WISCONSIN DEPARTMENT OF HEALTH SERVICES
PROPOSED ORDER TO ADOPT PERMANENT RULES

The Wisconsin Department of Health Services (the "department") proposes an order to **repeal** ss. DHS 10.13 (1) (b) 4. and 5., (12), (40m), 10.21 (3) (b), (5), 10.23 (2) (k), 10.33 (3), 10.42 (3) (a), (6) (b), 10.52 (4), 10.55 (e), 10.71, 73.03 (4), 73.05, 73.07 (2), 73.10 (3), 105.17 (1c) (c); **renumber** s. DHS 10.55 (1) (d), (f), and (h) to (k); **renumber and amend** s. DHS 10.53 (1) (c), and 10.55 (1) (g); **consolidate, renumber and amend** ss. DHS 10.21 (3) (intro.) and (a), and 10.42 (6) (intro.) and (a); **amend** ss. DHS 10.11 (5), 10.13 (1) (intro.), (b) 1., 2., and 7., (3m), (14), (16), (20), (28), (46) (a) to (c), 10.21 (4), 10.22 (3) and (4), 10.23 (2) (d) 3., (e), (h) and (j) 2., 10.23 (3) (intro.), (a) 2. (intro.), 2. c., 3., (6) (b), (c), and (e) 5. e., 10.31 (4) (a) and (b), (5), and (6) (a) and (b), 10.41 (2), 10.52 (1) (intro.), (3) (intro.), (3) (a) 2., (b) (intro.), and 1. to 9., 10.53 (title) and (1) (a) and (b), (2) (title), (a) and (b), 10.54 (1) (title), (intro.), (a) and (b), (2) (title), (3), 10.55 (title), (intro.), (1m), (2), (3) and (Note), (4) (title) and (b), (5) (a) 3.. 10.56 (1) and (2) to (3), 10.62 (1) (b), 10.73 (1) and (4) (a) 1., 73 (title), 73.01, 73.02, 73.03 (5), (8m), (11) and (14), 73.04 (1), 73.10 (1) and (2), 73.11 (1), 104.01 (5) (a) 1.; **repeal and recreate** s. DHS 10.53 (2) (c); and **create** ss. DHS 10.13 (1) (b) 8. to 10., (c), (8m), (14m), (36m), 10.31 (6) (am), 10,52 (3) (b) 1m., 10.53 (1) (c) 1. to 4., (d), (1m) (title), (a) and (b), (2) (bg) and (br), (d) to (f), 10.54 (2e), (2j), (2o), (2v), 10.55 (1g) (a), (c), and (d) to (h), 10.56 (1m), relating to long-term care services and Medical Assistance fair hearing process.

RULE SUMMARY

Statute interpreted
Sections 46.286 (7), 46.287 (2) (a) 1., and 49.665 (4) & (5), Stats.

Statutory authority

Section 46.03 (25), Stats.: UNIFORM REGULATION AND LICENSING. The department shall promulgate rules to establish licensing and program compliance standards for care and residential facilities, hospitals, hotels, restaurants and the vending of food and beverages after due consideration of the relationship of a licensing code to other related licensing codes, the need for uniform administration, the need to maximize the use of federal funds and the need to encourage the development and operation of needed facilities statewide. In establishing licensing standards designed to ensure that the facility qualifies for federal financial participation, the department shall establish federal regulations as the base requirement. The department may promulgate such additional health and safety standards as it determines to be in the public interest.

Section 46.277 (5) (d) 1n. b. and (5r), Stats.:

(5) (d) 1n. b. The county department or aging unit documents that the option of in-home services has been discussed with the person, thoroughly evaluated and found to be infeasible, as determined by the county department or aging unit in accordance with rules promulgated by the department of health services.

(5r) RULE MAKING. The department shall promulgate rules that specify conditions of hardship under which the department may grant an exception to the requirement of sub. (5) (d) 3.

Section 46.286 (4), (5) and (6):
(4) DIVESTMENT; RULES. The department shall promulgate rules relating to prohibitions on divestment of assets of persons who receive the family care benefit, that are substantially similar to applicable provisions under s. 49.453.

(5) TREATMENT OF TRUST AMOUNTS; RULES. The department shall promulgate rules relating to treatment of trust amounts of persons who receive the family care benefit, that are substantially similar to applicable provisions under s. 49.454.
(6) PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE; RULES. The department shall promulgate rules relating to protection of income and resources of couples for the maintenance of the spouse in the community with regard to persons who receive the family care benefit, that are substantially similar to applicable provisions under s. 49.455.

Section 46.288, Stats.: The department shall promulgate as rules all of the following:
(1) Standards for performance by resource centers and for certification of care management organizations, including requirements for maintaining quality assurance and quality improvement.
(2) Criteria and procedures for determining functional eligibility under s. 46.286 (1) (a), financial eligibility under s. 46.286 (1) (b), and cost sharing under s. 46.286 (2) (a).
(3) Procedures and standards for procedures for s. 46.287 (2), including time frames for action by a resource center or a care management organization on a contested matter.

Section 49.45 (10), Stats.: RULE−MAKING POWERS AND DUTIES. The department is authorized to promulgate such rules as are consistent with its duties in administering medical assistance. The department shall promulgate a rule defining the term "part−time intermittent care" for the purpose of s. 49.46.

Section 49.665 (3), Stats.: Administration. Subject to sub. (2) (a) 2., the department shall administer a program to provide the health services and benefits described in s. 49.46 (2) to persons that meet the eligibility requirements specified in sub. (4). The department shall promulgate rules setting forth the application procedures and appeal and grievance procedures. The department may promulgate rules limiting access to the program under this section to defined enrollment periods. The department may also promulgate rules establishing a method by which the department may purchase family coverage offered by the employer of a member of an eligible family or of a member of an eligible child's household, or family or individual coverage offered by the employer of an eligible unborn child's mother or her spouse, under circumstances in which the department determines that purchasing that coverage would not be more costly than providing the coverage under this section.

Section 50.02 (2) (d), Stats.: The department shall promulgate rules that prescribe all of the following:
1. The method by which community-based residential facilities shall make referrals to resource centers or county departments under s. 50.035 (4n) and the method by which residential care apartment complexes shall make referrals to resource centers under s. 50.034 (5n).
2. The time period for nursing homes to provide information to prospective residents under s. 50.04 (2g) (a) and the time period and method by which nursing homes shall make referrals to resource centers under s. 50.04 (2h) (a).

Explanation of agency authority
The department has explicit authority to promulgate the proposed rule. Section 49.45 (10), Stats., authorizes the department to "promulgate such rules as are consistent with its duties in administering medical assistance." Section 46.03 (25), Stats., authorizes the department to "promulgate rules to establish licensing and program compliance standards." Section 46.288 (3), Stats., authorizes the department to promulgate rules to establish procedures and standards for procedures for fair hearings.

