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Chapter DHS 10

FAMILY CARE

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Note: Chapter HFS 10 was created as an emergency rule effective February 1, 2000. Chapter HFS 10 was renumbered to chapter DHS 10 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

Subchapter I — General Provisions

DHS 10.11 Authority and purpose. This chapter is promulgated under the authority of ss. 46.281 (1n) (b) 1., 46.286 (4) to (7), 46.287 (2) (a) 1. (intro.), 46.288, 50.02 (2) (d), and 227.11 (2) (a), Stats., to implement a program called family care that is designed to help families arrange for appropriate long-term care services for older family members and for adults with physical or developmental disabilities. The chapter does all the following:

(1) Establishes functional eligibility criteria for the family care benefit.

(1m) Establishes financial eligibility criteria, entitlement criteria and cost sharing requirements for the family care benefit, including divestment of assets, treatment of trusts and spousal impoverishment protections.

(2) Establishes the procedures for applying for the family care benefit.

(3) Establishes standards for the performance of aging and disability resource centers.

(4) Establishes certification standards and standards for performance by care management organizations.

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

(6) Provides for the recovery of correctly and incorrectly paid family care benefits.

(7) Establishes requirements for the provision of information about the family care program to prospective residents of long-term care facilities and for referrals to resource centers by long-term care facilities.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; correction in (intro.) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 22-026: am. (5) Register May 2023 No. 809, eff. 6-1-23; CR 23-046: am. (intro.), (1), cr. (1m), am. (7) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.12 Applicability. This chapter applies to all of the following:

(1) The department and its agents.

(2) County agencies designated by the department to determine financial eligibility for the family care benefit.

(3) All organizations seeking or holding contracts with the department to operate an aging and disability resource center or a care management organization.

(4) All persons applying to receive the family care benefit.

(5) All persons found eligible to receive the family care benefit.

(6) All enrollees in a care management organization.

(7) Certain private pay individuals who may purchase certain services from a care management organization.

(8) Nursing homes, community-based residential facilities, residential care apartment complexes and adult family homes that are required to provide information to patients, residents and prospective residents and make certain referrals to an aging and disability resource center.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 23-046: am. (8) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.13 Definitions. In this chapter:

(1) "Adverse benefit determination" means any of the following:

(a) Any of the following acts taken by an aging and disability resource center or county economic support unit:

1. Denial of eligibility under s. DHS 10.31 (5) or 10.32 (4).

2. Determination of cost sharing requirements under s. DHS 10.34.

3. Determination of entitlement under s. DHS 10.36.

(b) Any of the following acts taken by a care management organization:

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1. The 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.

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.

3. The denial, in whole or in part, of payment for a service.

6. The development of an individualized service plan that is unacceptable to the member because any of the following apply:

a. The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee.

b. The plan does not provide sufficient care, treatment, or support to meet the enrollee's needs and identified family care outcomes.

c. The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.

7. Involuntary disenrollment from a CMO.

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.

(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 subch. V of this chapter to resolve grievances or appeals.

(1m) "Activities of daily living" or "ADLs" means bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.

(2) "Adult family home" or "AFH" has the meaning specified in s. 50.01 (1), Stats.

(3) "Adult protective services" means protective services for individuals with intellectual disabilities and other developmental disabilities, for individuals with degenerative brain disorder, for individuals with chronic mental illness, and for individuals with other like incapacities incurred at any age as defined in s. 55.02, Stats.

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

(4) "Applicant" means a person who directly or through a representative makes application for the family care benefit.

(5) "Assets" means any interest in real or personal property that can be used for support and maintenance. "Assets" includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.

(6) "Assistance" means cueing, supervision or partial or complete hands-on assistance from another person.

(7) "At risk of losing independence or functional capacity" means having the conditions or needs described in s. DHS 10.33 (2) (d).

(8) "Care management organization" or "CMO" means an entity that is certified as meeting the requirements for a care management organization under s. 46.284 (3), Stats., and this chapter and that has a contract under s. 46.284 (2), Stats., and s. DHS 10.42. "Care management organization" does not include an entity that contracts with the department to operate a PACE or Wisconsin partnership program.

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

(9) "Client" means a person applying for eligibility for the family care benefit, an eligible person or an enrollee.

(10) "Community-based residential facility" or "CBRF" has the meaning specified in s. 50.01 (1g), Stats.

(11) "Community spouse" means an individual who is legally married as recognized under state law to a family care spouse.

(13) "Countable assets" means assets that are used in calculating financial eligibility and cost sharing requirements for the family care benefit.

(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.

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

(14s) "Degenerative brain disorder" has the meaning given in s. 55.01 (1v), Stats.

(15) "Department" means the Wisconsin department of health services.

(16) "Developmental disability" has the meaning provided in s. 51.01 (5) (a), Stats.

(16m) "Disability benefit specialist" means a person providing services to individuals ages 18 to 59 under s. DHS 10.23 (2) (d).

(16p) "Electronic visit verification" or "EVV" means, with respect to personal care services or home health care services as defined and required in Section 12006 of the 21st Century Cures Act, 42 USC 1396b (l), a system under which in-home visits conducted as part of such services are electronically verified.

(16r) "EVV record" means the information or data related to an electronically verified visit which contains all of the following:

(a) The type of service performed.

(b) The individual receiving the service.

(c) The date of the service.

(d) The location of service delivery.

(e) The individual providing the service.

(f) The time the service begins and ends.

(17) "Eligible person" means a person who has been determined under ss. DHS 10.31 and 10.32 to meet all eligibility criteria under s. 46.286 (1), Stats., and this chapter.

(18) "Enrollee" means a person who is enrolled in a care management organization to receive the family care benefit.

(19) "Exceptional payments" means the state supplement to federal supplemental security income authorized under s. 49.77 (3s), Stats.

(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 administrative action under s. 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.

(21) "Family care benefit" has the meaning given in s. 46.2805 (4), Stats., namely, financial assistance for long-term care and support items for an enrollee.

(22) "Family care district" means a special purpose district created under s. 46.2895 (1), Stats.

(23) "Family care spouse" means an individual who is a family care applicant or enrollee and is legally married as recognized under state law to an individual who does not reside in a medical institution or a nursing facility.

(24) "Financial eligibility and cost-sharing screening" means a uniform screening tool prescribed by the department that is used to determine financial eligibility and cost-sharing under s. 46.286 (1) (b) and (2), Stats., and ss. DHS 10.32 and 10.34.

(25) "Food stamps" means the food stamp program authorized under 7 USC 2011.

(25m) "Frail elder" means an individual aged 65 or older who has a physical disability, or an irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.

(26) "Functional capacity" means the skill to perform activities in an acceptable manner.

(27) "Functional screening" means a uniform screening tool prescribed by the department that is used to determine functional eligibility under s. 46.286 (1) (a), Stats., and ss. DHS 10.32 and 10.33.

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

(29) "Home" means a place of abode and lands used or operated in connection with the place of abode.

Note: Note: In urban situations the home usually consists of a house and lot. There will be situations where the home will consist of a house and more than one lot. As long as the lots adjoin one another, they are considered part of the home. In farm situations, the home consists of the house and building together with the total acreage property upon which they are located and which is considered a part of the farm. There will be farms where the land is on both sides of a road, in which case the land on both sides is considered part of the homestead.

(30) "Hospital" has the meaning specified in s. 50.33 (2), Stats.

(32) "Instrumental activities of daily living" or "IADLs" means management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.

(34) "Long-term care facility" means a nursing home, adult family home, community-based residential facility or residential care apartment complex.

(35) "Medical assistance" or "MA" means the assistance program operated by the department under ss. 49.43 to 49.499, Stats., and chs. DHS 101 to 108.

(36) "Medical institution" means a facility that meets all of the following conditions:

(a) Is organized to provide medical care, including nursing and convalescent care.

(b) Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health care needs of patients on a continuing basis in accordance with accepted professional standards.

(c) Is authorized under state law to provide medical care.

(d) Is staffed by professional personnel who are responsible for professional medical and nursing services. The professional medical and nursing services include adequate and continual medical care and supervision by a physician, registered nurse or licensed practical nurse supervision and services and nurses' aide services sufficient to meet nursing care needs and a physician's guidance on the professional aspects of operating the institution.

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

(37) "Nursing home" has the meaning specified in s. 50.01 (3), Stats.

(38) "Older person" means a person who is at least 65 years of age.

(39) "PACE" means a program of all-inclusive care for the elderly authorized under 42 USC 1395 to 1395gg.

(40) "Physical disability" means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.

(41) "Residential care apartment complex" or "RCAC" has the meaning specified in s. 50.01 (6d), Stats.

(42) "Resource center" or "aging and disability resource center" means an entity that meets the standards for operation and is under contract with the department to provide services under s. 46.283 (3), Stats., and this chapter or, if under contract to provide a portion of the services specified under s. 46.283 (3), Stats., meets the standards for operation with respect to those services.

(43) "Respite care" means temporary placement in a long-term care facility for maintenance of care, treatment or services, as established by the person's primary care provider, in addition to room and board, for no more than 28 consecutive days at a time.

(44) "Secretary" means the secretary of the department.

(45) "Supplemental security income" means the supplemental security income program authorized under 42 USC 1381.

(46) "Target population" means any of the following groups that a resource center or a care management organization has contracted with the department to serve:

(a) Adults age 60 and older.

(b) Adults with a physical disability.

(c) Adults with a developmental disability.

(47) "Wisconsin partnership program" means a demonstration program known by this name under contract with the department to provide health and long-term care services under a federal waiver authorized under 42 USC 1315.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: renum. (1) to be (1m), cr. (1), (3m), and (25m), am. (24) and (27), r. and recr. (28), r. (31) Register November 2004 No. 587, eff. 12-1-04; correction in (17) made under s. 13.93 (2m) (b) 7., Stats., Register November 2004 No. 587; corrections in (15) and (35) made under s. 13.92 (4) (b) 6. and 7., Stats., Register November 2008 No. 635; CR 08-109: cr. (16m) Register June 2009 No. 642, eff. 7-1-09; corrections and renum. of (33) to be (40m) made under s. 13.92 (4) (b) 1., 6. and 7., Stats., Register November 2009 No. 647; correction in (41) made under s. 13.92 (4) (b) 7., Stats., Register December 2013 No. 696; 2019 Wis. Act 1: am. (3), (16) Register May 2019 No. 761, eff. 6-1-19; CR 22-026: am. (1) (intro.), (b) 1., 2., r. (1) (b) 4., 5., am. (1) (b) 7., cr. (1) (b) 8. to 10., (c), am. (3m), cr. (8m), r. (12), am. (14), cr. (14m), am. (16), (20), (28), cr. (36m), r. (40m), am. (46) Register May 2023 No. 809, eff. 6-1-

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23; correction in (1) (c) 2., (20) made under s. 35.17, Stats., Register May 2023 No. 809; EmR2306: emerg. cr. (16g), (16r), eff. 5-1-23; CR 23-045: cr. (16g), (16r) Register January 2024 No. 817, eff. 2-1-24; renum. (16g) to (16p) under s. 13.92 (4) (b) 1., Stats., Register January 2024 No. 817; CR 23-046: am. (3), cr. (14s), am. (16) Register April 2024 No. 820, eff. 5-1-24.

Subchapter II — Aging and Disability Resource Centers

DHS 10.21 Contracting. (1) The department may contract for resource center operation only with entities that do all of the following:

(a) Comply with the general requirements specified in s. 46.283, Stats., and s. DHS 10.22.

(b) Meet the standards for performance by resource centers specified in s. DHS 10.23.

(2) The department's contracts with organizations operating resource centers shall specify sanctions that may be taken if certain contract requirements are not met, including the withholding or deduction of funds.

(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 the secretary's council on long-term care.

(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.

(6) Prior to receiving funds to operate a resource center, an organization shall agree to the terms of the standard contract.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (3) (a) Register November 2004 No. 587, eff. 12-1-04; corrections in (3) (b) and (5) made under s. 13.92 (4) (b) 6. and 7., Stats., Register November 2009 No. 647; CR 22-026: cons. (3) (intro.) and (a) and renum. to (3) and am., r. (3) (b), am. (4), r. (5) Register May 2023 No. 809, eff. 6-1-23; CR 23-046: am. (1) (a) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.22 General requirements. (1) TARGET POPULATION. Each contract for operation of a resource center shall specify the target population that the resource center will serve. The target population to be served by the resource center includes all members of the specified group who reside in the geographic area served by the resource center regardless of whether they need or are seeking family care or other long-term care services or programs.

(2) NAME. (a) A resource center shall have a name that is appropriate to its target population and includes any of the following phrases:

1. "Aging and disability resource center."
2. "Aging resource center."
3. "Disability resource center."
4. "Developmental disabilities resource center."

(b) The resource center's name may be the primary name of the resource center or a subtitle to another name but shall be included in all advertising and materials, including any telephone book listings.

(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 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 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.

Note: Before July 1, 2001, the Wisconsin legislature has authorized the department to contract only with a county, a family care district, the governing body of a tribe or band or the Great Lakes Inter-tribal Council, Inc., or with 2 or more of these entities under a joint application, to operate a Resource Center. After June 30, 2001, the department is authorized to contract with these same entities, or with a private nonprofit organization if the department determines that the organization has no significant connection to an entity that operates a care management organization and if any of the following applies: (1) A county board of supervisors declines in writing to apply for a contract to operate a Resource Center; or (2) A county agency or a family care district applies for a contract but fails to meet the standards for performance for Resource Centers specified in s. DHS 10.23. Certain functions of the Resource Center, such as eligibility determination, must be performed by public employees. Section 46.285, Stats., further requires that no entity may directly operate both a Resource Center and a CMO, except that a pilot Resource Center is required to be structurally separate from the provision of CMO services by January 1, 2001.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 22-026: am. (3), (4) Register May 2023 No. 809, eff. 6-1-23.

