State of Wisconsin
2023 - 2024 LEGISLATURE

LRB-5507/1
JPC&SWB:cjs/wlj/skw

# 2023 ASSEMBLY BILL 1088

February 13, 2024 - Introduced by Representatives SNYDER, ROZAR, KURTZ and SUMMERFIELD, cosponsored by Senator CABRAL-GUEVARA. Referred to Committee on Family Law.

AN ACT ***to renumber and amend*** 50.06 (1); ***to amend*** 50.06 (2) (b), 50.06 (2) (c), 50.06 (5) (a) (intro.), 50.06 (5) (b), 50.06 (6) and 50.06 (7); and ***to create*** 50.06 (1) (b), 50.06 (5) (am) and 50.06 (8) of the statutes; **relating to:** consent to admissions to certain health care facilities by patient representatives, allocation of nursing beds for patients with certain complex needs, and a complex patient pilot program.

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***Analysis by the Legislative Reference Bureau***

The bill allows a patient's representative to consent to an admission of an incapacitated individual from a hospital to a nursing home or community-based residential facility without a petition for guardianship or protective placement and allows a patient's representative to make health care decisions and authorize expenditures related to health care on behalf of an incapacitated individual without certain time limitations that are imposed under current law if certain conditions are met. Under current law, an individual who is either related to an incapacitated individual as provided under current law or is an adult close friend of an incapacitated individual may consent to admission, directly from a hospital to a nursing home or community-based residential facility, of the incapacitated individual who does not have a valid power of attorney for health care and who has not been adjudicated incompetent in this state if certain conditions apply, including that the individual for whom admission is sought is not diagnosed as

developmentally disabled or as having a mental illness at the time of the proposed admission, that the incapacitated individual does not verbally object to or otherwise actively protest the admission, and that petitions for guardianship for the individual and for protective placement of the individual are filed prior to the proposed admission. An individual who consents to admission of an incapacitated individual may make health care decisions to the same extent as a guardian of the person and authorize expenditures related to health care to the same extent as a guardian of the estate until 60 days after the admission to the facility, discharge of the incapacitated individual from the facility, or appointment of a guardian for the incapacitated individual, whichever occurs first. The bill allows a patient's representative to consent to an admission of an incapacitated individual from a hospital to a nursing home or community–based residential facility as provided under current law without petitions for guardianship or protective placement of the incapacitated individual being filed if certain conditions apply, including that the patient's representative promptly notifies all of the incapacitated individual's family members that can be readily contacted that the patient's representative may make decisions or authorize expenditures on the incapacitated individual's behalf, that the patient's representative provides a written statement to the discharging hospital that contains certain information, and that the facility to which the incapacitated individual is admitted notifies a representative of the Board on Aging and Long Term Care of the admission. Further, the bill allows a patient's representative to make health care decisions and authorize expenditures related to health care without the time limitations that apply to other direct admissions under current law if the patient's representative satisfies the conditions for admission provided under the bill. The authority of a patient's representative to make health care decisions and authorize expenditures related to health care under the bill ends if a court appoints a guardian to make such decisions.

The bill allocates 250 nursing home beds to be awarded to applicants who agree to prioritize admissions of patients with complex needs and to prioritize admissions of patients who have been unable to find appropriate placement at another facility. Under current law, the maximum number of licensed nursing home beds that are available in the state is limited in order to enable the state to budget accurately and to allocate fiscal resources appropriately. At least once each year, the Department of Health Services is required to publish a notice concerning the number of nursing home beds that are available in each of its health planning areas. DHS is required to accept applications for available nursing home beds and review the applications based on criteria provided under current law, including cost containment, a need for additional beds in the health planning area where the beds are requested, and whether health care personnel, capital, and operating funds and other resources needed to provide proposed services are available. This bill directs DHS to allocate 250 nursing home beds to be awarded to applicants as provided in the bill. An applicant for nursing home beds allocated under the bill must apply to DHS on a form provided DHS and include a plan for the applicant to become licensed for the nursing home beds that the applicant requested, to become certified as a provider under the Medical Assistance program, and to hire sufficient health care personnel and expend