Related statute or rule
The following statues and rules are directly related to bringing the department's rules into compliance with 2019 Wis. Act 9:
42 USC 1396a(a)(3)
42 USC 1396u–2(b)(4)
42 CFR 431 Subpart E
42 CFR 438 Subpart F

Section 46.281 (1n) (d) and (3), Stats.
Section 46.2825, Stats.
Section 46.283 (3) (f), (3) (e), (3) (k), (4) (f), (4) (g), (4) (e), (6) (b) 7., and (6) (b) 9., Stats.
Section 46.287 (2) (a) and (b), Stats.
Section 49.45 (5) (a) and (ag), Stats.
2019 Act 9 section 448
2019 Act 9 section 477
2019 Act 9 section 478
Sections DHS 10.11, 10.13, 10.21, 10.23, 10.31, 10.42, 10.52, 10.53, 10.54, 10.55, and 10.56
Sections DHS 73.01, 73.02, 73.03, 73.05, and 73.10
Section DHS 90.06
Section DHS 104.01
Section DHS 105.17

Plain language analysis

The intent of the proposed rules is to bring the department's rules into compliance with 2019 Wis. Act 9 (the "Act") which made changes to ss. 46.27, 46.281 (1n) (d), 46.283 (3) (f), (4) (e), (4) (f), (6) (b) 7., and (6) (b) 9., 46.2825, 46.287 (2) (a) 1. and (2) (a) 1m., 46.287 (2) (b), 46.288 (2), and 49.45 (5) (a), (5) (ag) and (5) (ar), Stats., require the department to do all of the following to bring associated rules into compliance:

(1) Modify the availability and timing of the fair hearing process for certain community-based Medical Assistance programs and services.

(2) Define managed care organization decisions, omissions, or actions.

(3) Require members to first file grievances with managed care organizations, and limit members' ability to contest managed care organizations' grievance decisions with the department.

(4) Remove the Community Options Program as a Medical Assistance program.

(5) Eliminate regional long-term care advisory committees.

(6) Requiring each aging and disability resource center governing board to review the number and types of grievances and appeals related to the aging and disability resource center.

(7) Modify aging and disability resource center provisions to reflect availability statewide.

Summary of, and comparison with, existing or proposed federal regulations

42 USC 1396a(a)(3) and 1396u–2(b)(4) requires the Medical Assistance program to establish and ensure availability of fair hearing and managed care organization internal grievance procedures. 42 CFR 431 Subpart E sets forth Medical Assistance program fair hearing requirements for non-managed care programs and services. 42 CFR 431.221(d) requires the department to "allow the applicant or beneficiary a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearings." 42 CFR 438 Subpart F sets forth Medical Assistance grievance and appeal requirements for managed care programs. 42 CFR 438.402(c)(2)(ii) requires the Medical Assistance managed care program to ensure that "[f]ollowing receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan." 42 CFR 438.408(f)(2) requires that an "enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution to request a State fair hearing." 42 CFR 438.400(b) defines the MCO, PIHP, and PAHP acts, and failures to act, that are adverse benefit determinations. 42 CFR §438.400(b) defines an appeal as "a review by an MCO, PIHP, or PAHP of an adverse benefit determination." 42 CFR §438.400(b) defines grievance as "an expression of dissatisfaction about any matter other than an adverse benefit determination." 42 CFR 438.402(c)(1)(i) states that an "enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld."

Federal law does not establish specific requirements for provision and activities of the Community Options Program, regional long-term care advisory committees, or aging and disability resource centers.

Comparison with rules in adjacent states

Illinois:
Illinois statute generally requires grievance proceedings and fair hearings to be available to Medicaid applicants and enrollees under 305 ILCS 5/5-30.03(d). Illinois policy establishes that grievance proceedings must be requested within 60 calendar days and fair hearings must be requested within 30 calendar days. Illinois policy also establishes that each managed care organization establishes its own grievance and appeal process which must comply with federal law.

Illinois does not have a group that is comparable to the Wisconsin regional long-term care advisory committees.

Iowa:
Iowa statute requires fair hearings to be available to Medicaid applicants under Iowa Code § 249A.4 (11). Grievance proceedings must be requested within 60 calendar days under 42 CFR 438.402(c)(2)(ii). Iowa administrative code requires grievance proceedings of managed care organization adverse benefit determinations to be requested within the time specified by federal regulation under Iowa Admin Code § 441-73.12(249A) par. 73.12(1)e. Iowa administrative code requires fair hearings to be requested within 90 days of an adverse benefit determination for fee-for-services coverage and within 120 days of exhausting the managed care organization appeal process under Iowa Admin Code § 441-7.4(17A) par. 7.3(3).

Iowa does not have a group that is comparable to the Wisconsin regional long-term care advisory committees.

Michigan:
Michigan administrative code requires internal conferences and appeals for administrative hearings be available when adverse benefit determinations are made under Mich Admin Code, R 400.3404 Rule 4. Internal conferences must be requested within 30 days and hearings must be requested within 90 days of the date specified in the notice of adverse action under Mich. Admin Code, R 400.3404 Rule 4 and 42 CFR 431.221(d).

Michigan does not have a group that is comparable to the Wisconsin regional long-term care advisory committees.

Minnesota:
Minnesota statute requires grievance proceedings and fair hearings to be available to Medicaid applicants under MN s. 256.045 subd. 3 (i). Grievance proceedings must be offered by managed care organizations under MN s. 256L.12 subd. 7. (4). Minnesota policy establishes that fair hearings must be requested within 120 days.

Minnesota does not have a group that is comparable to the Wisconsin regional long-term care advisory committees.

Summary of factual data and analytical methodologies
The department formed an advisory committee that included representatives of the Aging and Disability Resource Center of Southwest Wisconsin, Aging & Disability Professionals Association of Wisconsin, Disability Rights Wisconsin, Greater Wisconsin Agency on Aging and Resources, Legal Action of Wisconsin, and MetaStar, Inc. Advisory committee members were provided a copy of draft language of the proposed rules and provided comments at an advisory committee meeting held on June 30, 2021.

Analysis and supporting documents used to determine effect on small business
The department published a solicitation in the Administrative Register from January 10, 2022, to February 7, 2022, in which it requested public comments on the economic impact of the proposed rule.

Effect on small business
Based on the economic impact public commenting period and the analysis provided in fiscal estimate and economic impact analysis, the proposed rule is anticipated to have no economic impact on small businesses.

Agency contact person
Bailey Dvorak, DHSDMSAdminRules@dhs.wisconsin.gov, 608-267-5210

Statement on quality of agency data
The data used by the department to prepare these proposed rules and analysis complies with s. 227.14 (2m), Stats.