DHS 10.23 Standards for performance by resource centers. (1) COMPLIANCE. An aging and disability resource center shall comply with all applicable statutes, all of the standards in this section and all requirements of its contract with the department.

(2) SERVICES. A resource center shall ensure that the following services, meeting the standards specified, are available to its target population:

(a) *Information and referral services and other assistance.* A resource center shall provide information, referral and assistance at hours that are convenient to the public and consistent with requirements of this chapter and its contract with the department, using a telephone number that is toll-free to all callers in its service area. The resource center shall be physically accessible and be able to provide information and assistance services in a private and confidential manner. The resource center shall be able to provide information and assistance services in a language that a person contacting the resource center can understand. Information and referral services include all of the following:

1. Current information on a wide variety of topics related to aging, physical and developmental disabilities, chronic illness and long-term care, as specified by the department and appropriate to the resource center's target population.

2. Referrals to and assistance in accessing an array of voluntary, purchased and public resources to help older people and people with disabilities secure needed services or benefits, live with dignity and security, and achieve maximum independence and quality of life. Referral and assistance includes all the following:

a. Professional advice and counseling to assist consumers in identifying needs, capacities and personal preferences.

b. Educating consumers regarding available service options and resources.

c. Identifying service providers capable of meeting the person's needs.

d. Actively assisting the consumer in accessing services when necessary.

3. Continued contact with people, as needed, to determine the outcomes of previous contacts and to offer additional assistance in locating or using services as necessary.

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(b) *Advocacy.* Advocacy on behalf of individuals and groups when needed services are not being adequately provided by an organization within the service delivery system.

(c) *Long-term care options counseling.* The resource center shall provide members of its target population and their families or other representatives with professional counseling about options available to meet long-term care needs and about factors to consider in making long-term care decisions. The resource center shall offer this counseling to any person in its target population who is seeking or who the resource center determines appears to need long-term care services, and to his or her family members or other representatives if applicable. In making the offer, the resource center shall inform the person that participation in counseling is voluntary on the part of any individual. Information provided shall be timely, factual, thorough, accurate, unbiased and appropriate to the individual's needs and situation. The resource center shall conduct long-term care options counseling at a location preferred by and at a time convenient to the individual consumer. Long-term care options counseling shall inform and advise the person concerning all of the following:

1. The availability of any long-term care options open to the individual, including home care, community services, case management services, residential care and nursing home options.

2. Sources and methods of both public and private payment for long-term care services, including family care and the fee-for-service system.

3. Factors to consider when choosing among the available programs, services and benefits, including cost, quality, outcomes, estate recovery and compatibility with the person's preferred lifestyle and residential setting.

4. Advantages and disadvantages of the various options in light of the individual's situation, values, capacities, knowledge and resources and the urgency of the individual's situation.

5. Opportunities and methods for maximizing independence and self-reliance, including the utilization of supports from family, friends and community.

(d) *Benefits counseling.* 1. The resource center shall ensure that people from its target populations have access to the services of a benefit specialist, including information about and assistance in applying for public and private benefits for which they may be eligible, assistance in preparing and filing grievances, appeals, requests for department review or fair hearing, and representation in grievance resolution and fair hearings.

2. Notwithstanding sub. (7) (b), a disability benefit specialist may not disclose information about a client without the informed consent of the client, unless required by law. A disability benefit specialist may also disclose information about a client without the informed consent of the client as permitted under s. 55.043 (1m) (br), Stats., if there is reasonable cause to believe that the adult at risk is at imminent risk of serious bodily harm, death, sexual assault, or significant property loss and is unable to make an informed judgment about whether to report the risk or if an adult at risk other than the subject of the report is at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by a suspected perpetrator.

3. When a benefit specialist represents a client in a matter in which a decision or 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.

(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 in making the transition from children's services to the adult long-term care system.

(f) *Prevention and early intervention.* The resource center shall develop a prevention and early intervention plan based on department priorities established through contract and provide prevention and intervention services consistent with the plan and within the limits of available funding. The plan shall include how the resource center will do both of the following:

1. Educate communities in its area on prevention of disabling conditions.

2. Provide specific prevention advice and education to individuals in its target group, regardless of whether they are eligible for the family care benefit.

(g) *Emergency response.* The resource center shall assure that emergency calls to the resource center are received 24 hours a day, seven days a week, responded to promptly and that people are connected promptly with the appropriate providers of emergency services.

(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 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 financial interest in a care management organization. Information provided under this paragraph shall include information about all of the following:

1. The availability of mechanisms for self-management of service funding under s. DHS 10.44 (2) (d) and (6), through which an enrollee may manage the funding for some or all of his or her own services under the family care benefit.

2. How to find additional assistance within or outside the resource center, a care management organization and the family care benefit.

3. Opportunities for enrollees in a CMO to do as much for themselves as possible and desired and for full participation in service planning and delivery.

(i) *Enrollment assistance.* The resource center shall assist a person found eligible for the family care benefit and wishing to enroll in a care management organization to enroll in the care management organization of the person's choice.

(j) *Disenrollment counseling.* The resource center shall provide information and counseling to assist persons in the process of voluntarily or involuntarily disenrolling from a care management organization, including all of the following:

1. Information about clients' rights and grievance procedures.

2. Advocacy resources available to assist the person in resolving appeals and grievances.

3. Service and program options available to the person if the disenrollment occurs.

4. Information about the availability of assistance with re-enrollment.

(3) ACCESS TO FAMILY CARE AND OTHER BENEFITS. Benefits to which the resource center shall provide access are all the following:

(a) *Family care.* 1. The requirements specified in s. DHS 10.31 shall govern application and determination of eligibility for the family care benefit.

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 6 months who appears to have a disability or condition requiring long-term care and who meets any of the following conditions:

a. The person requests or is referred for the screens.

b. The person is seeking access to the family care benefit.

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 s. DHS 10.73 (4) (a).

3. If a person accepts the offer, the resource center shall provide the screens.

(b) *Medical assistance, SSI, state supplemental payments and food stamps.* The resource center shall provide, directly or through referral, access to all of the following:

1. Medical assistance under s. 49.46, 49.468 or 49.47, Stats.

2. State supplemental payments under s. 49.77, Stats., to the federal supplemental security income (SSI) program under USC 1381 to 1383d, including the increased or "exceptional" payments (SSI-E) under s. 49.77 (3s), Stats.

3. The federal food stamp program under 7 USC 2011 to 2029.

(4) ELDER ABUSE AND ADULT PROTECTIVE SERVICES. (a) The resource center shall identify persons who may need elder abuse or adult protective services and shall provide or facilitate access to services for eligible individuals under s. 46.90 and chs. 51 and 55, Stats.

(b) The resource center may provide elder abuse and adult protective services directly, if a county agency, or through cooperation with the local public agency or agencies that provide the services. If the resource center is not the county agency designated under s. 46.90 or ch. 55, Stats., it shall have a memorandum of understanding with the designated agency or agencies regarding how these services are to be coordinated. The memorandum shall specify staff contacts, hours of operation and referral processes and procedures.

(5) STAFF QUALIFICATIONS. Persons providing resource center services, whether directly employed by the resource center or indirectly under subcontract or memorandum of understanding with another organization, shall have the following qualifications:

(a) Persons answering the information and assistance telephone line shall be trained and knowledgeable about all of the following:

1. The mission, operations and referral policies of the resource center.

2. The target populations served and their needs.

3. Telephone etiquette and communication skills, including how to recognize and respond to special hearing or language needs.

4. How to recognize and handle emergencies.

(b) Persons providing information and assistance services, long-term care options counseling, benefits counseling, the functional screen and financial eligibility and cost-sharing screen and choice counseling shall:

1. Be competent to provide these services to the resource center's target population.

2. Meet at least one of the following requirements for education and experience:

a. Bachelor of arts or science degree, preferably in a health or human services related field, and at least one year of experience working with at least one of the resource center's target populations.

b. Four years of post-secondary education and experience working with at least one of the target populations or an equivalent combination of education and experience, either in long-term support or a related human services field.

c. Other experience, training or both, as approved by the department based on a plan for providing formal and on-the-job training to develop the required expertise.

3. Be knowledgeable about the range, quality and availability of long-term care services offered within the resource center's service area.

(6) OPERATIONAL REQUIREMENTS. A resource center shall do all of the following:

(a) *Outreach and public education.* 1. Develop and implement an ongoing program of marketing and outreach to inform members of its target population and their families, community agencies, health professionals and service providers of the availability of resource center services.

2. Provide information about family care to all eligible persons who are members of a target population served by a CMO that operates in the county and who are residents of nursing homes, community-based residential facilities, adult family homes and residential care apartment complexes in the geographic area of the resource center. The information provided shall cover all of the following:

a. The family care benefit, and the opportunities for enrollee choice within the benefit, including the opportunity for self-management of service funding under s. DHS 10.44 (2) (d) and (6), which populations are subject to mandatory enrollment, which populations are subject to voluntary enrollment, which populations are ineligible, and the right to disenroll in accordance with 42 CFR 438.56.

b. The services of the resource center, including information and assistance, benefits counseling, long-term care options counseling, advocacy assistance, the functional screen and financial eligibility and cost-sharing screen, and eligibility determination and enrollment in family care.

c. The services of any available care management organization, including the comprehensive assessment and care plan.

d. How to contact the resource center for assistance.

e. The services of available advocacy services external to the resource center, including services under s. 16.009 (2) (p), Stats., and how to access these services.

f. The requirements and performance of available care management organizations as set forth in 42 CFR 438.66.

g. Any cost-sharing that will be imposed on members.

(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 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.

(c) *Grievance process.* Implement a process for reviewing and resolving client grievances as required under s. DHS 10.53 (1).

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(d) *Reporting and records.* 1. Except as provided in this par. and sub. (7), collect data about its operations as required by the department by contract. No data collection effort shall interfere with a person's right to receive information anonymously or require personally identifiable information unless the person has authorized the resource center to have or share that information.

2. Report information as the department determines necessary, including information needed for doing all of the following:

a. Determining whether the resource center is meeting minimum quality standards and other requirements of its contract with the department.

b. Determining the extent to which the resource center is improving its performance on measurable indicators identified by the resource center in its current quality improvement plan.

c. Evaluating the effects of providing long-term care options counseling and choice counseling under this section.

d. Evaluating the effects for enrollees and cost-effectiveness of providing the family care benefit.

3. Submit to the department all reports and data required or requested by the department, in the format and timeframe specified by the department.

(e) *Internal quality assurance and quality improvement.* Implement an internal quality assurance and quality improvement program that meets the requirements of its contract with the department. As part of the program, the resource center shall do all of the following:

1. Develop and implement a written quality assurance and quality improvement plan designed to ensure and improve outcomes for its target population. The plan shall be approved by the department and shall include at least all of the following components:

a. Identification of performance goals, specific to the needs of the resource center's customers, including any goals specified by the department.

b. Identification of objective and measurable indicators of whether the identified goals are being achieved, including any indicators specified by the department.

c. Identification of timelines within which goals will be achieved.

d. Description of the process that the resource center will use to gather feedback from the resource center's customers and staff and other sources on the quality and effectiveness of the resource center's performance.

e. Description of the process the resource center will use to monitor and act on the results and feedback received.

f. A process for regularly updating the plan, including a description of the process the resource center will use for annually assessing the effectiveness of the quality assurance and quality improvement plan and the impact of its implementation on outcomes.

2. Measure resource center performance, using standard measures as required by its contract with the department, and report its findings on these measurements to the department.

3. Achieve minimum performance levels and performance improvement levels, as demonstrated by standardized measures agreed to in its contract with the department.

4. Initiate performance improvement projects that examine aspects of services related to improving resource center quality. These projects shall include all of the following:

a. Measuring performance.

b. Implementing system interventions.

c. Evaluating the effectiveness of the interventions.

d. Planning for sustained or increased improvement in performance based on the findings of the evaluation.

5. Comply with quality standards for services included in the resource center's contract with the department in all of the following areas:

a. Timeliness and accuracy of the functional screen and financial eligibility and cost-sharing screen.

b. Timely and accurate eligibility determination and enrollment procedures.

c. Information and assistance services and long-term care options counseling.

d. Protection of applicant rights.

e. Effective processes for reviewing and resolving appeals and grievances of applicants and other persons who use resource center services.

f. Services to minority, rural and institutionalized populations.

6. Report all data required by the department related to standardized measures of performance, in the timeframes and format specified by the department.

7. Cooperate with the department in evaluating outcomes and in developing and implementing plans to sustain and improve performance.

(f) *Cooperation with external reviews.* Cooperate with any review of resource center activities by the department, another state agency or the federal government.

(7) CONFIDENTIALITY AND EXCHANGE OF INFORMATION. No record, as defined in s. 19.32 (2), Stats., of a resource center that contains personally identifiable information, as defined in s. 19.62 (5), Stats., concerning an individual who receives services from the resource center may be disclosed by the resource center without the individual's informed consent, except as follows:

(a) A resource center shall provide information as required to comply with s. 16.009 (2) (p) or 49.45 (4), Stats., or as necessary for the department to administer the family care program under ss. 46.2805 to 46.2895, Stats.