sufficient resources to provide 24–hour nursing services within 18 months of DHS approval. The bill requires that within 30 days of receipt of an application, DHS must review applications received and approve applications that contain reasonable plans to satisfy the above criteria within 18 months. The bill requires DHS to make determinations on applications in the order that they are received. If DHS approves an application, the bill requires DHS to award the beds requested in the application. If not enough beds remain under the program to award all of the beds requested in an application, DHS must contact the applicant and determine whether the applicant will accept some or all of the remaining beds instead of the beds requested in the application. If the applicant is willing to accept some or all of the remaining beds, DHS must award those beds. DHS must continue to request and approve applications until DHS awards all 250 nursing home beds allocated under the bill.

The bill requires DHS to select, using a competitive grant selection process, partnership groups to be designated as participating sites for a complex patient pilot program and then award grants to the partnership groups selected. The bill provides that a partnership group is one or more hospitals in partnership with one or more post–acute facilities. The bill provides that DHS must solicit feedback regarding the pilot program from representatives of healthcare system organizations, long–term care provider organizations, long–term care operator organizations, patient advocate groups, insurers, and any other organization determined to be relevant by the secretary of health services. Under the bill, DHS must require each partnership group that applies to be designated as a site for the pilot program to address certain issues in its application, including: 1) the number of complex patient care beds that will be set aside in a post–acute facility or through implementation of another innovative model of patient care in a post–acute facility to which participating hospitals agree; 2) defined goals and measurable outcomes of the partnership both during and after the pilot program; 3) the types of complex patients for whom care will be provided; 4) an operating budget for the proposed site; and 5) the participant group's expertise to successfully implement the proposal.

The bill requires DHS to reserve 10 percent of the pilot program funding for reconciliation to help address unanticipated costs. Under the bill, DHS must also develop a methodology to evaluate the pilot program and contract with an independent organization to complete the evaluation. Under the bill, DHS may pay the organization's fee from the funding appropriated for the pilot program. Under the bill, DHS must give additional weight to partnership groups that would ensure geographic diversity.

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

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

**SECTION 1.** 50.06 (1) of the statutes is renumbered 50.06 (1) (intro.) and amended to read:

50.06 **(1)** (intro.) In this section~~, "incapacitated"~~:

(a) "Incapacitated" means unable to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions, including decisions about his or her post–hospital care.

**SECTION 2.** 50.06 (1) (b) of the statutes is created to read:

50.06 **(1)** (b) "Patient's representative" means the individual described under sub. (3) who may consent to an admission of an incapacitated individual under sub. (2).

**SECTION 3.** 50.06 (2) (b) of the statutes is amended to read:

50.06 **(2)** (b) The individual for whom admission is sought is not diagnosed as developmentally disabled or as having a mental illness, as defined in s. 51.01 (13) (a), at the time of the proposed admission.

**SECTION 4.** 50.06 (2) (c) of the statutes is amended to read:

50.06 **(2)** (c) ~~A~~ Unless the incapacitated individual is admitted to a facility under sub. (8), a petition for guardianship for the individual under s. 54.34 and a petition under s. 55.075 for protective placement of the individual are filed prior to the proposed admission.

**SECTION 5.** 50.06 (5) (a) (intro.) of the statutes is amended to read:

50.06 **(5)** (a) (intro.) Except as otherwise provided in ~~par.~~ pars. (am) and (b), ~~an individual who consents to an admission under this section~~ a patient's representative may, for the incapacitated individual, make health care decisions to the same extent as a guardian of the person may and authorize expenditures related

to health care to the same extent as a guardian of the estate may, until the earliest of the following:

**SECTION 6.** 50.06 (5) (am) of the statutes is created to read:

50.06 **(5)** (am) Except as otherwise provided in par. (b), a patient's representative may, for the incapacitated individual, make health care decisions to the same extent as a guardian of the person may and authorize expenditures related to health care to the same extent as a guardian of the estate may if the patient's representative consents to admission for the incapacitated individual in the manner provided in sub. (8). The authority of a patient's representative to make health care decisions or authorize expenditures under this paragraph ends if a court appoints a guardian to make such decisions for the incapacitated individual.