Place where comments are to be submitted and deadline for submission
Comments may be submitted to the agency contact person that is listed above until the deadline given in the upcoming notice of public hearing. The notice of public hearing and deadline for submitting comments will be published in the Wisconsin Administrative Register and to the department's website, at https://www.dhs.wisconsin.gov/rules/active-rulemaking-projects.htm. Comments may also be submitted through the Wisconsin Administrative Rules Website, at: https://docs.legis.wisconsin.gov/code/chr/active.

RULE TEXT

SECTION 1. DHS 10.11 (5) is amended to read:

DHS 10.11 (5) Provides for the protection of applicants for the family care benefit and enrollees in care management organizations through ~~complaint~~ appeal, grievance and fair hearing procedures.

SECTION 2. DHS 10.13 (1) (intro.), (b) 1. and 2. are amended to read:

DHS 10.13 (1) "~~Action~~ Adverse Benefit Determination" means any of the following:

DHS 10.13 (1) (b) 1. The denial or limited authorization of a requested service, including ~~the~~ determinations based on type or level of service, requirements or medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

DHS 10.13 (1) (b) 2. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

SECTION 3. DHS 10.13 (1) (b) 4. and 5. are repealed.

SECTION 4. DHS 10.13 (1) (b) 7. is amended to read:

DHS 10.13 (1) (b) 7. ~~Termination of family care benefit or involuntary~~ Involuntary disenrollment from a CMO.

SECTION 5. DHS 10.13 (1) (b) 8. to 10. are created to read:

DHS 10.13 (1) (b) 8. The denial of functional eligibility under s. DHS 10.33 as a result of the care management organization's administration of the long-term care functional screen, including a change from a nursing home level of care to a non-nursing home level of care.

9. The denial of an enrollee's request to dispute a financial liability, including copayments, premiums, deductibles, coinsurance, other cost sharing, and other member financial liabilities.

10. The denial of an enrollee, who is a resident of a rural area with only one care management organization, to obtain services outside of the care management organization's network of contracted providers.

SECTION 6. DHS 10.13 (1) (c) is created to read:

DHS 10.13 (1) (c) Any of the following failures on the part of a care management organization:

1. The failure to provide services and support items included in the individualized service plan in a timely manner, as defined in the department's contract with care management organizations.

2. The failure to act in a timely manner as specified in subchapter V of this chapter to resolve grievances or appeals.

SECTION 7. DHS 10.13 (3m) is amended to read:

DHS 10.13 (3m) "Appeal" means a request for review of an ~~action~~ adverse benefit determination.

SECTION 8. DHS 10.13 (8m) is created to read:

DHS 10.13 (8m) "Choice counseling" means information and services designed to assist eligible applicants in making enrollment decisions.

SECTION 9. DHS 10.13 (12) is repealed.

SECTION 10. DHS 10.13 (14) is amended to read:

DHS 10.13 (14) "County agency" means a county department of aging, multicounty consortium, social services or human services, an aging and disability resource center, a family care district or a tribal agency, that has been designated by the department to determine financial eligibility and cost sharing requirements for the family care benefit.

SECTION 11. DHS 10.13 (14m) is created to read:

DHS 10.13 (14m) "Day" means calendar day, unless otherwise indicated.

SECTION 12. DHS 10.13 (16), (20), and (28) are amended to read:

DHS 10.13 (16) "Developmental disability" ~~means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, intellectual disability, or another neurological condition closely related to intellectual disability or requiring treatment similar to that required for intellectual disability, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. "Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging~~ has the meaning given in s. 51.01 (5) (a), Stats.

DHS 10.13 (20) "Fair hearing" means a de novo proceeding under ch. HA 3 before an impartial administrative law judge in which the petitioner or the petitioner's representative presents the reasons why an ~~action~~ administrative action under HA 3.03 or inaction by the department, a county agency, a resource center or a CMO in the petitioner's case should be corrected.

DHS 10.13 (28) "Grievance" means an expression of dissatisfaction about any matter that is not an ~~action~~ adverse benefit determination.

SECTION 13. DHS 10.13 (36m) is created to read:

DHS 10.13 (36m) DHS 10.13 (36m) "Multicounty consortium" means a group of counties specified in s. 49.78 (1) (br), Stats.

SECTION 14. DHS 10.13 (40m) is repealed.

SECTION 15. DHS 10.13 (46) (a) to (c) are amended to read:

DHS 10.13 (46) (a) ~~Older persons~~ Adults age 60 and older.

(b) ~~Persons~~ Adults with a physical disability.

(c) ~~Persons~~ Adults with a developmental disability.

SECTION 16 DHS 10.21 (3) (intro.) and (a) are consolidated, renumbered DHS 10.21 (3), and amended to read:

DHS 10.21 (3) The department shall use standard contract provisions for contracting with resource centers, except as provided in this subsection. The provisions of the standard contract shall comply with all applicable state and federal laws and may be modified only in accordance with those laws and after consideration of the advice of ~~all of the following:(a) The~~ the secretary's council on long−term care.

SECTION 17. DHS 10.21 (3) (b) is repealed.

SECTION 18. DHS 10.21 (4) is amended to read:

DHS 10.21 (4) The department shall annually provide to the members of the council on long−term care copies of the standard resource center contract the department proposes to use in the next contract period and seek the advice of the council regarding the contract's provisions. ~~The department shall consider any recommendations of the council and may make revisions, as appropriate, based on those recommendations. If the department proposes to modify the terms of the standard contract, including adding or deleting provisions, in contracting with one or more organizations, the department shall seek the advice of the council and consider any recommendations of the council before making the modifications.~~

SECTION 19. DHS 10.21 (5) is repealed.

SECTION 20. DHS 10.22 (3) and (4) are amended to read:

DHS 10.22 (3) GOVERNING BOARD. A resource center shall have a governing board that reflects the ethnic and economic diversity of the geographic area served by the 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, reflective of the resource center's target population. No member of the governing board may have any direct ~~or indirect~~ financial interest in a care management organization.

(4) INDEPENDENCE FROM CARE MANAGEMENT ORGANIZATION. To assure that persons receive long−term care counseling and eligibility determination services ~~from the resource center~~ in an environment that is free from conflict of interest, a resource center shall meet state and federal requirements for organizational independence from any care management organization.

SECTION 21. DHS 10.23 (2) (d) 3., (e), (h), and (j) 2. are amended to read:

DHS 10.23 (2) (d) 3. When a benefit specialist represents a client in a matter in which a decision or ~~action~~ administrative action under s. HA 3.03 of the resource center is at issue, the resource center may not attempt to influence the benefit specialist's representation of the client.

DHS 10.23 (2) (e) *Transitional services*. A resource center that serves young adults age 17 years and 6 months or older with physical or developmental disabilities shall coordinate with school districts, boards appointed under s. 51.437, Stats., county human services departments or departments of community programs to assist ~~young adults with physical or developmental disabilities~~ in making the transition from children's services to the adult long−term care system.