(b) Notwithstanding ss. 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.22, 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), Stats., and except as provided in sub. (2) (d) 2., a resource center may exchange confidential information about a client without the informed consent of the client, in the county of the resource center, if the exchange of information is necessary to enable the resource center to perform its duties or to coordinate the delivery of services to the client, as authorized 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), Stats.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (2) (d) 1., (3) (a) 2. (intro.) Register November 2004 No. 587, eff. 12-1-04; correction in (7) (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; EmR0834: emerg. am. (2) (d) 2., eff. 11-3-08; CR 08-109: am. (2) (d) 2. Register June 2009 No. 642, eff. 7-1-09; correction in (6) (b) made under s. 13.92 (4) (b) 6., Stats., Register November 2009 No. 647; CR 22-026: am. (2) (d) 3., (e), (h), (j) 2., r. (2) (k), am. (3) (intro.), (a) 2. (intro.), c., 3., (6) (b), (c), (e) 5. e. Register May 2023 No. 809, eff. 6-1-23; correction in (2) (h) made under s. 35.17, Stats., Register May 2023 No. 809; CR 23-046: am. (3) (a) 2. c., (6) (a) 2. (intro.), a., cr. (6) (a) 2. f., g. Register April 2024 No. 820, eff. 5-1-24; merger of (3) (a) 2. c. treatments by CR 22-026 and CR 23-046 made under s. 13.92 (4) (bm), Stats., Register April 2024 No. 820.

DHS 10.24 Department responsibilities for monitoring resource center quality and operations. (1) MONITORING. The department shall monitor the performance and operations of the resource center in all of the following areas:

(a) Providing information about long-term care options to persons who could benefit from the information and linking persons to needed services, including family care, when eligible.

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(b) Respecting individuals' rights and dignity and giving consumers a strong role in program and policy development.

(c) Providing early intervention and prevention services.

(2) INDICATORS. In order to monitor the performance of the resource center, the department shall develop and use indicators to measure and assess the performance of the resource center in the areas specified in sub. (1). The department shall use indicators to compare performance both within and across resource centers and against other programs in order to enable resource centers to improve the quality of their services. Where possible, the department shall measure indicators against available or created benchmarks and evaluate the resource centers' performance.

(3) MEASUREMENT INDICATORS. The department shall measure at least the following indicators:

(a) Information and assistance contacts and follow-ups:

(b) Persons who have received enrollment counseling who subsequently enroll in family care or who subsequently receive non-family care medical assistance-funded long-term care services.

(c) Referrals for, and timeliness of, pre-admission consultation under s. 46.283 (4) (g), Stats., and the functional screening.

(d) Referrals for medical assistance, supplemental security income, including the increased or exceptional payments, and food stamps.

(e) Referrals for emergency help, protective services, and other long-term care services.

(f) Grievances, appeals and fair hearings and their disposition.

(4) ASSESSMENT INDICATORS. The department shall use the following indicators to assess the performance of the resource center:

(a) Fair treatment.

(b) Consumer satisfaction.

(c) Consumer involvement in the planning and governance of the resource center.

(d) Collaborative arrangements with community agencies whose services are focused on preventing loss of health or the capacity to function independently in performing activities of daily living.

(5) COST-EFFECTIVENESS. The department shall measure resource center cost-effectiveness in carrying out its program responsibilities.

(6) REQUIRED REFERRALS. The department shall measure compliance with requirements for referrals to the resource center under subch. VII.

(7) FUNCTIONAL SCREENING ACCURACY AND RELIABILITY. The department shall measure the accuracy and reliability of functional screenings, including whether screens result in payment of appropriate rates to CMOs.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (3) (c) and (f) and (7) Register November 2004 No. 587, eff. 12-1-04.

Subchapter III — Access to the Family Care Benefit

DHS 10.31 Application and eligibility determination. (1) DEFINITION. In this section, "agency" means any county agency, or any resource center that is not a county agency, that is responsible for all or part of determination of functional, financial, and other conditions of eligibility for the family care benefit.

(2) GENERAL REQUIREMENT. Application for the family care benefit shall be made and reviewed in accordance with the provisions of this chapter.

(3) ACCESS TO INFORMATION. The agency shall provide information to persons inquiring about or applying for the family care benefit as required under s. DHS 10.23 (2) (c) and (h).

(4) APPLICATION. (a) *Making application.* Any person in the target population served by resource centers may apply for a family care benefit. 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 by the income maintenance agency serving the county or tribe in which the person resides. Functional eligibility determination shall be made by the resource center serving the county or tribe in which the person resides.

(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. The signatures of 2 witnesses are required when the applicant signs the application with a mark.

Note: This provision allows anyone acting responsibly for a person who is incapacitated to begin the application process for financial assistance with the costs of long-term care services. Other decisions regarding receipt of health or long-term care services, including placement in a long-term care facility, require consent of the individual or authorization by a person or court with the specific authority to make treatment or placement decisions.

(5) VERIFICATION OF INFORMATION. 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.

(6) ELIGIBILITY DETERMINATION. (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 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. If the applicant is the spouse of a family care member, the agency shall notify both spouses in accordance with the requirements of s. 49.455 (7), Stats.

(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.

(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 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 their right to appeal the delay by requesting a fair hearing under s. DHS 10.55.

(7) ENROLLMENT. The agency shall complete and transmit, as directed by the department, all enrollment forms and materials required to enroll persons who are eligible and who choose to enroll in a care management organization.

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(8) FRAUD. When the agency director or designee has reason to believe that an applicant or enrollee, or the representative of an applicant or enrollee, has committed fraud, the agency director or designee shall refer the case to the district attorney.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (6) (a) Register November 2004 No. 587, eff. 12-1-04; EmR2121: emerg. am. (4) (b), eff. 8-5-21; CR 21-081: am. (4) (b) Register May 2022 No. 797, eff. 6-1-22, am. (4) (b) eff. upon the termination of the Appendix K: Emergency Preparedness and Response and COVID-19 Addendum to the 1915 (c) Family Care program waiver; CR 22-026: am. (4) (a), (b), (5), (6) (a), cr. (6) (am), am. (6) (b) Register May 2023 No. 809, eff. 6-1-23.

DHS 10.32 General conditions of eligibility. (1) CONDITIONS. To be eligible for the family care benefit, a person shall meet all of the following conditions:

(a) *Age.* The person is at least 18 years of age at the time of application.

(b) *Residency.* The person is a resident of a county, family care district or service area of a tribe in which the family care benefit is available through a care management organization. This requirement does not apply to a person who is either of the following:

1. An enrollee who was a resident of the county, family care district or tribal area when he or she enrolled in family care, but currently resides in a long-term care facility outside the service area of the CMO under a plan of care approved by the CMO.

2. An applicant who, on the date that the family care benefit first became available in the county, was receiving services in a long-term care facility funded under any of the programs specified under s. DHS 10.33 (3) (c) administered by that county.

(c) *Family care target group.* The person has a physical disability, is a frail elder, or has a developmental disability.

(d) *Functional eligibility.* The person meets the functional eligibility conditions under s. DHS 10.33.

(e) *Financial eligibility.* The person meets the financial eligibility conditions under s. DHS 10.34.

(f) *Cost sharing.* The person pays any cost sharing obligations as required under s. DHS 10.34 (4).

(g) *Acceptance of medical assistance if eligible.* If the person is eligible for medical assistance, he or she applies for and accepts the medical assistance.

(h) *Other non-financial conditions.* The person meets the nonfinancial conditions of eligibility for medical assistance under s. DHS 103.03 (2) to (9).

(i) *Divestment.* The person is not currently ineligible for the family care benefit, under the provisions of ss. 49.453 and 49.454 (2) (c) and (3) (b), Stats., and s. DHS 103.065 because he or she divested assets. The divestment provisions of ss. 49.453, 49.454 (2) (c) and (3) (b), Stats., and s. DHS 103.065 apply to all family care applicants and enrollees, regardless of whether they are eligible for medical assistance.

(2) PROVISION OF NECESSARY INFORMATION. A client or person acting on behalf of a client shall provide full, correct and truthful information necessary to determine family care eligibility, entitlement status and cost sharing requirements, including the following:

(a) A declaration of assets on a form prescribed by the department.

(b) A declaration of income on a form prescribed by the department.

(c) Information related to the person's health and functional status, as required by the department.

(3) REPORTING OF CHANGES REQUIRED. An enrollee shall report to the county agency any change in circumstances that would affect his or her eligibility under this section, including income and asset changes that would affect cost sharing obligations, as specified under s. DHS 10.34 (3) (f).

(4) REVIEW OF ELIGIBILITY. Enrollees' eligibility for the family care benefit shall be re-determined annually or more often when a county agency has information indicating that a change has occurred in an enrollee's circumstances that would affect his or her eligibility or cost sharing requirements.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (b) 2. and (c) Register November 2004 No. 587, eff. 12-1-04; corrections in (1) (h) and (i) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; EmR2121: emerg. r. (4), eff. 8-5-21; CR 21-081: am. (4) Register May 2022 No. 797, eff. 6-1-22, am. (4) eff. the first day of the month after the emergency period, as defined in section 1135 (g) (1) (b) of the Social Security Act, 42 USC 1320b-5 (g) (1) (B) and declared in response to the COVID-19 pandemic, ends; correction in (4) made under s. 35.17, Stats., Register May 2022 No. 797; CR 23-046: am. (1) (a) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.33 Conditions of functional eligibility. (1) DEFINITIONS. In this section:

(a) "ADL" means activities of daily living.

(b) "IADL" means instrumental activities of daily living.

(c) "Appropriately" means suitable in terms of time and place.

(d) "Long-term or irreversible condition" means a physical or cognitive impairment that is expected to last for more than 90 days or result in death within one year.

(e) "Requires ongoing care, assistance or supervision" means a person cannot safely or appropriately perform one or more ADLs or IADLs, as is evidenced by findings from functional screening.

(f) "Safely" means without significant risk of harm to oneself or others.

(2) DETERMINATION OF FUNCTIONAL ELIGIBILITY. (a) *Determination.* Functional eligibility for the family care benefit shall be determined pursuant to s. 46.286 (1), Stats., and this chapter, using a uniform functional screening prescribed by the department. To have functional eligibility for the family care benefit, the functional eligibility condition under par. (b) shall be met and, except as provided under sub. (3), the functional capacity level under par. (c) or (d) shall be met.

(b) *Long-term condition.* The person shall have a long-term or irreversible condition.

(c) *Nursing home level.* A person is functionally eligible at the nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screening:

1. The person cannot safely or appropriately perform 3 or more activities of daily living.

2. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living.

3. The person cannot safely or appropriately perform 5 or more IADLs.

4. The person cannot safely or appropriately perform one or more ADL and 3 or more IADLs and has cognitive impairment.

5. The person cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment.

6. The person has a complicating condition that limits the person's ability to independently meet his or her needs as evidenced by meeting both of the following conditions:

a. The person requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or requires frequent changes in service due to intermittent or unpredictable changes in his or her condition; or requires a range

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of medical or social interventions due to a multiplicity of conditions.

b. The person has a developmental disability that requires specialized services; or has impaired cognition exhibited by memory deficits or disorientation to person, place or time; or has impaired decision making ability exhibited by wandering, physical abuse of self or others, self neglect or resistance to needed care.

(d) *Non-nursing home level.* A person is functionally eligible at the non-nursing home level if the person is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others, as is evidenced by a finding from application of the functional screening that the person needs assistance to safely or appropriately perform either of the following:

1. One or more ADL.

2. One or more of the following critical IADLs:

a. Management of medications and treatments.

b. Meal preparation and nutrition.

c. Money management.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (c) and (2) (a), (c) and (d) Register November 2004 No. 587, eff. 12-1-04; CR 22-026: r. (3) Register May 2023 No. 809, eff. 6-1-23; CR 23-046: renum. (1) (a) to (d) to be (1) (c) to (f), cr. (1) (a), (b), am. (2) (c) (intro.), (d) (intro.) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.34 Financial eligibility and cost sharing.

(1) DEFINITIONS. In this section:

(a) "Actual maintenance costs" means the sum of the following:

1. Shelter costs determined according to s. 49.455 (4) (d) 1. and 2., Stats.

2. An amount equal to the maximum food stamp allotment for a household of one under 7 USC 2017.

3. An allowance for clothing as determined by the department.

(b) "Certification period" means a 12-month period for which financial eligibility and cost sharing requirements for the family care benefit are determined for a non-MA eligible person.

(c) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(d) "Earned income" has the meaning given under s. DHS 101.03 (51).

(e) "Unearned income" has the meaning given under s. DHS 101.03 (180).

(2) INDIVIDUALS ELIGIBLE FOR MEDICAL ASSISTANCE. A person who is eligible for medical assistance under ch. 49, Stats., and chs. DHS 101 to 108 is financially eligible for the family care benefit. Cost sharing requirements for the family care benefit for a medical assistance-eligible person are those that apply under ch. 49, Stats., and chs. DHS 101 to 108.