**SECTION 7.** 50.06 (5) (b) of the statutes is amended to read:

50.06 **(5)** (b) ~~An individual who consents to an admission under this section~~ A patient's representative may not authorize expenditures related to health care if the incapacitated individual has an agent under a durable power of attorney, as defined in s. 244.02 (3), who may authorize expenditures related to health care.

**SECTION 8.** 50.06 (6) of the statutes is amended to read:

50.06 **(6)** ~~If~~ Unless the incapacitated individual was admitted to a facility under sub. (8), if the incapacitated individual is in the facility after 60 days after admission and a guardian has not been appointed, the authority of the ~~person who consented to the admission~~ patient's representative to make decisions and, if sub. (5) (a) applies, to authorize expenditures is extended for 30 days for the purpose of allowing the facility to initiate discharge planning for the incapacitated individual.

**SECTION 9.** 50.06 (7) of the statutes is amended to read:

50.06 **(7)** ~~An individual who consents to an admission under this section~~ A patient's representative may request a functional screening and a financial and cost–sharing screening to determine eligibility for the family care benefit under s. 46.286 (1). If admission is sought on behalf of the incapacitated individual or if the incapacitated individual is about to be admitted on a private pay basis, the ~~individual who consents to the admission~~ patient's representative may waive the requirement for a financial and cost–sharing screening under s. 46.283 (4) (g), unless the incapacitated individual is expected to become eligible for medical assistance within 6 months.

**SECTION 10.** 50.06 (8) of the statutes is created to read:

50.06 **(8)** (a) A patient's representative may consent to an admission of an incapacitated individual under sub. (2) without a petition for guardianship or protective placement of the incapacitated individual being filed if all of the following apply:

1. The patient's representative acknowledges in writing that he or she agrees to make health care decisions on the incapacitated individual's behalf under this subsection and provides the acknowledgment to the discharging hospital and the accepting facility.

2. The patient's representative promptly notifies all of the incapacitated individual's family members that can be readily contacted that the patient's representative may make decisions or authorize expenditures under sub. (5) (am).

3. The patient's representative provides a written statement to the discharging hospital and the accepting facility that states all of the following:

a. To the best knowledge of the patient's representative, a family member in a higher priority class under sub. (3) does not exist or no family member in a higher

priority class is willing to make health care decisions on the incapacitated individual's behalf under this subsection.

b. To the best knowledge of the patient's representative, the incapacitated individual does not have a health care agent, as defined in s. 155.01 (4), or guardian of the person, as defined in s. 54.01 (12).

c. The incapacitated individual's family members who have received notice as provided under subd. 2.

4. The facility to which the incapacitated individual is admitted under this subsection notifies a representative of the board on aging and long–term care of the admission no later than 72 hours after the admission.

(b) A hospital discharging an incapacitated patient to a facility under this subsection shall be in compliance with 42 CFR 482.13 (b) (3) or 42 CFR 485.608 (a) regarding the implementation of the patient's rights to formulate advance directives. A nursing home admitting the incapacitated individual shall be in compliance with the requirements under 42 CFR 483.10 (b) (3) to (6) that a resident be afforded the right to designate a representative, including the requirement that if the nursing home has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of the resident then the nursing home shall report such concerns as required by state law.

(c) Nothing in this subsection may be construed to preclude the administration of health care treatment in accordance with accepted standards of medical practice and as otherwise provided by law.