DHS 10.23 (2) (h) *Choice counseling*. The resource center shall provide information and counseling to assist persons who are eligible for the family care benefit and their families or other representatives with respect to the person's choice of whether or not to enroll in a care management organization and, if so, which available care management organization would best meet ~~his or her~~ their needs. To assure that persons receive choice counseling in an environment that is free from conflict of interest, resource center staff in the choice counseling session may not have a direct or indirect interest in a care management organization. Information provided under this paragraph shall include information about all of the following.

DHS 10.23 (2) (j) 2. Advocacy resources available to assist the person in resolving ~~complaints~~ appeals and grievances.

SECTION 22. DHS 10.23 (2) (k) is repealed.

SECTION 23. DHS 10.23 (3) (intro.), (a) 2. (intro.) and c., 3., (6) (b), (c), and (e) 5. e. are amended to read:

DHS 10.23 (3) ACCESS TO FAMILY CARE AND OTHER BENEFITS. ~~If it is a county agency, the resource center shall provide to members of its target population access to the benefits under pars. (a) and (b) directly or through subcontract or other arrangement with the appropriate county agency. If it is not a county agency, the resource center shall have a departmentally approved memorandum of understanding with a county agency to which it will make referrals for access to these benefits. The memorandum of understanding shall clearly define the respective responsibilities of the two organizations, and how eligibility determination for the benefits under pars. (a) and (b) will be coordinated with other resource center functions for the convenience of members of the resource center's target population.~~ Benefits to which the resource center shall provide access are all the following:

DHS 10.23 (3) (a) 2. A resource center shall offer a functional screening and a financial eligibility and cost−sharing screening to any individual over the age of 17 years and ~~9~~ 6 months who appears to have a disability or condition requiring long−term care and who meets any of the following conditions:

DHS 10.23 (3) (a) 2. c. The person is seeking admission to a nursing home, community−based residential facility, adult family home, or residential care apartment complex, subject to the exceptions under ~~ss.~~ s. DHS ~~10.72 (4) and~~ 10.73 (4) (a) and when the person declined referral under s. DHS 10.73 (3).

DHS 10.23 (3) (a) 3. If a person accepts the offer, the resource center ~~or the county agency~~ shall provide the screens.

DHS 10.23 (6) (b) *Community needs identification*. Implement a process for identifying unmet needs of its target population in the geographic area it serves. The process shall include input from ~~the regional long−term care advisory committee,~~ members of the target populations and their representatives, and local government and service agencies including the care management organization, if any. The process shall include a systematic review of the needs of populations residing in public and private long−term care facilities, populations in need of public or private long-term care services, members of minority groups and people in rural areas. A resource center shall target its outreach, education, prevention and service development efforts based on the results of the needs identification process.

DHS 10.23 (6) (c) *Grievance ~~and appeal~~ processes*. Implement a process for reviewing and resolving client ~~complaints and resolving client~~ grievances as required under s. DHS 10.53 (1).

DHS 10.23 (6) (e) 5. e. Effective processes for ~~considering~~ reviewing and ~~acting on complaints and~~ resolving appeals and grievances of applicants and other persons who use resource center services.

SECTION 24. DHS 10.31 (4) (a) and (b), (5), and (6) (a) are amended to read:

DHS 10.31 (4) (a) *Making application*. Any person in the target population served by resource centers may apply for a family care benefit ~~on a form prescribed by the department and available from a resource center~~. Application for the family care benefit requires that a person apply for financial, non-financial and functional eligibility. Financial and non-financial eligibility determination shall be made ~~to~~ by the income maintenance agency serving the county~~,~~ or tribe ~~or family care district~~ in which the person resides. ~~Application may not be made to an agency in a county or tribe in which the family care benefit is not available.~~ Functional eligibility determination shall be made by the resource center serving the county or tribe in which the person resides.

DHS 10.31 (4) (b) *Signing the financial and non-financial eligibility application.* The applicant or the applicant's legal guardian, authorized representative or, where the applicant is incapacitated, someone acting responsibly for the applicant, shall sign each application form ~~in the presence of a representative of the agency~~. The signatures of 2 witnesses are required when the applicant signs the application with a mark.

DHS 10.31 (5) VERIFICATION OF INFORMATION. ~~An~~ A financial and non-financial eligibility application for the family care benefit shall be denied when the applicant or enrollee is able to produce required verifications but refuses or fails to do so. If the applicant or enrollee is not able to produce verifications or requires assistance to do so, the agency taking the application may not deny assistance but shall proceed immediately to assist the person to secure necessary verifications.

DHS 10.31 (6) (a) *Decision date for financial and non-financial eligibility*. Except as provided in par. (b), as soon as practicable, but not later than 30 days from the date the agency receives ~~an~~ a financial and non-financial eligibility application that includes at least the applicant's name, address, unless the applicant is homeless, and signature, the agency shall determine the applicant's financial and non-financial eligibility and cost sharing requirements for the family care benefit~~, using a functional screening and a financial eligibility and cost−sharing screening prescribed by the department~~. If the applicant is the spouse of a family care ~~spouse~~ member, the agency shall notify both spouses in accordance with the requirements of s. 49.455 (7), Stats.

SECTION 25. DHS 10.31 (6) (am) is created to read:

DHS 10.31 (6) (am) *Decision date for functional eligibility*. Except as provided in par. (b), as soon as practicable, but not later than 30 days from the date the resource center receives verbal acceptance from the applicant to proceed with the functional screen, the resource center will determine the applicant's functional eligibility for the family care benefit.

SECTION 26. DHS 10.31 (6) (b) is amended to read:

DHS 10.31 (6) (b) *Notice*. The agency shall notify the applicant in writing of its determination. If a delay in processing the financial and non-financial eligibility application or determining functional eligibility occurs because of a delay in securing necessary information, the agency shall notify the applicant ~~in writing~~ that there is a delay in processing the application. Communications with the applicant, either orally or in writing, in the attempt to obtain the missing information shall serve as notice of the delay. If the delay is not resolved within 30 days following this notice to the applicant of the missing information, the agency shall notify the applicant in writing of the delay in completing the determination, specify the reason for the delay, and inform the applicant of ~~his or her~~ their right to appeal the delay by requesting a fair hearing under s. DHS 10.55.

SECTION 27. DHS 10.33 (3) is repealed.

SECTION 28. DHS 10.41 (2) is amended to read:

DHS 10.41 (2) SERVICES. Services provided under the family care benefit shall be determined through individual assessment of enrollee needs and values and detailed in an individual service plan unique to each enrollee. As appropriate to its target population and as specified in the department's contract, each CMO shall have available at least the services and support items covered under the home and community−based waivers under 42 USC 1396n (c) and ss. 46.275, 46.277 and 46.278, Stats., ~~the long−term support community options program under s. 46.27, Stats.,~~ and specified services and support items under the state's plan for medical assistance. In addition, a CMO may provide other services that substitute for or augment the specified services if these services are cost−effective and meet the needs of enrollees as identified through the individual assessment and service plan

SECTION 29. DHS 10.42 (3) (a) is repealed.