(3) INDIVIDUALS NOT ELIGIBLE FOR MEDICAL ASSISTANCE. (a) *Conditions of financial eligibility.* Eligibility under this subsection is effective beginning July 1, 2000. For persons who are not eligible for medical assistance, financial eligibility and cost sharing requirements for the family care benefit shall be determined pursuant to applicable provisions of s. 46.286 (1) (b) and (2), Stats., and this chapter. The maximum cost-sharing requirement for a non-MA-eligible person shall be determined by a county agency using a uniform financial eligibility and cost-sharing screening prescribed by the department. A non-MA-eligible person is financially eligible for the family care benefit if the projected cost of the person's care plan exceeds the person's maximum cost-sharing requirement.

(b) *Calculation of maximum cost share requirement at initial determination and annual re-determination of eligibility.* A non-MA-eligible family care enrollee shall contribute to the cost of his or her care an amount that is calculated as provided under this section. Treatment of assets, including assets in trusts, and income shall be as provided under ss. 49.454 and 49.47, Stats., and ss. DHS 103.06 and 103.07 unless specified otherwise in this section. All dollar amounts specified in this section shall be updated annually based on changes in the consumer price index. The following calculation shall determine the applicant's or enrollee's maximum cost-sharing requirement:

1. Determine total countable assets according to ss. 49.454 and 49.47, Stats., and s. DHS 103.06. If the applicant or enrollee is legally married, include the countable assets of both members of the couple.

2. Determine monthly net countable assets by subtracting from total countable assets the following allowances, as applicable, and dividing the result by 12:

a. Subject to subd. 6., if the applicant or enrollee is a family care spouse, the amount of the community spouse resource allowance under s. 49.455 (6) (b), Stats.

b. If the person resides in a nursing home, community-based residential facility or adult family home, an allowance of $9,000.

c. If the person resides in his or her own home, including a residential care apartment complex or in the private home of a relative or other person, an allowance of $12,000.

3. Determine countable monthly income by adding together all of the following:

a. Monthly unearned income less a $20 disregard from unearned income, or if the person has less than $20 of unearned income, the remainder from earned income.

b. Total monthly earned income, less the first $200, and then less two-thirds of any remaining earned income.

4. Add together the monthly net countable assets and the countable monthly income.

5. Deduct from the amount calculated under subd. 4. all of the following:

a. Subject to subd. 6., if the person is a family care spouse, the community spouse monthly income allowance under s. 49.455 (4) (b), Stats.

b. The amount of any payments the person is required to pay by court order.

c. If the person resides in a nursing home, community-based residential facility or adult family home, a personal maintenance allowance of $65.

d. If the person resides in his or her own home, including a residential care apartment complex or the home of another person, a personal maintenance allowance equal to the greater of the combined benefit amount available under 42 USC 1381 to 1383 and s. 49.77 (3s), Stats., or actual maintenance costs, as defined under sub. (1) (a), up to the maximum personal maintenance allowance for persons receiving home and community-based waiver services funded under 42 USC 1396 (b) or (c).

e. If the person resides in a medical institution, the monthly cost of maintaining a homestead property when the applicant or enrollee can reasonably be expected to return within 6 months or the anticipated absence of the applicant or enrollee from the home is for more than 6 months but there is a realistic expectation, as verified by a physician, that the person will return to the home. The monthly cost shall not exceed the SSI payment level for one person living in that person's own household.

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f. The average monthly out-of-pocket cost of necessary medical or remedial care, including health insurance premiums and cost-sharing requirements for other state or federal programs.

g. An allowance for dependents who live in the home of the person or the person's community spouse equal to the allowance payable under s. 49.455 (4) (a) 3., Stats.

h. Any special allowances approved by the department.

6. If both members of a married couple are family care spouses, the community spouse resource allowance under subd. 2. a. and the community spouse monthly income allowance under subd. 5. a. may be included in the calculation of cost share for either spouse, but not for both.

(c) *Recalculation of maximum cost-sharing requirement during a certification period.* When changes in income, assets or cost of care necessitate a re-determination of a person's maximum cost-sharing requirement during a certification period as described in par. (f), the calculation for the remainder of the certification period shall be the same as under par. (b) except that the amount already incurred and paid by the person from countable assets during the certification period shall be added to the amount under par. (b) 4.

(d) *Treatment of assets.* In determining financial eligibility and cost sharing requirements for the family care benefit, the department or the county agency shall treat assets, including assets in trusts, according to ss. 49.454 and 49.47 (4) (b), Stats., and s. DHS 103.06, except as follows:

1. All funds in an independence account shall be considered as an exempt asset. In this subdivision, "independence account" means one or more separate accounts at a financial institution, approved by the department, that are in the sole ownership of the client, and that consist solely of savings, and dividends or other gains derived from those savings, from earned income received after application for the family care benefit.

2. Spousal impoverishment provisions under s. DHS 10.35 apply.

(e) *Treatment of income.* In determining financial eligibility and cost sharing requirements for the family care benefit, the department or the county agency shall treat income according to applicable provisions of s. 49.47 (4) (c), Stats., and s. DHS 103.07 except that worker's compensation cash benefits under ch. 104, Stats., and unemployment insurance benefits received under ch. 108, Stats., shall be treated as earned income for purposes of par. (b) 3. b.

(f) *Certification period.* Cost sharing requirements as determined under this section shall be in effect for a full 12-month certification period except as follows:

1. An enrollee shall report, within 10 days of the change, increases in assets that exceed a total of at least $1000 in a calendar month.

2. At any time, an enrollee may report decreases of any amount in assets other than decreases resulting from payment of required cost sharing under this section.

3. An enrollee shall report any change in income within 10 days of the change.

4. Cost-sharing requirements shall be re-determined whenever any of the following occurs:

a. Reported changes in income, assets, or both, would result in a lower cost-sharing requirement.

b. Countable assets increase more than $1000 in a calendar month.

c. Monthly income increases by any amount.

(4) PAYMENT OF COST SHARE REQUIRED. (a) Except as provided in par. (b), a person who is required to contribute to the cost of his or her care but who fails to make the required contributions is ineligible for the family care benefit.

(b) If the department or its designee determines that the person or his or her family would incur an undue financial hardship as a result of making the payment, the department may waive or reduce the requirement. Any reduction or waiver of cost share shall be subject to review at least every 12 months. A reduction or waiver under this paragraph shall meet all of the following conditions:

1. The hardship is documented by financial information beyond that normally collected for eligibility and cost-sharing determination purposes and is based on total financial resources and total obligations.

2. Sufficient relief cannot be provided through an extended or deferred payment plan.

3. The person is notified in writing of approval or denial within 30 days of providing necessary information to the department or its designee.

Note: The forced sale of a family residence or cessation of an education program for a person or his or her family member are examples of genuine hardships under this provision. Reductions or waivers of cost sharing requirements are generally restricted to situations where services are provided for a relatively long term, when deferred payments will not provide sufficient relief.

(c) A CMO shall collect or monitor the collection of its enrollees' cost sharing payments. If an enrollee does not meet his or her cost sharing obligations, the CMO shall notify the resource center in the county in which the enrollee resides. The resource center, directly or through arrangement with the county agency, shall notify the enrollee that he or she will be ineligible on a specified date unless cost sharing obligations are met. If the client has not paid the cost share amount due by the date specified, the county agency shall determine the person to be ineligible and disenroll the person from the CMO.

(d) Until an enrollee is disenrolled, a CMO remains responsible for provision of services in the enrollee's plan of care and for payment to providers for those services.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (3) (a) Register November 2004 No. 587, eff. 12-1-04; corrections in (1) (d), (e), (2), (3) (b) (intro.), 1., (d) (intro.) and (e) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; EmR2121: emerg. r. (4) (a), eff. 8-5-21; CR 21-081: am. (4) (a) Register May 2022 No. 797, eff. 6-1-22, am. (4) (a) eff. the first day of the month after the emergency period, as defined in section 1135 (g) (1) (b) of the Social Security Act, 42 USC 1320b-5 (g) (1) (B) and declared in response to the COVID-19 pandemic, end; correction in (4) (a) made under s. 35.17, Stats., Register May 2022 No. 797.

DHS 10.35 Protections against spousal impoverishment. The provisions related to spousal impoverishment under s. 49.455, Stats., and s. DHS 103.075 apply to all family care spouses, regardless of their eligibility for medical assistance.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; correction made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 10.36 Eligibility and entitlement. (1) ENTITLEMENT. Except as provided in sub. (2), a person who meets all of the conditions of eligibility under s. DHS 10.32 is entitled to enroll in a care management organization and to receive the family care benefit if any of the following apply:

(a) The person meets the conditions of functional eligibility at the nursing home level under s. DHS 10.33 (2) (c).

(b) The person meets the conditions of functional eligibility at the non-nursing home level under s. DHS 10.33 (2) (d) and at least one of the following applies:

1. The person is in need of adult protective services as substantiated by a county agency under s. 46.90 (2), Stats., or specified in s. 55.01 (1f), Stats.

2. The person is eligible for medical assistance.

(c) The person meets the criteria under s. DHS 10.33 (3).

(2) PHASE-IN OF ENTITLEMENT. (a) *Effective date.* Except as provided in pars. (b) and (c), within each county and for each CMO target population, entitlement to the family care benefit first applies on the effective date of a contract under which a CMO accepts a per person per month payment to provide services under the family care benefit to eligible persons in that target population in the county.

(c) *Phase-in of capacity.* To provide time for a newly established care management organization to develop sufficient capacity to serve all individuals who meet the conditions of entitlement, a care management organization may limit enrollment. If enrollment is limited during this phase-in period, a resource center may place persons otherwise entitled under sub. (1) on a waiting list until a CMO can accept the enrollment. Any waiting list created under this paragraph shall conform to department requirements.

(3) ELIGIBILITY WITHOUT ENTITLEMENT. A person who is found eligible but who does not meet any of the conditions of sub. (1) (a) to (c) is not entitled to the family care benefit. The person may be placed on a waiting list to receive the family care benefit when funds are available. The county agency shall inform the person of his or her right to receive a new functional screening or financial eligibility and cost-sharing screening if the person's circumstances change. Waiting lists under this subsection shall conform to criteria established by the department. While waiting for enrollment, a person who has been found eligible but not entitled may purchase services from a CMO as provided under s. DHS 10.37.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (2) (b) and (3) Register November 2004 No. 587, eff. 12-1-04; correction in (1) (b) 1. made under s. 13.93 (2m) (b) 7., Stats., Register November 2004 No. 587; correction in (1) (b) 1. made under s. 13.92 (4) (b) 7., Stats., Register November 2009 No. 647; CR 23-046: am. (1) (a), (b) (intro.), r. (2) (b) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.37 Private pay individuals. (1) DEFINITIONS. In this section:

(a) "Case management" means assessment, care planning, assistance in arranging and coordinating services in the care plan, assistance in filing grievances and appeals and obtaining advocacy services, and periodic reassessment and updates to the person's care plan.

(b) "Private pay individual" means any of the following:

1. A person who is a member of a CMO's target population and who does not qualify financially for the family care benefit under s. DHS 10.34.

2. A person who is eligible for the family care benefit under s. DHS 10.32, but who is not entitled to receive the benefit immediately as specified in s. DHS 10.36 (3).

3. A person who meets the entitlement conditions specified in s. DHS 10.36 (1), but who is waiting for enrollment in a CMO under the phase-in provisions of s. DHS 10.36 (2).

(2) CASE MANAGEMENT AVAILABLE FOR PURCHASE. A care management organization shall offer case management services, at rates approved by the department, to private pay individuals who wish to purchase the services. A private pay individual may purchase from the CMO any types and amounts of case management. The types and amounts of case management and the cost of the services shall be specified in a written agreement signed by the authorized representative of the CMO and the individual purchasing the service or the person's authorized representative.

(3) LIMITATIONS ON PURCHASE OF OTHER SERVICES. (a) A private pay individual may not enroll in a care management organization, but, subject to pars. (b) and (c), may purchase services other than case management services, on a fee-for-service basis, from a care management organization.

(b) An individual who meets the definition under sub. (1) (b) 1. may purchase any service that the CMO provides directly and offers to the general public, at prices normally charged to the public.

(c) An individual who meets the definition under sub. (1) (b) 2. or 3. may purchase any service purchased or provided by the CMO for its members.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (a) Register November 2004 No. 587, eff. 12-1-04.

Subchapter IV — Family Care Benefit; Delivery Through Care Management Organizations (CMOs)

DHS 10.41 Family care services. (1) ENROLLMENT REQUIRED. The family care benefit is available to eligible persons only through enrollment in a care management organization (CMO) under contract with the department.

(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. When providing applicable services, CMOs shall comply with EVV requirements.

Note: The services that typically will be required to be available include adaptive aids; adult day care; assessment and case planning; case management; communication aids and interpreter services; counseling and therapeutic resources; daily living skills training; day services and treatment; home health services; home modification; home delivered and congregate meal services; nursing services; nursing home services, including care in an intermediate care facility for individuals with intellectual disabilities or in an institution for mental diseases; personal care services; personal emergency response system services; prevocational services; protective payment and guardianship services; residential services in an RCAC, CBRF or AFH; respite care; durable medical equipment and specialized medical supplies; outpatient speech; physical and occupational therapy; supported employment; supportive home care; transportation services; mental health and alcohol or other drug abuse services; and community support program services.

(3) PAYMENT MECHANISMS. Payment to a care management organization shall be on a per enrollee per month basis. Any contractual agreements for shared financial risk between the department and a CMO shall meet applicable federal requirements.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 22-026: am. (2) Register May 2023 No. 809, eff. 6-1-23; EmR2306: emerg. am. (2), eff. 5-1-23; CR 23-045: am. (2) Register January 2024 No. 817, eff. 2-1-24; correction in (2) made under s. 35.17, Stats., Register January 2024 No. 817.