(d) The discharging hospital and the accepting facility shall include a copy of the written acknowledgment under par. (a) 1. and a copy of the written statement under par. (a) 3. in the incapacitated individual's health care record.

(e) Any interested party may petition the court to review whether the patient's representative is acting in accordance with the known wishes or in the best interest of the incapacitated individual and is exercising the degree of care, diligence, and good faith when acting on behalf of the incapacitated individual that an ordinarily prudent person exercises in his or her own affairs. The court may issue orders that the court determines necessary to protect the incapacitated individual, including any of the following:

1. Directing the patient's representative to act in the best interest of the incapacitated individual.

2. Requiring the patient's representative to report to the court periodically on the incapacitated individual's status. The court may require that the report include a financial accounting of expenditures made under sub. (5) (am) within 72 hours of the court's order.

3. Directing the patient's representative not to make certain decisions or authorize certain expenditures under sub. (5) (am).

**SECTION 11. Nonstatutory provisions.**

(1) ALLOCATION OF NURSING HOME BEDS.

(a) *Definitions.* In this subsection, "department" means the department of health services.

(b) *Applicability.* Beginning on July 1, 2024, the department shall allocate 250 nursing home beds as provided under this subsection.

(c) *Applications.* The department shall request applications for nursing home beds allocated under this subsection. An applicant for nursing home beds allocated under this subsection shall submit an application to the department on a form

provided by the department. The application shall include a plan for the applicant to satisfy all of the following criteria within 18 months of department approval:

1. Become licensed under subch. I of ch. 50 for the nursing home beds that the applicant requested in the application.

2. Become certified as a provider under the medical assistance program under subch. IV of ch. 49.

3. Hire sufficient health care personnel and expend sufficient resources to provide 24–hour nursing services.

(d) *Approval.*

1. Within 30 days of receipt of an application under this subsection, the department shall review the application and, if it contains reasonable plans to satisfy the criteria under par. (c) within 18 months of approval, approve the application. The department shall review and approve applications in the order that the applications are received. If the department approves an application under this paragraph, the department shall award the applicant the number of nursing home beds requested in the application, subject to subd. 2.

2. If there is not a sufficient number of beds remaining under this subsection to award an applicant the number of nursing home beds requested in the application, the department shall contact the applicant and determine whether the applicant will accept some or all of the remaining beds under this subsection instead of the beds requested in the application. If the applicant is willing to accept some or all of the remaining beds under this subsection instead of the beds requested in the application, the department shall award those beds. If the applicant is not willing to accept some or all of the remaining beds under this subsection, the department shall discard the application.

3. The department shall continue to request applications for nursing home beds and approve applications as provided under this paragraph until the department awards all nursing home beds allocated under this subsection.

(e) *Conditions of approval.* As a condition of being awarded nursing home beds under this subsection, an applicant shall agree to do all of the following:

1. Prioritize admissions of patients with complex needs and conditions, such as patients with mental health and behavioral needs, serious wound care needs, bariatrics, substance use disorder, nonambulatory disability, intravenous therapy needs, or dialysis needs.

2. Prioritize admissions of patients who have been unable to find appropriate placement at another facility.

(f) *Compliance.* Each person awarded nursing home beds under this subsection shall biennially or upon request from the department report to the department whether the person has satisfied the criteria under par. (c) and the conditions under par. (e), including all of the following information:

1. The number of patients served utilizing the nursing home beds awarded under this subsection.

2. The complex conditions that were served utilizing the nursing home beds awarded under this subsection.

3. The number of patients served and the number of patient days for each of those complex conditions under subd. 2.

4. Any other information required by the department.

(g) *Miscellaneous.*

1. No application under this subsection may be for more than 50 nursing home beds.

2. If an applicant that is awarded nursing home beds under par. (d) fails to satisfy any of the criteria under par. (c) within 24 months following department approval under par. (d), the applicant shall reapply for the awarded nursing home beds by submitting an application to the department as provided under par. (c) or surrender the awarded nursing home beds.