SECTION 30. DHS 10.42 (6) (intro.) and (a) are consolidated, renumbered DHS 10.42 (6), and amended to read:

DHS 10.42 (6) Except as provided in this subsection, the department shall use standard contract provisions for contracting with CMOs. The provisions of the standard contract shall comply with all applicable state and federal laws and may be modified only in accordance with those laws and after consideration of the advice of ~~all of the following: (a) The~~ the secretary's council on long-term care.

SECTION 31. DHS 10.42 (6) (b) is repealed.

SECTION 32. DHS 10.52 (1) (intro.), (3) (intro.), (a) 2., and (b) (intro.) and 1. are amended to read:

DHS 10.52 (1) NOTIFICATION OF GENERAL CLIENT RIGHTS AND RESPONSIBILITIES. Each resource center, county agency and CMO shall provide clients with written notification of their rights and responsibilities in accordance with timelines and other requirements established in its contract with the department in every instance in which:

DHS 10.52 (3) NOTIFICATION OF INTENDED ~~ACTION~~ ADVERSE BENEFIT DETERMINATION. Clients shall be given written notice of any intended adverse ~~action~~ benefit determination at least 10 days prior to the date of the intended ~~action.~~ adverse benefit determination in accordance with all of the following:

DHS 10.52 (3) (a) 2. By the CMO in every instance in which ~~the CMO intends to reduce or terminate a service or deny payment for a service~~ the CMO makes an adverse benefit determination under s. DHS 10.13 (1) (b).

DHS 10.52 (3) (b) The notification of intended ~~action~~ adverse benefit determination shall include an explanation of all the following, as applicable:

1. The ~~action~~ adverse benefit determination the county agency, resource center or CMO intends to take, including how the ~~action~~ adverse benefit determination will affect any services that the ~~client~~ applicant or enrollee currently receives.

SECTION 33. DHS 10.52 (3) (b) 1m. is created to read:

DHS 10.52 (3) (b) 1m. The effective date of the adverse benefit determination.

SECTION 34. DHS 10.52 (3) (b) 2. to 9. are amended to read:

DHS 10.52 (3) (b) 2. The reasons for the ~~intended action~~ adverse benefit determination.

3. Any laws that support the ~~action~~ adverse benefit determination.

4. The ~~client's~~ applicant's or enrollee's right to file ~~a grievance or~~ an appeal with the CMO or request a fair hearing with the resource center~~,~~ or county agency ~~or CMO, to request a department review and to request a fair hearing~~.

5. How to file ~~a grievance, or request a department review~~ an appeal or a fair hearing and the timelines for doing so.

5m. The circumstances under which expedited resolution of ~~a grievance or~~ an appeal is available and how to request it.

6. That if the ~~client~~ applicant or enrollee files ~~a grievance~~ an appeal, he or she has a right to appear in person before the ~~county agency, the resource center or~~ CMO personnel assigned to resolve the ~~grievance~~ appeal.

7. The If the adverse benefit determination will affect any services that the enrollee currently receives through the family care benefit, the circumstances ~~under~~ in which ~~an~~ the enrollee's ~~current services provided through the family care benefit~~ services will be continued under s. DHS 10.56 pending the outcome of ~~a grievance, department review or fair hearing~~ an appeal, how the enrollee can request that the services be continued, and the circumstances in which the enrollee may be required to re-pay the costs of the continued services.

8. The availability of independent advocacy services and other local organizations that might assist a ~~client in a grievance, department review~~ applicant or enrollee with an appeal or fair hearing.

9. That the ~~enrollee~~ applicant or enrollee may obtain, free of charge, copies of client records relevant to the ~~grievance, department review~~ appeal or fair hearing, and how to obtain the copies.

SECTION 35. DHS 10.52 (4) is repealed.

SECTION 36. DHS 10.53 (title) and (1) (a) and (b) are amended to read:

DHS 10.53 **Grievances and appeals**. (1) GRIEVANCE PROCESS IN RESOURCE CENTERS. (a) The governing board of each resource center shall approve and effectively operate a process for reviewing and resolving client grievances ~~and appeals~~. The board may delegate, in writing, its responsibility for ~~review of appeals~~ reviewing and ~~resolution of~~ resolving grievances to a committee of the resource center's senior management, provided the process ensures that the board is made aware of grievances and requests for department review and fair hearings.

(b) The department shall review and approve a resource center's grievance ~~and appeal~~ process as part of its contracting with the resource center.

SECTION 37. DHS 10.53 (1) (c) is renumbered DHS 10.53 (1) (c) (intro.) and amended to read:

(c) A resource center shall ~~assist individuals to file and resolve grievances or appeals, including assistance with committing an oral grievance or appeal to writing.~~ inform clients of all of the following:

SECTION 38. DHS 10.53 (1) (c) 1. to 4., (d), and (1m) (title), (a) and (b) are created to read:

DHS 10.53 (1) (c) 1. The circumstances under which expedited resolution of a grievance is available and how to request it.

2. The client has the right to appear in person before the resource center personnel assigned to resolve a grievance filed, if the enrollee files the grievance.

3. The availability of independent advocacy services and other local organizations that might assist a client with a grievance.

4. The client may obtain, free of charge, copies of client records relevant to the grievance and how to obtain the copies.

DHS 10.53 (1) (d) A resource center shall assist individuals with the filing of grievances with the resource center.

DHS 10.53 (1) (e) A client may file a grievance with the resource center at any time.

DHS 10.53 (1) (f) The resource center shall complete its review of a grievance and issue its written decision to the client within 10 business days of its receipt of the grievance, unless the client and the resource center agree to an extension for a specified period of time.

DHS 10.53 (1m) APPEALS PROCESS IN RESOURCE CENTERS. (a) Resource center adverse benefit determinations are appealed through the fair hearing process under s. DHS 10.55.

(b) A resource center shall assist clients with the filing of requests for fair hearings with the division of hearings and appeals.

SECTION 39. DHS 10.53 (2) (title), (a) and (b) are amended to read:

DHS 10.53 (2) GRIEVANCE AND APPEALS PROCESS IN CARE MANAGEMENT ORGANIZATIONS. (a) The governing board of each CMO shall approve and shall effectively operate a process for reviewing and resolving ~~client~~ enrollee grievances and appeals. The board may delegate, in writing, its responsibility for ~~review of complaints~~ reviewing and ~~resolution of~~ resolving grievances and appeals to a committee of the CMO's senior management, provided that the board is made aware of grievances and requests for department review and fair hearings.