DHS 10.42 Certification and contracting. (1) No entity may receive payment of funds for the family care benefit as a care management organization unless it is certified by the department as meeting all of the requirements of s. 46.284, Stats., and this chapter and is under contract with the department.

(2) (a) To obtain and retain certification, an organization shall submit all information and documentation required by the department, in a format prescribed by the department. The department shall review and make a determination on the application within 90 calendar days of receipt of a complete application containing complete and accurate supporting documentation that the organization meets the standards under s. DHS 10.43. The

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department may conduct any necessary investigation to verify that the information submitted by the organization is accurate. The organization shall consent to disclosure by any third party of information the department determines is necessary to review the application.

(am) For initial certifications, or when a currently certified organization will provide or arrange for the provision of services to new eligibility groups, the organization shall submit to an on-site readiness review which will assess all of the following:

1. Operations and administration, including all of the following:

a. Administrative staffing and resources.

b. Delegation and oversight of entity responsibilities.

c. Enrollee and provider communications.

d. Grievance and appeals.

e. Member services and outreach.

f. Provider network management.

g. Program integrity compliance.

2. Service delivery, including all of the following:

a. Case management/care coordination/service planning.

b. Quality improvement.

c. Utilization review.

3. Financial management, including all of the following:

a. Financial reporting and monitoring.

b. Financial solvency.

4. Systems management, including all of the following:

a. Claims management.

b. Encounter data and enrollment information management.

(b) If the department denies CMO certification for the organization, the department shall provide written notice to the organization that clearly states the reasons for the denial and describes the manner by which the organization may appeal the department's decision.

(3) If an organization applying to operate a CMO meets standards for certification under s. 46.284 (2) and (3), Stats., and s. DHS 10.43, the department shall certify the organization as meeting the requirements. Certification by the department does not bind the department to contracting with the organization to operate a CMO. The department may contract with a certified organization to operate a CMO only if all of the following apply:

(c) The department has determined that the organization's services are needed to provide sufficient access to the family care benefit for eligible individuals.

(d) Before January 1, 2003, the organization is a county or a family care district, unless the governing body of a tribe or band or the Great Lakes inter–tribal council, inc., elects to operate a care management organization within the area and is certified under sub. (2).

(e) After December 31, 2002, and before January 1, 2004, the organization is a county or a family care district unless any of the following applies:

1. Paragraph (d) applies.

2. The county or family care district fails to meet requirements of s. DHS 10.43 or 10.44 or the requirements under its contract with the department.

3. The department determines that the county or family care district does not have the capacity to serve all county residents who are entitled to the family care benefit in the client group or groups that the county or family care district serves and cannot develop the capacity. If this subd. 3. applies, the department may contract with an organization in addition to the county.

(4) After December 31, 2003, the department may contract with counties, family care districts, the governing body of a tribe or band or the Great Lakes inter–tribal council, inc., or under a joint application of any of these, or with a private organization that has no significant connection to an entity that operates a resource center. Proposals for contracts under this subsection shall be solicited under a competitive sealed proposal process under s. 16.75 (2m), Stats., and the department shall evaluate the proposals primarily as to the quality of care that is proposed to be provided and certify those applicants that meet the requirements specified in s. 46.284 (2) and (3), Stats., and s. DHS 10.43. The department may select certified applicants for contract and contract with the selected applicants.

Note: Until July 1, 2001, the Wisconsin Legislature has authorized the Department to establish Family Care pilots in areas of the state in which not more than 29% of the state's eligible population lives. After that date, if specifically authorized and funded by the Legislature, the Department may contract with additional entities certified as meeting requirements for a CMO. The Department is required to submit, prior to November 1, 2000, a report to the Governor that describes the implementation and outcomes of the pilots and makes recommendations about further development of Family Care.

(5) The department's contracts with CMOs shall specify a range of remedies that may be taken in the event of noncompliance by the CMO with contract requirements. The remedies may include the following:

(a) Suspension of new enrollment.

(b) Enrollment reductions.

(c) Withholding or reduction of payments.

(d) Imposition of damages.

(e) Appointment of temporary management of the CMO.

(f) Contract termination.

(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 the secretary's council on long-term care.

(7) The department shall annually provide to the members of the secretary's council on long-term care copies of the standard CMO 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.

(9) Prior to receiving funds to provide the family care benefit, an organization shall agree to the terms of the standard CMO contract.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (6) (a) and (7) Register November 2004 No. 587, eff. 12-1-04; corrections in (2) (a), (3) (a), (b), (c), (d) 1., (4), (6) (b) and (8) made under s. 13.92 (4) (b) 7., Stats., Register November 2009 No. 647; CR 22-026: r. (3) (a), cons. (6) (intro.) and (a) and renum. to (6) and am., r. (6) (b) Register May 2023 No. 809, eff. 6-1-23; CR 23-046: cr. (2) (am) Register April 2024 No. 820, eff. 5-1-24; **CR 24-087: am. (2) (a), r. (3) (b), am. (3) (c), cons. (3) (d) (intro.) and 2. and renum. to (3) (d) and am., r. (3) (d) 1., am (3) (e) 1., (4), r. (8) Register February 2025 No. 830, eff. 3-1-25.**

DHS 10.43 CMO certification standards. If an organization applies for a contract to operate a CMO, the department shall determine whether the organization meets the requirements of s. 46.284 (2) and (3), Stats., and all of the following standards:

(1) CASE MANAGEMENT CAPABILITY. Each organization applying to operate a CMO shall demonstrate to the department that it has expertise in determining and arranging for services and

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supports to meet the needs of its target population. Demonstration of this expertise includes evidence that the organization, a subcontractor, or both, has all of the following:

(a) A sufficient number of qualified and competent staff to meet case management standards under s. DHS 10.44.

(b) Thorough knowledge of local long-term care and other community resources.

(c) Thorough knowledge of methods for maximizing informal caregivers and community resources and integrating them into individual service plans.

(d) Strong linkages with systems and services that are not directly within the scope of the CMO's responsibility but that are important to the organization's target population, including primary and acute health care services, and the capacity to arrange for those services to be made available to its enrollees.

(e) Mechanisms to coordinate services internally and with services available from community organizations and other social programs.

(f) Thorough knowledge of employment opportunities and barriers for the organization's target population.

(g) Thorough knowledge of methods for promoting and supporting the use of mechanisms under which individuals direct and manage their own service funding.

(2) ADEQUATE AVAILABILITY OF PROVIDERS. Each organization applying to operate a CMO shall demonstrate to the department that it has adequate availability of qualified providers with the expertise and ability to serve its target population in a timely manner. To demonstrate an adequate availability of qualified providers, an organization shall assure the department that it has all of the following:

(a) Agreements with providers who can provide all required services in the family care benefit.

(b) Appropriate provider connections to qualify providers, on a timely basis, as needed to directly reflect the specific needs and preferences of particular enrollees in its target population.

(c) Agreements with a broad array of providers representing diverse programmatic philosophies and cultural orientations to accommodate a variety of enrollee preferences and needs within its target population.

(d) The ability to provide services at various times, including evenings, weekends and, when applicable, on a 24-hour basis.

(e) The ability to provide an appropriate range of residential and day services that are geographically accessible to proposed enrollees' homes, families, guardians or friends.

(f) Supported living arrangements of the types and sizes that meet its target population's preferences and needs and staff to coordinate residential placements who have shown capability in recruiting, establishing and facilitating placements with appropriate matching to enrollee needs.

(g) The ability to recruit, select and train new service providers, including in-home providers, in a timely fashion and a program designed to retain individual providers.

(h) The ability to develop residential options that meet individual needs and desired outcomes of its enrollees.

(i) Mechanisms for assuring that all service providers meet required licensure, accreditation, or other quality assurance standards.

(j) Mechanisms for assuring that any service provider dissatisfied with the CMO's contract requirements shall have the opportunity to request review by the department.

(k) A provider network that meets the department's quantitative network adequacy standards.

(3) CERTIFICATION AS A MEDICAL ASSISTANCE PROVIDER. The organization shall be certified by the department under s. DHS 105.47.

(4) ORGANIZATIONAL CAPACITY. The organization shall demonstrate that it has the organizational capacity to operate a CMO, including all of the following:

(a) Financial solvency and stability and the ability to assume the level of financial risk required under the contract.

(b) The ability to collect, monitor and analyze data for purposes of financial management and quality assurance and improvement and to provide that data to the department in the manner required under the contract.

(c) The capacity to support consumer employment, training and supervision of family members, friends and community members in carrying out services under the consumer's service plan.

(5) GRIEVANCE AND APPEAL PROCESSES. The organization shall have a process for reviewing and resolving client grievances and appeals that meets the requirements under s. DHS 10.53 (2).

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (5) Register November 2004 No. 587, eff. 12-1-04; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 23-046: cr. (2) (k) Register April 2024 No. 820, eff. 5-1-24.

DHS 10.44 Standards for performance by CMOs.

(1) COMPLIANCE. A care management organization shall comply with all applicable statutes, all of the standards in this subchapter and all requirements of its contract with the department.

(2) CASE MANAGEMENT STANDARDS. The CMO shall provide case management services that meet all of the following standards:

(a) The CMO's case management personnel shall meet staff qualification standards contained in its contract with the department.

(b) The CMO shall designate for each enrollee a case management team that includes at least a social service coordinator and a registered nurse. The CMO shall designate additional members of the team as necessary to ensure that expertise needed to assess and plan for meeting each member's needs is available.

(c) The CMO shall employ or contract with a sufficient number of case management personnel to ensure that enrollees' services continue to meet their needs.

(d) The CMO shall provide the opportunity for enrollees to manage service and support funds, as provided under sub. (6). For enrollees managing service funding under sub. (6), the role of the case management team in providing assistance in planning, arranging, managing and monitoring the enrollee's budget and services shall be negotiated between the enrollee and the case management team and at a level tailored to the enrollee's need and desire for assistance. At a minimum, the case management team's role shall include:

1. An initial assessment sufficient to provide information necessary to establish an individual budget amount and to identify health and safety issues.

2. Monitoring the enrollee's use of the individual budget amount for purchase of services or support items.

3. Monitoring the health and safety of the enrollee.

4. Monitoring to ensure the enrollee reports service utilization adequately to allow the CMO to meet federal and state reporting requirements.

(e) The CMO shall use assessment protocols that include a face-to-face interview with the enrollee and that comprehensively assess and identify all of the following:

1. The needs and strengths of each enrollee in at least the following areas:

a. Activities of daily living and instrumental activities of daily living.

b. Physical health and medical needs.

c. Nutrition.

d. Autonomy and self-determination.

e. Communication.

f. Mental health and cognition.

g. Presence of, and opportunities for enhancing, informal supports.

h. Understanding and exercising rights and responsibilities.

i. Community integration.

j. Safety.

k. Personal values.

L. Education and vocational activities, including any needs for job development, job modifications, and ongoing support on the job.

m. Economic resources.

n. Religious affiliations, if any.

2. Long-term care outcomes that are consistent with the values and preferences of the enrollee in at least the following areas:

a. Safety.

b. Best possible health.

c. Self-determination of daily routine, services, activities and living situation.

d. Privacy.

e. Respect.

f. Independence.

g. Social roles and ties to family, friends and community.

h. Educational and vocational activities.

i. Desired level and type of participation in community life.

j. Spiritual needs and desired participation in religious activities.

(f) The CMO, in partnership with the enrollee, shall develop an individual service plan for each enrollee, with the full participation of the enrollee and any family members or other representatives that the enrollee wishes to participate. The CMO shall provide support, as needed, to enable the enrollee, family members or other representatives to make informed service plan decisions, and for the enrollee to participate as a full partner in the entire assessment and individual service plan development process. The service plan shall meet all of the following conditions:

1. Reasonably and effectively addresses all of the long-term care needs and utilizes all enrollee strengths and informal supports identified in the comprehensive assessment under par. (e) 1.

2. Reasonably and effectively addresses all of the enrollee's long-term care outcomes identified in the comprehensive assessment under par. (e) 2. and assists the enrollee to be as self-reliant and autonomous as possible and desired by the enrollee.

3. Is cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes.

4. Is agreed to by the enrollee, except as provided in subd. 5.

5. If the enrollee and the CMO do not agree on a service plan, provide a method for the enrollee to file a grievance under s. DHS 10.53, request department review under s. DHS 10.54, or request a fair hearing under s. DHS 10.55. Pending the outcome of the grievance, review or fair hearing, the CMO shall offer its service plan for the enrollee, continue negotiating with the enrollee and document that the service plan meets all of the following conditions:

a. Meets the conditions specified under subds. 1. to 3.

b. Would not have a significant, long-term negative impact on the enrollee's long-term care outcomes identified under par. (e) 2.

c. Balances the needs and outcomes identified by the comprehensive assessment with reasonable cost, immediate availability of services and ability of the CMO to develop alternative services and living arrangements.

d. Was developed after active negotiation between the CMO and the enrollee, during which the CMO offered to find or develop alternatives that would be more acceptable to both parties.

(g) The CMO shall reassess each enrollee's needs and strengths as specified under par. (e) 1. and long-term care outcomes as specified under par. (e) 2. and adjust the individual service plan based on the findings of the re-assessment, as specified in par. (j) 5.

