional care management organization is necessary or desirable or the governing body of a tribe or band or the Great Lakes inter–tribal council, inc., elects to operate a care management organization within the area and is certified by DHFS.

Under the bill, a county, a tribe or band, a family care district or an organization may not directly operate both a resource center and a care management organization. If a county board of supervisors and, if applicable, a county executive or county administrator elect to apply to DHFS for a contract to operate a resource center, the county board may create a family care district to apply to DHFS for a contract to operate a care management organization; if the county board and county executive or county administrator elect to apply for a contract to operate a care management organization, the county board may create a family care district to apply for a contract to operate a resource center. If the governing body of a tribe or band elects to apply for a contract to operate a resource center, the tribe or band members may form a separate corporation to apply for a contract to operate a care management organization; if the governing body elects to apply for a contract to operate a care management organization, the tribe or band members may form a separate corporation to apply for a contract to operate a resource center. A county or family care district may apply jointly with a tribe or band or tribal or band corporation for a contract to operate a care management organization or resource center.

The bill authorizes a county department of social services, human services, developmental disabilities services or community programs or an aging unit authorized by the applicable county board of supervisors to apply to DHFS to operate a resource center or a care management organization. The bill also authorizes the secretary of health and family services, in order to facilitate the transition to the family care benefit system, to grant a county limited waivers to certain COP and CIP statutes and rules promulgated under those statutes.

Requirements of care facilities

The bill requires the secretary of health and family services to certify to each county, nursing home, 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, home, facility or complex is first available, with respect to specific groups of eligible individuals or for specified facilities, to provide a functional and financial screen. Within a time period prescribed by DHFS by rule, if the certification has taken place, each affected nursing home, community–based residential facility, adult family home and residential care apartment complex must inform prospective residents of the facility about the services of a resource center, the family care benefit and the availability of a functional and financial screen to determine eligibility. Also, these facilities and hospitals must refer to the resource center persons who seek admission and who are aged at least 65 years or have a

physical disability unless the person has received a screen for functional eligibility within the previous six months, is entering the facility only for respite care or is an enrollee of a care management organization. Failure to comply with these requirements subjects the facility to an administrative forfeiture. Current prohibitions on the admittance to nursing homes of persons without a COP or other assessment do not apply to persons for whom the secretary of health and family services has certified that a resource center is available.

Council on long–term care and board on aging and long–term care

The bill creates in DHFS a 15–member council on long–term care that terminates on July 1, 2001. The council must assist DHFS in developing policy related to long–term care issues. The council also must review and make nonbinding recommendations to DHFS concerning the DHFS standard contract provisions for resource centers and care management organizations, the family care benefit and other matters, and must monitor patterns of complaints, persons on waiting lists and patterns of enrollments and disenrollments.

The bill provides for two additional members for the current seven–member board on aging and long–term care and requires that at least five members of the council be aged 65 or older, have physical or developmental disabilities or be family members, guardians or other advocates of the persons. Further, the bill requires the board on aging and long–term care to contract with organizations to provide advocacy services, including negotiation, mediation and assistance in administrative hearings or judicial proceedings, to potential or actual recipients of the family care benefit or their families or guardians.

This bill will be referred to the joint survey committee on retirement systems for a detailed analysis, which will be printed as an appendix to this bill.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 13.94 (4) (a) 1. of the statutes is amended to read:

13.94 **(4)** (a) 1. Every state department, board, examining board, affiliated credentialing board, commission, independent agency, council or office in the executive branch of state government; all bodies created by the legislature in the legislative or judicial branch of state government; any public body corporate and politic created by the legislature including specifically a professional baseball park district and a family care district under s. 46.2895; every Wisconsin works agency

it recovers under ss. 46.495 (2) (b) and 51.423 (15) from prior year audit adjustments including those resulting from audits of services under s. 46.26, 1993 stats., or s. 46.27. Except for amounts authorized to be carried forward under s. 46.45, all funds recovered under ss. 46.495 (2) (b) and 51.423 (15) and all funds allocated under s. 46.40 and not spent or encumbered by December 31 of each year shall lapse to the general fund on the succeeding January 1 unless carried forward to the next calendar year by the joint committee on finance.

SECTION 21. 20.435 (7) (bd) of the statutes is amended to read:

20.435 **(7)** (bd) *Community options program ~~and~~ ~~long-term support~~ pilot projects; family care benefit.* 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)~~, to fund services provided by resource centers under s. 46.283 (5), for services under the family care benefit under s. 46.284 (5) and for the payment of premiums under s. 49.472 (5). If the department transfers funds to this appropriation from the appropriation account under sub. ~~(5)~~ (4) (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~~,~~ or 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.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

****NOTE: This is reconciled s. 20.435 (7) (bd). This paragraph has been affected by drafts with the following LRB numbers: LRB–0028/6, LRB–0030/P4 and LRB–1057/1.

SECTION 22. 20.435 (7) (im) of the statutes is amended to read:

20.435 **(7)** (im) *Community options program and family care benefit; recovery of costs ~~of care~~.* From the moneys received from the recovery of costs of care under ss. 46.27 (7g) and 867.035 and rules promulgated under s. 46.286 (7), all moneys not appropriated under sub. ~~(1)~~ (4) (in), for payments to county departments and aging units under s. 46.27 (7g) (d), payments to care management organizations for provision of the family care benefit under s. 46.284 (5), payment of claims under s. 867.035 (3) and payments for long–term community support services funded under s. 46.27 (7) as provided in ss. 46.27 (7g) (e) and 867.035 (4m).