(b) The department shall review and approve a ~~resource center's~~ CMO's grievance and appeal process as part of its contracting with the CMO.

(c) ~~A CMO shall individuals to file and resolve grievances or appeals, including assistance with committing an oral grievance or appeal to writing.~~ The CMO shall inform enrollees of all of the following:

SECTION 40. DHS 10.53 (2) (bg) and (br) are created to read:

DHS 10.53 (2) (bg) An enrollee may file a grievance at any time.

DHS 10.53 (2) (br) The CMO shall complete its review of a grievance and issue its written decision to the enrollee within 90 days of its receipt of the grievance, unless the grievance decision timeframe is extended under the extension requirements specified in the contract with the department.

SECTION 41. DHS 10.53 (2) (c) is repealed and recreated to read:

DHS 10.53 (2) (c) The CMO shall inform enrollees of all of the following:

1. The circumstances under which expedited resolution of a grievance is available and how to request it.

2. The enrollee has the right to appear in person before the CMO personnel assigned to resolve a grievance, if the enrollee files the grievance.

3. The availability of independent advocacy services and other local organizations that might assist an enrollee with a grievance.

4. The enrollee may obtain, free of charge, copies of enrollee records relevant to the grievance and how to obtain the copies.

SECTION 42. DHS 10.53 (2) (d), (e) and (f) are created to read:

DHS 10.53 (2) (d) A CMO shall assist enrollees with filing grievances with the CMO. If an enrollee is dissatisfied with the CMO's grievance decision, or the CMO fails to render a grievance decision within the timeframe specified under par. (br), a CMO shall assist the individual with requesting a department review of the grievance under s. DHS 10.54.(e) An enrollee must request department review within 45 days of the date on the grievance decision.

(e) The CMO shall complete its review of an appeal and issue its written decision to the enrollee within 30 days of its receipt of the appeal, unless the appeal decision timeframe is extended under the extension requirements specified in the contract with the department.

(f) A CMO shall assist enrollees with filing appeals with the CMO. If the enrollee is dissatisfied with the CMO's appeal decision, or the MCO fails to render an appeal decision within the timeframe specified under sub. (3) (f), a CMO shall assist the individual with requesting a fair hearing with the division of hearings and appeals under s. DHS 10.55.

SECTION 43. DHS 10.54 (1) (title), (intro.), (a) and (b), and (2) (title) are amended to read:

DHS 10.54 **Department reviews**. (1) ~~GENERAL~~ DEPARTMENT REVIEW PROCESS FOR GRIEVANCES FILED WITH A RESOURCE CENTER. The department shall ~~establish a process for the timely~~ review, ~~investigation~~ investigate, and ~~analysis of~~ analyze the facts surrounding client grievances ~~or appeals~~ in an attempt to resolve concerns and problems informally, whenever either of the following occurs:

(a) A client makes a grievance ~~or appeal~~ directly to the department.

(b) A client requests department review of a decision arrived at through a county agency~~,~~ or resource center ~~or care management organization~~ grievance process.

DHS 10.54 (2) TIMELINESS OF ~~REVIEWS~~ REVIEW.

SECTION 44. DHS 10.54 (2e), (2j), (2o), and (2v) are created to read:

DHS 10.54 (2e) DEPARTMENT REVIEW PROCESS FOR GRIEVANCES FILED WITH A CMO. The department shall review and resolve enrollee grievances whenever either of the following occurs:

(a) An enrollee requests department review of a decision arrived at through a care management organization grievance process under s. DHS 10.53 (2).

(b) An enrollee requests department review of a grievance request that the CMO has failed to act on within the timeframe specified under s. DHS 10.53 (2) (d).

DHS 10.54 (2j) TIMEFRAME FOR REQUESTING DEPARTMENT REVIEW. An enrollee must file the request for grievance review within 45 days of the receipt of the CMO's written decision regarding the enrollee's grievance or, if the CMO fails to issue a written grievance decision to the enrollee within the timeframe specified under s. DHS 10.53 (2) (d), within 45 days of the date that timeframe expires.

DHS 10.54 (2o) TIMELINESS OF REVIEW. The department shall complete its review under sub. (2e) within 30 days of receiving a request for review from an enrollee, unless the enrollee and the department agree to an extension for a specified period of time.

DHS 10.54 (2v) TIMELINESS OF DECISION. The department shall mail or hand deliver to the enrollee and the CMO a written decision resolving the grievance within 7 days of the completion of the grievance review. This decision is final and binding on both the enrollee and CMO. Department review is the final process in resolving enrollee grievances.

SECTION 45. DHS 10.54 (3) is amended to read:

DHS 10.54 (3) ~~CONCURRENT~~ DEPARTMENT REVIEW PROCESS FOR FAIR HEARINGS. Whenever the department receives notice from the department of administration's division of hearings and appeals that it has received a fair hearing request under s. DHS 10.55 ~~(1) (d) to (g)~~ (3), the department shall ~~use the process in sub. (1) to~~ conduct ~~a concurrent~~ an informal review in accordance with s. DHS 10.55 (4).

SECTION 46. DHS 10.55 (1) (title), (intro.) is amended to read:

DHS 10.55 (1) RIGHT TO FAIR HEARING IN RESOURCE CENTER AND COUNTY AGENCY ADVERSE BENEFIT DETERMINATIONS. Except as limited in ~~subs. (1m), (2) and~~ sub. (3) and s. DHS 10.62 (4), a client ~~has a right to a fair hearing under s. 46.287, Stats. The contested matter may be a decision or action by the department, a resource center, county agency or CMO, or the failure of the department, a resource center, county agency or CMO to act on the contested matter within timeframes specified in this chapter or in the~~

~~contract with the department. The following matters may be contested through a fair hearing~~ may contest any of the following adverse benefit determinations by filing, within 45 days of receipt of notice of the adverse benefit determination, a written request for a hearing to the division of hearings and appeals:

SECTION 47. DHS 10.55 (1) (d) is renumbered DHS 10.55 (1g) (b).

SECTION 48. DHS 10.55 (1) (e) is repealed.

SECTION 49. DHS 10.55 (1) (f) is renumbered DHS 10.55 (1g) (i).

SECTION 50. DHS 10.55 (1) (g) is renumbered DHS 10.55 (1g) (j) and amended to read:

DHS 10.55 (1g) (j) Termination of the family care benefit ~~or involuntary disenrollment from a CMO~~.