(h) The CMO shall provide, arrange, coordinate and monitor services as required by its contract with the department and as specified in the enrollee's individual service plan. The CMO shall provide opportunity for each enrollee to be involved, to the extent that he or she is able and willing, in all of the following:

1. The selection of service providers from within the CMO's network of providers.

2. The recruiting, interviewing, hiring, training and supervision of individuals providing personal care and household assistance in the enrollee's home.

(i) The CMO shall provide assistance to enrollees in arranging for and coordinating services that are outside the direct responsibility of the CMO.

(j) The CMO shall meet timeliness standards as specified in its contract with the department, that shall include all of the following:

1. Immediately upon enrollment, the CMO shall provide services to preserve the health and safety of the enrollee. Within 5 days of enrollment, the CMO shall develop and implement an initial service plan based on information received from the resource center and the CMO's initial assessment of the enrollee's needs.

2. The CMO shall complete a comprehensive assessment, as specified under par. (e) not later than 30 days after enrollment.

3. Within 60 days of enrollment, the CMO shall, jointly with the enrollee and any other individual identified by the enrollee, develop an individualized service plan as specified under par. (f).

4. The CMO shall provide services and support items in accordance with the time frames specified in each enrollee's individualized service plan.

5. The CMO shall review each enrollee's service plan and adjust services if indicated by the review, as follows:

a. Whenever a significant change occurs in the enrollee's health, functional capacity or other circumstances.

b. When requested by the enrollee, the enrollee's representative, the enrollee's primary medical provider, or an agency providing services to the enrollee.

c. As often as necessary in relation to the stability of the enrollee's health and circumstances, but not less than every 180 days.

6. The CMO shall provide required reports in a timely manner as specified in its contract with the department.

(3) SERVICE MONITORING. A CMO shall do all the following:

(a) Develop and implement standards for CMO service provider qualifications and written procedures and protocols for

assessing whether providers meet the standards. Provider qualification standards established by a CMO shall meet or exceed standards that are specified in its contract with the department.

(b) Develop and implement written procedures and protocols that assure that services furnished are consistent with the needs and strengths identified under sub. (2) (e) 1., the long-term care outcomes identified under sub. (2) (e) 2. and the individual service plan under sub. (2) (f) for each enrollee.

(c) Develop and implement written procedures and protocols that assure that enrollee problems related to services are detected and promptly addressed.

(d) Maintain a process to consider an enrollee's request to receive services from a provider who does not have an agreement with the CMO for providing services to the CMO's enrollees. The CMO shall arrange for services with non-CMO providers if the enrollee's request is authorized by the CMO. Instances where the enrollee's request for a non-CMO provider is warranted include all of the following:

1. When the CMO does not have the capacity to meet the identified needs of its enrollees.

2. When the CMO does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers.

3. When the CMO cannot meet the enrollee's need on a timely basis.

4. When transportation or physical access to the CMO providers causes an undue hardship to the enrollee.

(e) Offer each enrollee the opportunity to participate in the monitoring and improvement of services in the enrollee's care plan.

(4) INTERNAL QUALITY ASSURANCE AND QUALITY IMPROVEMENT. The CMO shall implement an internal quality assurance and quality improvement program that [meets] the requirements of its contract with the department. As part of the program, the CMO shall do all of the following:

(a) Measure CMO performance, using standard measures as required in its contract with the department, and report its findings on these measurements to the department.

(b) Demonstrate, through the standard measures agreed to in its contract with the department, that the CMO meets or exceeds minimum performance standards and that the CMO is continuously improving its performance in achieving enrollee outcomes in all of the areas specified in sub. (2) (e) 2.

(c) Comply with the standards for quality of services included in the CMO's contract with the department in all of the following areas:

1. Availability of services and adequacy of the CMO's provider network.

2. Continuity and coordination of care.

3. Coverage and authorization of services.

4. Provision of information to enrollees.

5. Protection of enrollee rights, including processes for protecting confidentiality and for acting on and resolving grievances and appeals.

6. Mechanisms to detect and correct both underutilization and overutilization of services.

(d) Develop and implement a written quality assurance and quality improvement plan designed to ensure and improve outcomes for its target population. The plan shall be approved by the department and shall include at least all of the following components:

1. Identification of performance goals, specific to the needs of the CMO's enrollees, including any goals specified by the department.

2. Identification of objective and measurable indicators of whether the identified goals are being achieved, including any indicators specified by the department.

3. Identification of timelines within which goals for improvement will be achieved.

4. Description of the process that the CMO will use to gather feedback from enrollees, staff, people who have disenrolled from the CMO and other sources on the quality and effectiveness of the CMO's performance.

5. A description of the process the CMO will use to monitor and act on the results and feedback received.

6. A process for regularly updating the plan, including a description of the process the CMO will use for annually assessing the effectiveness of the quality assurance and quality improvement plan and the impact of its implementation on outcomes.

(e) Conduct, as specified in its contract with the department, at least one performance improvement project annually that examines aspects of care and services related to improving CMO quality and enrollee outcomes. Each project shall include all of the following:

1. Measuring performance.

2. Implementing system interventions.

3. Evaluating the effectiveness of the interventions.

4. Planning for sustained or increased improvement in performance, based on the findings of the evaluation.

(f) Report all data required by the department related to standardized measures of performance, in the timeframes and format specified by the department.

(g) Cooperate with the department in evaluating outcomes and in developing and implementing plans to sustain and improve performance.

(5) EXTERNAL REVIEW. A CMO shall comply with all state and federal requirements for external review of quality of care and services furnished to its enrollees. A CMO shall cooperate with any review of CMO activities by the department, another state agency or the federal government.

Note: All enrollees in Family Care are encouraged to participate in the direction of their own care and supports as much as they are willing and able. The full range of self-determination is to be encouraged and supported for all enrollees, including identification and setting priorities among long-term care outcomes, and direction of all long-term care services and health care, including end-of-life issues. As provided under s. DHS 10.44 (2) (e) and (f), all enrollees are to be full partners in the assessment of needs and strengths and in the development of care plans. Provisions at s. DHS 10.44 (2) (h) and (3) (d) require that each enrollee is to be offered the opportunity to take as much responsibility as he or she is willing and able in the selection, arrangement and monitoring of services.

Note: The option provided in the following sub. (6) is one in which the enrollee takes full responsibility for managing the funding for all or part of his or her services, with some oversight from the CMO. Primary differences from the usual Family Care model are: (1) the ability to purchase services from outside the CMO network of providers; (2) the ability to receive assistance in planning, arranging and monitoring services from a broker or case manager outside the CMO; and (3) within the individual's established budget, having a greater degree of control over payment, including adjustments to payment rates, for services received.

(6) OPTION FOR ENROLLEE SELF-MANAGEMENT OF SERVICE FUNDING. (a) The CMO shall provide enrollees with an opportunity to manage funding for services and supports, including an opportunity for an enrollee who chooses to participate to plan, arrange for, manage and monitor services under his or her family care benefit directly or with the assistance of another person chosen by the enrollee. The department may, through its contract with the CMO, limit the self-management of services not covered by federal home and community based waivers under 42 USC 1396n (c). The CMO shall provide the opportunity to self-man-

age service funding under a plan approved by the department under par. (b) or (c).

(b) On or before December 31, 2002, the department may approve the CMO plan for self-directed support only if:

1. The CMO offers the opportunity to participate in self-managing all or some of the funding for his or her services under par. (a), with the assistance and support described in this paragraph, to a significant number of enrollees, and has a phase-in plan under which the opportunity to self-manage service funding is offered to an increasing number of enrollees in each year.

2. For individuals participating in a self-management option, the plan complies with the provisions of par. (c) or, for any provision with which the plan does not comply, provides interim procedures and a plan and time-frame for achieving compliance.

(c) On or after January 1, 2003, the department may approve the CMO plan for self-managed service funding only if the plan provides all of the following:

1. The CMO offers each enrollee the opportunity to self-manage some or all of the funding for his or her services under par. (a), with the assistance and support described in this paragraph.

2. The CMO, as part of the comprehensive assessment under sub. (2) (e), identifies whether the enrollee needs support to effectively self-manage funding for his or her services, whether needed support is available to the person from one or more other persons, and whether the enrollee will accept the needed help. If the CMO determines that an enrollee who wants to self-manage his or her service funding is not able to do so independently and that the support available and acceptable to an enrollee is insufficient to support the person to effectively plan and manage funding for services and supports, the CMO, through the case management team, shall do all of the following:

a. Work with the enrollee and available supports to develop a case plan that specifies any limits on the level of control exercised by the enrollee that the CMO finds necessary under subd. 13.

b. Identify and recruit one or more individuals to provide the assistance needed by the enrollee.

c. Assist the enrollee to develop skills and knowledge needed to participate more fully in self-managing service funding.

d. Inform the enrollee of his or her right to file a grievance under s. DHS 10.53, request department review under s. DHS 10.54, or request a fair hearing under s. DHS 10.55 if he or she disagrees with the determination of need for support or the level of self-management provided by the plan.

3. The CMO offers training in the effective planning and management of service funding and supports to enrollees using the self-managed service funding mechanism and to individuals assisting these enrollees to manage funding for their services.

4. Subject to any limitations under subd. 2., the enrollee may choose the long-term care outcomes for which he or she wishes to manage funding for services or supports directly and the degree to which he or she wishes the CMO to assist in the management of funding for those services or supports beyond the minimum described in sub. (2) (d).

5. The CMO has a system in place for establishing and modifying an individualized budget amount or range available to the enrollee to pay for the services and supports to be self-managed. The individualized budget amount or range is based on the comprehensive assessment and on a methodology approved by the department for estimating the cost of services the CMO would have provided if the funding for the services and supports were not self-managed.

6. The enrollee submits a plan for managing funding for those supports or services the member has chosen to manage directly. The CMO reviews the plan to ensure that the plan does not jeopardize the enrollee's health and safety and that expenditures are within the budget agreed to by the CMO and meets any other condition approved by the department.

7. Within the budget established under subd. 5. and the plan established under subd. 6., the enrollee may purchase any service or support consistent with the long-term care outcomes identified under sub. (2) (e) 2., including assistance with planning and coordinating services to the extent that this assistance is not provided by the CMO.

8. The individual service plan for each enrollee participating in the self-managed service funding mechanism and the plan under subd. 6. includes a plan for how the CMO will monitor all of the following:

a. The health and safety of the enrollee and other people are not significantly threatened.

b. The enrollee's expenditures are consistent with the budget established under subd. 5. and the plan established under subd. 6.

c. Safeguards are in place to ensure that the conflicting interests of other people are not taking precedence over the desires and interests of the enrollee.

9. If the self-managed expenditures of CMO enrollees are less than the amounts budgeted under subd. 5., the savings are used only for services and supports consistent with the long-term care outcomes of enrollees, as identified under sub. (2) (e) 2. Savings shall not be used for administrative costs of a CMO.

10. The self-managed supports budget for an enrollee is not reduced in a subsequent year solely because the enrollee did not expend the full amount budgeted in a given year. Each year's budget is based on a re-assessment of needs and identified long-term care outcomes under subd. 5.

11. The CMO has in place policies and procedures under which the enrollee can make or authorize payments to providers and receive timely information on expenditures made and budget status.

12. The policies and procedures under subd. 11. include mechanisms for assuring compliance with requirements for the deduction and payment of payroll taxes and for providing legally mandated fringe benefits for individuals employed by the enrollee and makes assistance available to the enrollee for all of the following employment-related tasks:

a. Recruiting.

b. Screening.

c. Interviewing.

d. Hiring and firing.

e. Setting the level of wages.

f. Setting workers tasks and hours.

g. Authorizing and making payment for services delivered.

h. Setting the level of benefits, if any, to be provided in addition to requisite state and federal payroll benefits, such as vacation, sick leave or health insurance.

i. Assistance in procuring additional optional employee benefits.

j. Training workers.

k. Assessing member liability.

L. Supervising and disciplining workers.

m. Arranging back-up workers or services.

13. The CMO has policies and procedures under which the CMO may restrict the level of self-management of service funding exercised by an enrollee or for increasing the level of involve-

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ment of the case management team where the team finds any of the following:

a. The health and safety of the enrollee or another person is threatened.

b. The enrollee's expenditures are inconsistent with the budget established under subd. 5. and the plan established under subd. 6.

c. The conflicting interests of another person are taking precedence over the desires and interests of the enrollee.

d. Funds have been used for illegal purposes.

e. Negative consequences have occurred under other policies approved by the department.

14. The CMO informs each enrollee whose level of self-management of service funding is restricted under subd. 13. about what actions by the enrollee will result in removal of the restrictions.

15. The CMO informs the enrollee whose level of self-management of service funding is restricted under subd. 13. about his or her right to file a grievance under s. DHS 10.53, request department review under s. DHS 10.54, or request a fair hearing under s. DHS 10.55 if he or she disagrees with any limit on the level of self-management.

16. The CMO has policies and procedures in place related to self-management of service funding of an enrollee under guardianship that include all of the following:

a. Training for guardians to assist them in learning and respecting enrollees' preferences and goals.

b. Assistance to enrollees and their guardians in building the enrollees' skills in the area of self-determination.

c. Periodic re-assessment of enrollees' competency to exercise rights directly and assistance to enrollees in attaining or regaining rights the CMO believes they are competent to exercise.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (4) (c) 5. Register November 2004 No. 587, eff. 12-1-04; EmR2121: am. (2) (e), eff. 8-5-21; CR 21-081: am. (2) (e) (intro.) Register May 2022 No. 797, eff. 6-1-22, am. (2) (e) (intro.) eff. upon the termination of the Appendix K: Emergency Preparedness and Response and COVID-19 Addendum to the 1915 (c) Family Care program waiver.