3. If any nursing home beds awarded under this subsection are surrendered, the department shall request applications for the surrendered nursing home beds as provided under par. (c).

(h) *Reporting.* By September 1, 2025, and biennially thereafter, the department shall submit to the chief clerk of each house of the legislature, for distribution to the appropriate standing committees in the manner required under s. 13.172 (3), a report on the performance of the program under this subsection, including the total number of patients served, the complex conditions addressed, the number of patients served and the number of patient days for each complex condition, and any cost savings associated with the program.

(2) COMPLEX PATIENT PILOT PROGRAM.

(a) In this subsection:

1. "Department" means the department of health services.

2. "Partnership group" means one or more hospitals in partnership with one or more post–acute facilities.

(b) The department shall use a competitive grant selection process to select partnership groups to be designated as participating sites for a complex patient pilot program under this subsection and, from the appropriation under s. 20.435 (7) (d), award grants to the groups selected.

(c) The department shall solicit feedback regarding the complex patient pilot program from representatives of healthcare system organizations, long–term care provider organizations, long–term care operator organizations, patient advocate groups, insurers, and any other organization determined to be relevant by the secretary of health services.

(d) The department shall require that each partnership group that applies to the department to be designated as a site for the complex patient pilot program shall address all of the following issues in its application:

1. The number of complex patient care beds that will be set aside in a post–acute facility or through implementation of an innovative model of patient care in a post–acute facility to which participating hospitals agree, such as dedicated staffing for dementia or a behavioral health unit.

2. Defined goals and measurable outcomes of the partnership group during the pilot program and after the pilot program.

3. The types of complex patients for whom care will be provided, which may include patients needing total care for multiple conditions or comorbidities such as cardiac and respiratory diseases, obesity, mental health, substance use, or dementia.

4. An operating budget for the proposed site that details how fiscal responsibility will be shared among members of the partnership group and includes all of the following:

a. Estimated patient revenues from other sources, including the Medical Assistance program under subch. IV of ch. 49, and estimated total costs.

b. A margin to account for reserved beds.

5. The partnership group's expertise to successfully implement the proposal, which may include a discussion of the following issues:

a. Documented experience of the partners working together to serve complex patients.

b. The implementation timeline and the plan for post–acute facilities to accept admissions and transfer patients within 72 hours of a request submitted by a hospital.

c. The plan for an interdisciplinary team that will staff the unit in the post–acute facility, including the availability of staff with appropriate expertise that includes physicians, nurses, advance practice health professionals, pharmacists, physical therapists, occupational therapists, and social workers.

d. Ability to electronically exchange health information.

e. Resources to conduct patient intake and discharge planning from the post–acute facility, including case managers and social workers.

f. Ability to conduct monthly case management reviews with the interdisciplinary team for every complex care patient that cover care plan progress and any readmissions to an acute care hospital.

g. Ability to conduct monthly quality assurance reviews.

h. Ability of the treatment model to be replicated by other healthcare systems.

i. Plans to document decreases in lengths of stay for complex patients in hospitals and avoided hospital days.

j. Documentation of stable finances among partnership group members to support the proposal, including matching funds that could be dedicated to the pilot program under this subsection. No applicant may be required to provide matching funds or a contribution, but the department may take into consideration the availability of matching funds or a contribution in evaluating an application.

k. Description of anticipated impediments to successful implementation and how the partnership group intends to overcome the anticipated impediments.

(e) In implementing this subsection, the department shall do all of the following:

1. Reserve 10 percent of the funding appropriated under s. 20.435 (7) (d) for the complex patient pilot program for reconciliation to help address unanticipated costs.

2. Develop a methodology to evaluate the complex patient pilot program and contract with an independent organization to complete the evaluation. The department may pay the fee of the organization selected from the appropriation under s. 20.435 (7) (d).

3. Give additional weight to partnership groups that would ensure geographic diversity.

**(END)**