SECTION 51. DHS 10.55 (1) (h) to (k) are renumbered DHS 10.55 (1g) (k) to (n):

SECTION 52. DHS 10.55 (1g) (a), (c), and (d) to (h) are created to read:

DHS 10.55 (1g) RIGHT TO A FAIR HEARING. Care management organization adverse benefit determinations. Except as limited in subs. (1m), (2) and (3), an enrollee may contest any of the following adverse benefit determinations by filing, within 90 days of the failure of a care management organization to act on a contested adverse benefit determination within the time frame specified under s. DHS 10.53 (2) (e) or within 90 days after receipt of notice of a decision upholding the adverse benefit determination, a written request for a hearing to the division of hearings and appeals:

(a) Denial of functional eligibility under s. DHS 10.33 as a result of the care management organization's administration of the long-term care functional screen, including a change from a nursing home level of care to a non-nursing home level of care.

DHS 10.55 (1g) (c) Denial or limited authorization of a requested service, including determinations based on type or level of service, requirements or medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(d) Reduction, suspension or termination of services to support items in the enrollee's service plan, except when either of the following apply:

1. The reduction, suspension or termination was agreed to by the enrollee.

2. The reduced, suspended or terminated service or support was only authorized for a limited amount or duration and that amount or duration has been completed.

(e) Denial, in whole or in part, of payment for a service.

(f) Failure of a CMO to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(g) Denial of an enrollee's request to dispute financial liability, including copayments, premiums, deductibles, coinsurance, other cost sharing, and other enrollee financial liabilities.

(h) Denial of an enrollee, who is a resident of a rural area with only one CMO, to obtain services outside the CMO's network of contracted providers.

SECTION 53. DHS 10.55 (1m), (2), (3) and (Note), (4) (title), (b), and (5) (a) 3. are amended to read:

DHS 10.55 (1m) EXCEPTION TO RIGHT TO FAIR HEARING. An enrollee does not have a right to a fair hearing under sub. ~~(1)~~ (1g), if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all enrollees and the enrollee does not dispute that ~~he or she falls~~ they fall within the category of enrollees to be affected by the change.

DHS 10.55 (2) ~~LIMITED RIGHT TO FAIR HEARING~~ GRIEVANCES. An enrollee may contest~~, through fair hearing,~~ any decision, omission or action of a CMO other than those specified under sub. ~~(1) (d) to (f) only if a~~ (1g) by filing a grievance with the CMO ~~grievance decision~~ under s. DHS 10.53 ~~(2) (a) or a~~ (2).

If the enrollee is not satisfied with the CMO's grievance decision, or if the CMO fails to issue a grievance decision within the timeframes specified under s. DHS 10.53 ~~(2) (a) or~~ (2) (d), the enrollee may request a department review under s. DHS 10.54 ~~has failed to resolve the matter to the satisfaction of the enrollee within the time period approved by the department in s. DHS 10.53 (2) (b) or specified under s. DHS 10.54 (2)~~.

DHS 10.55 (3) REQUESTING A FAIR HEARING. ~~A client shall request a fair hearing within 45 days after receipt of notice of a decision in a contested matter, or after a resource center or CMO has failed to respond within timeframes specified by this chapter or the department.~~ Receipt of notice is presumed within 5 days of the date the notice was mailed. A client shall file ~~his or her~~ their request for a fair hearing in writing within the timeframes specified under subs. (1) and (1g) with the division of hearings and appeals in the department of administration. A hearing request shall be considered filed on the date of actual receipt by the division of hearings and appeals, or the date of the postmark, whichever is earlier. A request filed by facsimile is complete upon transmission. If the request is filed by facsimile transmission and such transmission is completed between 5 p.m. and midnight, one day shall be added to the prescribed period. If a client asks the department, a county agency, a resource center or CMO for assistance in writing a fair hearing request, the department, resource center or CMO shall provide that assistance.

Note: A hearing request can be submitted by mail or hand−delivered to the Division of Hearings and Appeals, at ~~505 University Ave., Room 201~~ 4822 Madison Yards Way, 5th Floor North, Madison, WI 53705−5400, ~~or~~ faxed to the Division at (608) 264−9885, or emailed to the Division at DHAMail@wisconsin.gov. The Division's telephone number is (608) 266−3096.

DHS 10.55 (4). DEPARTMENT ~~CONCURRENT~~ REVIEW OF FAIR HEARING REQUESTS.

DHS 10.55 (4) (b) When ~~a client~~ an enrollee has requested a fair hearing under sub. ~~(1) (d) to (g)~~ (3), the department shall ~~concurrently~~ conduct an informal review ~~and investigate the facts surrounding the client's request using the process established under s. DHS 10.54 in an attempt to resolve the problem informally~~ to identify, and, as appropriate, intervene in, fair hearing requests related to member health and safety, contract non-compliance and complex situations, if it appears to the department that informal resolution of the matter may be appropriate.

DHS 10.55 (5) (a) 3. In the case of an enrollee ~~grievance against~~ appealing a CMO decision, the person voluntarily disenrolls from the CMO.

SECTION 54. DHS 10.56 (1) is amended to read:

DHS 10.56 **Continuation of services**. (1) REQUEST FOR CONTINUATION OF SERVICES PENDING OUTCOME OF CMO APPEAL. Prior to reducing, suspending or terminating services under the family care benefit, a CMO shall provide to the enrollee prior notification of its intent to reduce, suspend or terminate the services in accordance with s. DHS 10.52 (3). If an enrollee who has received a notice that services will be reduced, suspend or terminated files ~~a grievance~~ an appeal with the CMO under s. DHS 10.53 (2)~~, or requests a department review under s. DHS 10.54 or a fair hearing under s. DHS 10.55 related to the reduction or termination of services and~~ before the effective date of the reduction, suspension or termination, the enrollee may request that the CMO continue to provide the services pending the outcome of the ~~grievance, department review or fair hearing~~ appeal.

SECTION 55. DHS 10.56 (1m) is created to read:

DHS 10.56 (1m) REQUEST FOR CONTINUATION OF SERVICES PENDING OUTCOME OF DHA FAIR HEARING. An enrollee is entitled to continuation of services pending the outcome of a fair hearing if all of the following apply:

(a) The CMO's decision on appeal under s. DHS 10.53 (2) is to proceed with reducing, suspending, or terminating the enrollee's service.

(b) The enrollee's services were continued pending the outcome of the CMO appeal decision.

(c) The enrollee requests a fair hearing on the CMO's appeal decision before the effective date of the CMO's appeal decision.

(d) The enrollee requests continuation of services before the effective date of the CMO's appeal decision.

SECTION 56. DHS 10.56 (2) to (3) are amended to read:

(2) REQUIREMENT FOR CONTINUATION. Except as provided in sub. (2m), a CMO may not reduce, suspend or terminate services under dispute pending the outcome of the enrollee's ~~grievance~~ appeal under s. DHS 10.53 (2)~~, department review under s. DHS 10.54~~ or fair hearing under s. DHS 10.55 if a request for continued benefits was made under sub. (1) or (1m).