DHS 10.45 Operational requirements for CMOs. (1) GOVERNING BOARD. A care management organization shall have a governing board that reflects the ethnic and economic diversity of the geographic area served by the CMO. 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 who are representative of the CMO's enrollees.

(2) OPEN ENROLLMENT. (a) Except as provided in s. DHS 10.36 (2), a CMO shall conduct a continuous open enrollment period, accepting enrollment of any member of its target population who is enrolled by an aging and disability resource center serving the area of the CMO, without regard to life situation, health or disability status or cost sharing requirements.

(b) A CMO may not disenroll any enrollee except under circumstances specified in its contract with the department and the express approval of the department, unless the enrollee has requested to be disenrolled. When a CMO requests department approval to disenroll an enrollee, the CMO shall refer the enrollee to the resource center for counseling under s. DHS 10.23 (2) (j). A CMO may not encourage any enrollee to disenroll.

(3) SERVICE TO PRIVATE PAY INDIVIDUALS. The CMO shall provide, on a fee-for-service basis, case management and other services to private pay individuals as necessary to meet the requirements specified in s. DHS 10.37.

(4) REPORTING AND RECORDS. (a) The department shall require each CMO to report information as the department determines necessary, including information needed for all of the following:

1. Determination of whether the CMO is meeting minimum quality standards, including adequate long-term care outcomes for its enrollees.

2. Determination of the extent to which the CMO is improving its performance on measurable indicators identified by the CMO in its current quality improvement plan.

3. Determination of whether the CMO is meeting the requirements of its contract with the department.

4. Determination of the adequacy of the CMO's fiscal management and financial solvency.

5. Evaluation of the effects for enrollees and cost-effectiveness of providing the family care benefit.

(b) A CMO shall submit to the department all reports and data required or requested by the department, in the format and timeframe specified by the department.

(5) CONFIDENTIALITY AND EXCHANGE OF INFORMATION. No record, as defined in s. 19.32 (2), Stats., of a CMO that contains personally identifiable information, as defined in s. 19.62 (5), Stats., concerning a current or former enrollee may be disclosed by the CMO without the individual's informed consent, except as follows:

(a) A CMO shall provide information as required to comply with s. 16.009 (2) (p) or 49.45 (4), Stats., or as necessary for the department to administer the family care program under ss. 46.2805 to 46.2895, Stats.

(b) Notwithstanding ss. 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.22, 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), Stats., a CMO may exchange confidential information about a client without the informed consent of the client, in the county of the CMO, if necessary to enable the CMO to perform its duties or to coordinate the delivery of services to the client, as authorized 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), Stats.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; correction in (5) (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; EmR2121: r. (2) (b), eff. 8-5-21; CR 21-081: am. (2) (e) Register May 2022 No. 797, eff. 6-1-22, am. (2) (b) eff. the first day of the month after the emergency period, as defined in section 1135 (g) (1) (b) of the Social Security Act, 42 USC 1320b-5 (g) (1) (B) and declared in response to the COVID-19 pandemic, ends; correction in (2) (b) made under s. 35.17, Stats., Register May 2022 No. 797.

DHS 10.46 Department responsibilities for monitoring CMO quality and operations. (1) MONITORING. The department shall monitor CMO operations to assure quality of services and delivery, including consumer satisfaction. The department shall develop indicators to measure and assess quality in all of the following areas:

(a) Family care benefit effectiveness in increasing consumer long-term care choices, including choice of services, service providers, living arrangement and daily routine.

(b) Family care benefit effectiveness in improving access to long-term care services to support member care and choice of living arrangement.

(c) Family care benefit effectiveness at meeting the expectations of members in care and services received, reliability of the long-term care system and providers, fair and respectful treatment and privacy.

(d) Family care benefit effectiveness in assuring member health and safety, including being free from abuse and neglect, being protected against misappropriation of funds, being safe in

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chosen living arrangement, and receiving needed health services, consistent with member choices and preferences.

(2) INDICATORS. The department shall measure and assess CMOs' quality based on the areas in sub. (1) by establishing indicators. The department shall use indicators to compare performance within and across CMOs and against other programs to help improve CMO performance and ensure quality. Where possible, the department shall measure indicators against available or created benchmarks and evaluate CMOs' performance. The department shall assess the CMO's performance for the non-quantifiable indicators by using an assessment mechanism based on outcome measurement.

(3) MEASUREMENT INDICATORS. The department shall measure at least the following indicators:

(a) Preventable hospitalizations and emergency room visits.

(b) Voluntary and involuntary disenrollment.

(c) Pressure sores.

(d) Movement of members among residential settings.

(e) Medication management.

(f) Grievances, appeals and fair hearings and their disposition.

(g) Providers with consumers on governance boards and committees.

(h) Change in ability to carry out activities of daily living.

(i) Employment or other activities sought by consumers.

(j) Influenza vaccinations.

(4) ASSESSMENT INDICATORS. The department shall assess CMOs in meeting member needs through qualitative indicators in at least the following areas:

(a) Fair treatment.

(b) Privacy.

(c) Choice of routine.

(d) Maintenance of family involvement.

(e) Satisfactory community contact.

(f) Access to transportation.

(g) Choice of living arrangement.

(5) COST- EFFECTIVENESS. The department shall measure:

(a) CMO cost-effectiveness in meeting member needs within available resources.

(b) CMO financial condition.

(6) COST OF SERVICES. The department shall measure the cost of all department-funded health care services received by CMO enrollees.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (3) (f) Register November 2004 No. 587, eff. 12-1-04.

Subchapter V — Protection of Applicant, Eligible Person and Enrollee Rights

DHS 10.51 Client rights. Clients shall have the rights in family care that are outlined in the applicant information materials they receive when contacting a resource center and in the member handbook they receive prior to enrollment in a care management organization. The department shall review and approve the statement of client rights and responsibilities in each resource center's applicant information materials and in each CMO's member handbook. Client rights shall, at a minimum, include an explanation of client rights in the following areas:

(1) RIGHTS OF CLIENTS. Clients have the right to all of the following:

(a) Freedom from unlawful discrimination in applying for or receiving the family care benefit.

(b) Accuracy and confidentiality of client information.

(c) Prompt eligibility, entitlement and cost-sharing decisions and assistance.

(d) Access to personal, program and service system information.

(e) Choice to enroll in a CMO, if eligible, and to disenroll at any time.

(f) Information about and access to all services of resource centers and CMOs within standards established under this chapter to the extent that the client is eligible for such services.

(g) Support for all clients in understanding their rights and responsibilities related to family care, including due process procedures, and in providing their comments about resource centers, CMOs and services, including through grievances, appeals and requests for department review and fair hearings. Resource centers, CMOs and county agencies under contract with the department shall assist clients to identify all rights to which they are entitled and, if multiple grievance, review or fair hearing mechanisms are available, which mechanism will best meet client needs.

(h) Support for all clients in the exercise of any rights and available grievance and appeal procedures beyond those specified in this chapter.

Note: Examples of other rights and procedures available to clients include those afforded to persons who receive treatment or services for developmental disability, mental illness or substance abuse under ch. 51, Stats. and ch. DHS 94, and those afforded to persons who reside in a nursing home, community-based residential facility, adult family home or residential care apartment complex, or who receive services from a home health agency under statutes and rules of those programs.

(2) RIGHTS OF ENROLLEES. Enrollees have the right to all of the following:

(a) Support from the CMO in all of the following:

1. Self-identifying long-term care needs and appropriate family care outcomes.

2. Securing information regarding all services and supports potentially available to the enrollee through the family care benefit.

3. Actively participating in planning individualized services and making reasonable service and provider choices for achieving identified outcomes.

(b) Receipt of services identified in the individualized service plan.

(3) APPLICATION OF OTHER RULES AND REGULATIONS. Nothing in this chapter shall limit or adversely affect the rights afforded to clients in accordance with other state or federal laws or regulations. To the extent that provisions in this chapter differ from provisions affording a client rights under other state or federal laws or regulations, the provision that does most to promote the rights of the client shall be controlling.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (g) and (2) (b), cr. (1) (h) and (3), Register November 2004 No. 587, eff. 12-1-04.

DHS 10.52 Required notifications. (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:

(a) The client applies for the family care benefit and is initially counseled by a resource center about the family care benefit or enrollment in a specific care management organization.

(b) The client enrolls in a care management organization.

(2) NOTIFICATION OF ELIGIBILITY OR ENTITLEMENT. Every applicant for the family care benefit shall be notified in writing of decisions regarding eligibility, entitlement and cost sharing requirements as required under s. DHS 10.31 (6) (b).

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

(a) Notification shall be provided as follows:

1. By the county agency in every instance in which a client's eligibility or entitlement for family care will be discontinued, terminated, suspended or reduced, or in which the client's maximum cost sharing requirement will be increased.

2. By the CMO in every instance in which the CMO makes an adverse benefit determination under s. DHS 10.13 (1) (b).

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

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

1m. The effective date of the adverse benefit determination.

2. The reasons for the adverse benefit determination.

3. Any laws that support the adverse benefit determination.

4. The applicant's or enrollee's right to file an appeal with the CMO or request a fair hearing with the resource center or county agency.

5. How to file an appeal or a fair hearing and the timelines for doing so.

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

6. That if the applicant or enrollee files an appeal, he or she has a right to appear in person before the CMO personnel assigned to resolve the appeal.

7. If the adverse benefit determination will affect any services that the enrollee currently receives through the family care benefit, the circumstances in which the enrollee's services will be continued under s. DHS 10.56 pending the outcome of an appeal, how the enrollee can request that the services be continued, and the circumstances in which the enrollee may be required to repay the costs of the continued services.

8. The availability of independent advocacy services and other local organizations that might assist an applicant or enrollee with an appeal or fair hearing.

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

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (3) (b) 4. and (4) (a) and (e), cr. (3) (b) 5m. Register November 2004 No. 587, eff. 12-1-04; CR 22-026: am. (1) (intro.), (3) (intro.), (a) 2., (b) (intro.), 1., cr. (3) (b) 1m., am. (3) (b) 2. to 9., r. (4) Register May 2023 No. 809, eff. 6-1-23; correction in (3) (b) 8. made under s. 35.17, Stats., Register May 2023 No. 809.

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. The board may delegate, in writing, its responsibility for reviewing and 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 process as part of its contracting with the resource center.

(c) A resource center shall inform clients of all of the following:

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.

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

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

(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.

(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.

(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 enrollee grievances and appeals. The board may delegate, in writing, its responsibility for reviewing and 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 CMO's grievance and appeal process as part of its contracting with the CMO.

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

(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.

(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.

(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.

(dm) 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 un-

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der 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 CMO fails to render an appeal decision within the timeframe specified under sub. (2) (e), a CMO shall assist the individual with requesting a fair hearing with the division of hearings and appeals under s. DHS 10.55.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (a) to (c) and (2) (a) to (c) Register November 2004 No. 587, eff. 12-1-04; CR 22-026: am. (title), (1) (a), (b), renum. (1) (c) to (1) (c) (intro.) and am., cr. (1) (c) 1. to 4., (d) to (f), (1m), am. (2) (title), (a), (b), cr. (2) (bg), (br), r. and recr. (2) (c), cr. (2) (d) to (f) Register May 2023 No. 809, eff. 6-1-23; correction in (2) (d), (f) made under s. 35.17, Stats.,correction in numbering of (2) (dm) made under s. 13.92 (4) (b) 1., Stats., and correction in (2) (f) made under s. 13.92 (4) (b) 7., Stats., Register May 2023 No. 809.

DHS 10.54 Department reviews. (1) DEPARTMENT REVIEW PROCESS FOR GRIEVANCES FILED WITH A RESOURCE CENTER. The department shall review, investigate, and analyze the facts surrounding client grievances in an attempt to resolve concerns and problems informally, whenever either of the following occurs:

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

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

(2) TIMELINESS OF REVIEW. The department shall complete its review under sub. (1) within 20 days of receiving a request for review from a client, unless the client and the department agree to an extension for a specified period of time.

(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).

(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.

(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.

(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.

(3) 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 (3), the department shall conduct an informal review in accordance with s. DHS 10.55 (4).

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (intro.) (a) and (3) Register November 2004 No. 587, eff. 12-1-04; CR 22-026: am. (1), (2) (title), cr. (2e) to (2v), am. (3) Register May 2023 No. 809, eff. 6-1-23.

DHS 10.55 Fair hearing. (1) RIGHT TO FAIR HEARING IN RESOURCE CENTER AND COUNTY AGENCY ADVERSE BENEFIT DETERMINATIONS. Except as limited in sub. (3) and s. DHS 10.62 (4), a client 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:

(a) Denial of eligibility under s. DHS 10.31 (6) or 10.32 (4).

(b) Determination of cost sharing requirements under s. DHS 10.34.

(c) Determination of entitlement under s. DHS 10.36.

(1g) RIGHT TO A FAIR HEARING. 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.

(b) Failure of a CMO to provide timely services and support items that are included in the plan of care.

(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.

(i) An individualized service plan that is unacceptable to the enrollee because any of the following apply:

1. The plan is contrary to an enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee.

2. The plan does not provide sufficient care, treatment or support to meet the enrollee's needs and identified family care outcomes.

3. The plan requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.

Note: The rights guaranteed to persons receiving treatment or services for developmental disability, mental illness or substance abuse under ch. 51, Stats., and ch. DHS 94 are also guaranteed under par. (f), and enrollees may request a fair hearing related to such matters in accordance with this section and ch. HA 3, or may choose the grievance resolution procedure under Subchapter III of ch. DHS 94 to grieve a violation of those rights, and if necessary may choose to appeal a provider or CMO

grievance decision to the department of health services as specified in ss. DHS 94.42 and 94.44.

(j) Termination of the family care benefit.

(k) Determinations of protection of income and resources of a couple for maintenance of a community spouse under s. DHS 10.35 to the extent a hearing would be available under s. 49.455 (8) (a), Stats.

(L) Recovery of incorrectly paid family care benefit payments as provided under s. DHS 108.03 (3).

(m) Hardship waivers, as provided in s. DHS 108.02 (12) (e), and placement of liens as provided in ch. HA 3.

(n) Determination of temporary ineligibility for the family care benefit resulting from divestment of assets under s. DHS 10.32 (1) (i).

(1m) EXCEPTION TO RIGHT TO FAIR HEARING. An enrollee does not have a right to a fair hearing under sub. (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 they fall within the category of enrollees to be affected by the change.

(2) GRIEVANCES. An enrollee may contest any decision, omission or action of a CMO other than those specified under sub. (1g) by filing a grievance with the CMO under s. DHS 10.53 (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) (d), the enrollee may request a department review under s. DHS 10.54.

(3) REQUESTING A FAIR HEARING. Receipt of notice is presumed within 5 days of the date the notice was mailed. A client shall file 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 4822 Madison Yards Way, 5th Floor North, Madison, WI 53705-5400, 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.

(4) DEPARTMENT REVIEW OF FAIR HEARING REQUESTS. (a) When the division of hearings and appeals receives a request for a fair hearing under this chapter, it shall set the date for the hearing in accordance with ch. HA 3 and notify the department that it has received the request.

(b) When an enrollee has requested a fair hearing under sub. (3), the department shall conduct an informal review 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.

(5) FAIR HEARING PROCEDURES. (a) The division of hearings and appeals shall conduct a fair hearing pursuant to this section in accordance with ch. HA 3, in response to each fair hearing requested unless, prior to the scheduled hearing date, any of the following occurs:

1. The client withdraws the request in writing.
2. The contested matter is resolved under sub. (4).
3. In the case of an enrollee appealing a CMO decision, the person voluntarily disenrolls from the CMO.
4. The petitioner has abandoned the hearing request. The division of hearings and appeals shall determine that abandonment has occurred when the petitioner, without good cause, fails to appear personally or by representative at the time and place set for the hearing. Abandonment may also be deemed to have occurred when the petitioner or the authorized representative fails to respond within a reasonable time to correspondence from the division regarding the hearing.
5. An informal resolution is proposed that is acceptable to the client, and the client agrees, in writing, to the resolution or withdraws the request for fair hearing.
6. An informal resolution acceptable to the client appears imminent to all parties, and the client requests rescheduling of the fair hearing. If the informal resolution that was anticipated is, in fact, not acceptable to the client, a new hearing date shall be set promptly.

(b) In accordance with ch. HA 3, the division of hearings and appeals:

1. Shall consider and apply all standards and requirements of this chapter.
2. Shall issue a decision within 90 days of the date of receipt of the request for fair hearing.
3. May dismiss the petition if the client does not appear at a scheduled hearing and does not contact the division of hearings and appeals with good cause for postponement.

(c) An applicant for or recipient of medical assistance is not entitled to a hearing concerning the identical dispute or matter under both this section and 42 CFR 431.200 to 431.246.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 04-040: am. (1) (a), (2), and (4) (b) Register November 2004 No. 587, eff. 12-1-04; corrections in (1) (i) and (j) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 09-003: am. (1), cr. (1m) Register November 2009 No. 647, eff. 12-1-09; CR 22-026: am. (1), renum. (1) (d) to (1g) (b), r. (1) (e), renum. (1) (f) to (1g) (i), renum. (1) (g) to (1g) (j) and am., renum. (1) (h) to (k) to (1g) (k) to (n), cr. (1g) (intro.) (a), (c), (d) to (h), am. (1m) to (3), (4) (title), (b), (5) (a) 3. Register May 2023 No. 809, eff. 6-1-23; correction in (1g) (title) made under s. 13.92 (4) (b) 2., Stats., Register May 2023 No. 809.

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 an appeal with the CMO under s. DHS 10.53 (2) 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 appeal.

(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.

Published under s. 35.93, Wis. Stats., by the Legislative Reference Bureau.

(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 appeal under s. DHS 10.53 (2) 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 appeal under s. DHS 10.53 (2) 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 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.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 09-003: am. (2), cr. (2m) Register November 2009 No. 647, eff. 12-1-09; CR 22-026: am. (1), cr. (1m), am. (2) to (3) Register May 2023 No. 809, eff. 6-1-23.

DHS 10.57 Cooperation with advocates. (1) DEFINITIONS. In this section:

(a) "Advocate" means an individual or organization whom a client has chosen to assist him or her in articulating the client's preferences, needs and decisions.

(b) "Cooperate" means:

1. To provide any information related to the client's eligibility, entitlement, cost sharing, care planning, care management, services or service providers to the extent that the information is pertinent to matters in which the client has requested the advocate's assistance.

2. To assure that a client who requests assistance from an advocate is not subject to any form of retribution for doing so.

(2) COOPERATION WITH ADVOCATES. The department and each resource center and CMO shall cooperate with any advocate selected by a client. Nothing in this section allows the unauthorized release of client information or abridges a client's right to confidentiality.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00.

Subchapter VI — Recovery of Paid Benefits

DHS 10.61 Recovery of incorrectly paid benefits. County agencies, on behalf of the department, shall recover benefits incorrectly paid under the family care benefit, whether paid on behalf of individuals eligible for medical assistance or not, according to provisions of s. 49.497, Stats., s. DHS 108.03 (3) and policies established by the department or by the department of workforce development. The amount to be recovered is the amount actually paid by a CMO on behalf of a family care enrollee.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; correction made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

DHS 10.62 Recovery of correctly paid benefits. (1) RECOVERY FROM THE ESTATE OF AN ENROLLEE. The department shall file a claim against the estate of an enrollee to recover all medical assistance services provided to an individual 55 years or older while the individual was enrolled in family care. Recoveries from the estates of all family care enrollees shall be made in accordance with the provisions in ss. 49.496 (1), (3), (6m), and (7), and 49.849, Stats., and s. DHS 108.02 (11) and (12). The amount to be recovered under this section shall be equal to the amount of the total capitated payment made by the department to the CMO for the enrollee.

(a) The amount to be recovered under this section shall be the actual cost of services received by an enrollee through the family care benefit as reported to the department by the CMO in which the person was enrolled.

Note: Paragraph (a) was inadvertently left in by rule CR 23-046 and will be removed in future rulemaking.

(2) LIENS ON THE HOMES OF NURSING HOME RESIDENTS AND INPATIENTS AT HOSPITALS. The department may obtain a lien on an enrollee's home if the enrollee resides in a hospital and is required to contribute to the cost of care, or if the enrollee resides in a nursing home, and the enrollee cannot reasonably be expected to be discharged from the hospital or nursing home and return home. The department shall obtain liens under this subsection in accordance with the provisions in s. 49.496 (1) and (2), Stats. The lien is for the amount that is recoverable under sub. (1) and for costs that are recoverable under ss. 49.496 and 49.849, Stats.

(3) USE OF FUNDS. The department shall deposit amounts recovered under this section to the appropriation under s. 20.435 (4) (im), Stats.

(4) HEARING RIGHTS. An enrollee's exclusive administrative hearing rights are those specified in s. 49.496 (2), Stats., and ch. HA 3 for liens and in s. DHS 108.02 (12) for hardship waivers.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; corrections in (1) (intro.), (b) (intro.) and (4) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; correction in (1) (b) (intro.) made under s. 13.92 (4) (b) 7., Stats., Register November 2009 No. 647; corrections in (1), (2) made under s. 13.92 (4) (b) 7., Stats., Register December 2013 No. 696; corrections in (3) (b) made under s. 13.92 (4) (b) 7., Stats., Register November 2015 No. 719; CR 22-026: am. (1) (b) Register May 2023 No. 809, eff. 6-1-23; CR 23-046: renum. (1) to (1) (intro.) and am., r. (1) (b), renum. (3) (intro.) to (3) and am., r. (3) (a), (b) Register April 2024 No. 820, eff. 5-1-24.

Subchapter VII — Assuring Timely Long-term Care Consultation

DHS 10.73 Information and referral requirements for long-term care facilities. (1) PURPOSE. This section implements ss. 50.034 (5m) to (5n) and (8), 50.035 (4m) to (4n) and (11) and 50.04 (2g) to (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.

(2) APPLICABILITY. Except as otherwise specified, this section applies to a long-term care facility only to the extent that the secretary has certified under s. DHS 10.71 that one or more resource centers are available for referrals from the facility for one or more specified target groups.

(3) PROVISION OF INFORMATION REQUIRED. Subject to sub. (2), the long-term care facility shall give to each prospective resident, the resident's guardian, or a representative designated by the resident written information about the services of a resource center, the family care benefit and the availability of screening to determine the prospective resident's eligibility for the family care benefit. The facility shall provide the information at the time it

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first provides, in response to a request from the person or his or her representative, any written information about the facility, its services or potential admission, or at the time that it accepts an application for admission from the person, whichever is first. The written information shall be provided to the facility by the department or by the resource center that is the subject of the information.

(4) REQUIRED REFERRAL. (a) Subject to sub. (2), a long-term care facility shall refer a person seeking admission to the facility to the resource center serving the county in which the person resides or intends to reside, if the person has a disability or condition expected to last at least 90 days and is at least 65 years or age or has a developmental or physical disability. The facility shall make the referral when it first provides an assessment of the person's needs for nursing or residential services, or at the time that it accepts an application for admission from the person. The facility is not required to make the referral if any of the following applies:

1. The person is under the age of 17 years and 6 months.

2. A functional screen under s. DHS 10.33 has been completed for the person within the previous 6 months.

3. The person is seeking admission to the long-term care facility only for respite care.

4. The person is an enrollee of a care management organization.

5. The long-term care facility has been notified that the person was referred to the resource center by another entity within the previous 30 days.

(b) If the long-term care facility admits a person without referral because the person's disability or condition is not expected to last at least 90 days, the facility shall later refer the person to the resource center if the person's disability or condition is later expected to last at least 90 days. The facility shall refer the person within three business days of determining that the person's disability or condition is likely to last longer than was expected at the time of admission.

(c) A person seeking admission or about to be admitted to a long-term care facility on a private pay basis who is referred to a resource center need not provide financial information to a resource center or county agency, unless the person is expected to be eligible for medical assistance within 6 months or unless the person wishes to apply for the family care benefit.

(5) PENALTIES FOR RCACS AND CBRFS. (a) *Forfeiture.* If the department finds that a residential care apartment complex or a community-based residential facility has not complied with the requirements of this section, it may directly impose a forfeiture of not more than $500 for each violation. If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the facility. The notice shall specify the amount of the forfeiture assessed, the violation and the statute or rule alleged to have been violated, and shall inform the facility of the right to a hearing under par. (b).

(b) *Right to hearing.* A residential care apartment complex or a community-based residential facility may contest an assessment of a forfeiture by sending, within 10 days after receipt of notice under par. (a), a written request for a hearing under s. 227.44, Stats., to 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. The hearing shall be scheduled and conducted in accordance with the requirements of ss. 50.034 (8) (c) and 50.035 (11) (c), Stats.

Note: A hearing request should be addressed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707. Hearing requests may be delivered in person to that office at 5005 University Avenue, Room 201, Madison, WI.

(c) *Payment of forfeitures.* All forfeitures shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under par. (b), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund.

(6) PENALTIES FOR NURSING HOMES. Failure to comply with the requirements of s. 50.04 (2g) and (2h), Stats., and this section is a class "C" violation under s. 50.04 (4) (b) 3., Stats.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; correction in (1) made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635; CR 22-026: am. (1), (4) (a) 1. Register May 2023 No. 809, eff. 6-1-23.

DHS 10.74 Requirements for resource centers. The department shall establish, through its contracts with resource centers, minimum timeliness requirements for completion of resource center duties related to responding to referrals from long-term care facilities. Minimum timeliness requirements shall specify that the resource center initiate contact with the person who was referred or the person's designated representative as soon as practical following receipt of a request or referral for the screen or for long-term care services. The resource center's initial contact is for the purpose of informing the person about the family care benefit and the availability of functional and financial eligibility and cost-sharing screens and long-term care options consultation, and for setting an appointment to provide further consultation and to conduct the screen. The consultation provided by the resource center shall meet the requirements for long-term care options counseling under s. DHS 10.23 (2) (c) and shall be provided in conjunction with performance of the functional and financial eligibility and cost-sharing screens or at another mutually agreed upon time.

History: Cr. Register, October, 2000, No. 538, eff. 11-1-00; CR 23-046: am. Register April 2024 No. 820, eff. 5-1-24.