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

****NOTE: This is reconciled s. 20.435 (7) (im). This paragraph has been affected by drafts with the following LRB numbers: LRB–0030/P4 and LRB–0028/6.

SECTION 23. 20.927 (1) of the statutes is amended to read:

20.927 **(1)** Except as provided under subs. (2) and (3), no funds of this state or of any county, city, village ~~or~~, town or family care district under s. 46.2895 or of any subdivision or agency of this state or of any county, city, village or town and no federal funds passing through the state treasury shall be authorized for or paid to a physician or surgeon or a hospital, clinic or other medical facility for the performance of an abortion.

SECTION 24. 20.9275 (1) (b) of the statutes is amended to read:

resource center. At least one–fourth of the members of the governing board shall be older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates.

(7) EXCHANGE OF INFORMATION. Notwithstanding ss. 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.06 (17) (c), 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), a resource center acting under this section may exchange confidential information about a client, as defined in s. 46.287 (1), without the informed consent of the client, under s. 46.21 (2m) (c), 46.215 (1m), 46.22 (1) (dm), 46.23 (3) (e), 46.284 (7), 46.2895 (10), 51.42 (3) (e) or 51.437 (4r) (b) in the county of the resource center, if necessary to enable the resource center to perform its duties or to coordinate the delivery of services to the client.

SECTION 61. 46.284 of the statutes is created to read:

46.284 Care management organizations. (1) APPLICATION FOR CONTRACT. (a) A county board of supervisors and, in a county with a county executive or a county administrator, the county executive or county administrator, 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 (1) (a) 1. or 2. to apply to the department for a contract to operate a care management organization and, if so, which to authorize and what client group to serve.

2. Whether to create a family care district to apply to the department for a contract to operate a care management organization.

(b) The governing body of a tribe or band or of the Great Lakes inter–tribal council, inc., may decide whether to authorize a tribal agency to apply to the

department for a contract to operate a care management organization for tribal members and, if so, which client group to serve.

(c) Under the requirements of par. (a), a county board of supervisors may decide to apply to the department for a contract to operate a multicounty care management organization in conjunction with the county board or boards of one or more other counties or a county–tribal care management organization in conjunction with the governing body of a tribe or band or the Great Lakes inter–tribal council, inc.

(d) Under the requirements of par. (b), the governing body of a tribe or band may decide to apply to the department for a contract to operate a care management organization in conjunction with the governing body or governing bodies of one or more other tribes or bands or the Great Lakes inter–tribal council, inc., or with a county board of supervisors.

(2) 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. (3). 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) ~~Except as provided in par. (c),~~ 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. (3) 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~~ 24 months 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.~~ have the capacity to serve all county residents who are entitled to the family care benefit in the client group or groups that the county serves and cannot develop the 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. (3).

(c) During the first 24 months in which a county under s. 46.281 (1) (d) 2. has a contract under which the county 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 that county unless either of the conditions under par. (b) 1. or 3. applies.

~~(d)~~ (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. (3) (a), select certified applicants for contract and contract with the selected applicants.

(3) CERTIFICATION; REQUIREMENTS. (a) If an entity meets the requirements under par. (b) and applicable rules of the department and submits to the department

(7) EXCHANGE OF INFORMATION. Notwithstanding ss. 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.06 (17) (c), 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), a care management organization acting under this section may exchange confidential information about a client, as defined in s. 46.287 (1), without the informed consent of the client, under s. 46.21 (2m) (c), 46.215 (1m), 46.22 (1) (dm), 46.23 (3) (e), 46.283 (7), 46.2895 (10), 51.42 (3) (e) or 51.437 (4r) (b) in the county of the care management organization, if necessary to enable the care management organization to perform its duties or to coordinate the delivery of services to the client.

SECTION 62. 46.284 (2) (d) of the statutes, as created by 1999 Wisconsin Act .... (this act), is amended to read:

46.284 **(2)** (d) 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. (3) (a), select certified applicants for contract and contract with the selected applicants.

SECTION 63. 46.285 of the statutes is created to read:

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, a county, a tribe or band, a family care district or an organization, including a private, nonprofit corporation, may not directly operate both a resource center and a care management organization. All of the following apply to operation of both a resource center and a care management organization:

SECTION 9123. Nonstatutory provisions; health and family services.

(1) RULES FOR FAMILY CARE BENEFIT. Using the procedure under section 227.24 of the statutes, the department of health and family services shall promulgate the rules required under sections 46.286 (4) to (7), 46.288 (1) to (4) and 50.02 (2) (d) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under sections 46.286 (4) to (7), 46.288 (1) to (4) and 50.02 (2) (d) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the department is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 9423. Effective dates; health and family services.

(1) ELIMINATION OF COUNCIL ON LONG–TERM CARE. The repeal of sections 15.07 (2) (m), 15.197 (5), 46.281 (1) (a) and (b) and 46.282 of the statutes and the amendment of section 46.284 (2) (c) of the statutes take effect on July 1, 2001, on the day after publication of the 2001–03 biennial budget act, whichever is later.

****NOTE: This is reconciled SECTION 9423 (1). This SECTION has been affected by drafts with the following LRB numbers: LRB–0030/P4, LRB–1922/4 and LRB–2005/4.

(END)