(2m) EXEMPTION FROM RIGHT TO CONTINUATION. If the sole issue is a federal or state law requiring an automatic change adversely affecting some or all enrollees and the enrollee does not dispute that he or she falls within the category of enrollees to be affected by the change, the enrollee does not have the right to continuation of services pending the outcome of the enrollee's ~~grievance~~ appeal under s. DHS 10.53 (2)~~, department review under s. DHS 10.54,~~ or fair hearing under s. DHS 10.55. A CMO will not receive a monthly capitated payment for such an individual and is not required to continue services in such circumstances.

(3) LIABILITY FOR CONTINUATION OF SERVICES. The enrollee shall be liable for the cost of services provided during the period in which services have been continued under this section if the outcome of the ~~grievance, department review~~ appeal or fair hearing is unfavorable to the enrollee. The CMO shall notify in writing an enrollee who requests continuation of services under this section of the potential for liability under this subsection and the time period during which the enrollee will be liable. If the department or its designee determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided, the department may waive or reduce the enrollee's liability under this subsection.

SECTION 57. DHS 10.62 (1) (b) is amended to read:

DHS 10.62 (1) (b) Recovery under this section from the estate of an enrollee who was not found eligible under s. 46.286 (1) (b) 2m. a., Stats., and who did not receive services that are recoverable under s. ~~46.27 (7g),~~ 49.496 (3) or 49.682, Stats., shall be treated as follows:

SECTION 58. DHS 10.71 is repealed.

SECTION 59. DHS 10.73 (1) and (4) (a) 1. are amended to read:

DHS 10.73 (1) PURPOSE. This section implements ss. 50.034 (5m) to ~~(5p)~~ (5n) and (8), 50.035 (4m) to ~~(4p)~~ (4n) and (11) and 50.04 (2g) to ~~(2i)~~ (2h), Stats., which establish requirements for adult family homes, residential care apartment complexes, community−based residential facilities and nursing homes to provide information to prospective residents and to refer certain prospective or newly admitted residents to a resource center and establish penalties for non−compliance.

DHS 10.73 (4) (a) 1. The person is under the age of 17 years and ~~9~~ 6 months.

SECTION 60. DHS 73 (title) is amended to read:

DHS 73 SELECTED FISCAL MANAGEMENT PROCEDURES AND STANDARDS UNDER THE ~~COMMUNITY OPTIONS PROGRAM AND~~ MEDICAL ASSISTANCE HOME AND COMMUNITY−BASED SERVICES WAIVER

SECTION 61. DHS 73.01 is amended to read:

DHS 73.01 **Authority and purpose**. This chapter is promulgated under the authority of ss. ~~46.27 (2) (h) 2., (7) (cj) 3. b., (11) (c) 5n. b. and (12),~~ 46.277 (5) (d) 1n. b. and (5r), and 227.11 (2) (a), Stats., to establish certain standards and procedures related to assessments, case plans, service agreements, participant payment of service providers and verification that services have been received for ~~county administration of the community options program (COP) under s. 46.27, Stats., and~~ county administration of home and community−based services waivers from medical assistance requirements that the department receives from the secretary of the U.S. department of health and human services under 42 USC 1396n (c), to establish conditions of hardship under which the department may grant exceptions in individual cases to limits on spending by counties for care provided in CBRFs and to establish criteria for county agency determination of the infeasibility of in−home services as a condition for paying for services provided to a program participant residing in a CBRF.

SECTION 62. DHS 73.02 is amended to read:

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

SECTION 63. DHS 73.03 (4) is repealed.

SECTION 64. DHS 73.03 (5), (8m), (11), and (14) are amended to read:

DHS 73.03 (5) "County department" means ~~a county department designated under s. 46.27 (3) (b), Stats.,~~ a county department established under s. 46.215, 46.22, 46.23, 46.272, 51.42, or 51.437, Stats., which provides home and community−based services under a medical assistance waiver or a private non−profit agency designated by the department to provide services under a medical assistance waiver.

DHS 73.03 (8m) "Initially applies for services" means applies for the first time for services in addition to an assessment or care plan under ~~COP, the COP−waiver under s. 46.27 (11), Stats., or~~ the community integration program under s. 46.277, Stats., and has not previously received the services.

DHS 73.03 (11) "Participant" means a person receiving an assessment, case plan or supportive home care services funded ~~under s. 46.27 (7), Stats., or~~ under a medical assistance waiver.

DHS 73.03 (14) "Private non−profit agency" has the meaning specified in s. ~~46.27 (1) (bm)~~ 181.0103 (17), Stats., which provides a program of all-inclusive care for the elderly under 42 USC 1395eee or 1396u-4.

SECTION 65. DHS 73.04 (1) is amended to read:

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

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

SECTION 66. DHS 73.05 is repealed.

SECTION 67. DHS 73.07 (2) is repealed.

SECTION 68. DHS 73.10 (1) and (2) are amended to read:

DHS 73.10 (1) LIMITATION ON FUNDING. Each county shall annually establish limits on spending for services for persons who reside in CBRFs from the allocations received under ~~s. 46.27 (7) and (11), Stats., and~~ s. 46.277 (5), Stats., for community long−term support services. ~~A county department shall include those limits in the county plan for participation in COP under s. 46.27 (4) (c), Stats.~~

(2) LIMITATION ON ELIGIBILITY. If the projected cost of the services for an individual who is residing or intending to reside in a CBRF and initially applies for services to a county department would cause the county department to exceed a limit on spending for services provided to persons who reside in CBRFs under sub. (1), the individual is not eligible for those services using funds allocated under s. ~~46.27 or~~ 46.277 (5), Stats.~~, unless the department grants a hardship exception under sub. (3) for the individual.~~

SECTION 69. DHS 73.10 (3) is repealed.

SECTION 70. DHS 73.11 (1) is amended to read:

DHS 73.11 (1) A county may use long−term support funds under s. ~~46.27 or~~ 46.277, Stats., to provide services to a person residing in a CBRF if the county department or aging unit has determined that all 5 conditions under s. ~~46.27 (7) (cj) 3., 46.27 (11) (c) 5n., or~~ 46.277 (5) (d) 1n., Stats., have been met.

SECTION 71. DHS 104.01 (5) (a) 1. is amended to read:

DHS 104.01 (5) (a) 1. Applicants and recipients have the right to a fair hearing in accordance with procedures set out in this subsection when aggrieved by action or inaction of the agency or the department. This subsection does not apply to actions taken by a PRO or to adverse benefit determinations made by a care management organization or managed care organization under s. 46.287 (2) (a) 1m. or 49.45 (5) (ag), Stats.

SECTION 72. DHS 105.17 (1c) (c) is repealed.

SECTION 73. EFFECTIVE DATE. This rule takes effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22 (2) (intro.), Stats.

Wisconsin Department of Health Services

Dated: _____ _____

Kirsten Johnson, Secretary-designee

SEAL: