Chapter DHS 73

SELECTED FISCAL MANAGEMENT PROCEDURES AND STANDARDS UNDER THE MEDICAL ASSISTANCE HOME AND COMMUNITY–BASED SERVICES WAIVER

Note: Chapter HSS 73 was renumbered chapter HFS 73 under s. 13.93 (2m) (b) 1., Stats., and corrections were made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, July, 2000, No. 535. Chapter HFS 73 was renumbered to chapter DHS 73 under s. 13.92 (4) (b) 1., Stats., and corrections made under s. 13.92 (4) (b) 7., Stats., Register November 2008 No. 635.

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

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93; emerg. am. eff. 1–1–96; am. Register, May, 1996, No. 485, eff. 6–1–96; CR 00–056: am. Register August 2001 No. 548, eff. 9–1–01; **CR 22–026: am. Register May 2023 No. 809, eff. 6–1–23.**

DHS 73.02 Applicability. This chapter applies to county departments and private non–profit agencies with which the department contracts to provide home and community–based services through a medical assistance waiver, and to vendors providing assessments, case plans or supportive home care services funded under a medical assistance waiver.

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93; **CR 22–026: am. Register May 2023 No. 809, eff. 6–1–23.**

DHS 73.03 Definitions. In this chapter:

(1) "Assessment" means a process for determining a person's functional abilities and disabilities and the person's need for and preferences in regard to medical and social long–term community support services.

(2) "Case manager" means an employee of a county department or vendor agency responsible for locating, managing, coordinating and monitoring the services and informal community supports identified in a participant's case plan.

(3) "Case plan" means a comprehensive community services plan specifying the types and amounts of services to be provided, the methods of service delivery and the coordination with informal community supports.

(3m) "CBRF" or "community–based residential facility" has the meaning specified in s. 50.01 (1g), Stats.

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

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

(7) "Home and community–based services" means services that are provided under a medical assistance waiver as an alternative to institutional care.

(8) "Household care" means household tasks and home maintenance activities that do not change the physical structure of the home, including shopping, meal preparation, cleaning, laundry, bed–making, simple home repairs, errands and seasonal chores.

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

(9) "Medical assistance" means the assistance program operated by the department under ss. 49.43 to 49.497, Stats.

(10) "Medical assistance waiver" means a waiver granted to the department by the secretary of the U.S. department of health and human services under 42 USC 1396n (c), authorizing the department to provide home and community–based services as part of the medical assistance program.

(11) "Participant" means a person receiving an assessment, case plan or supportive home care services funded under a medical assistance waiver.

(12) "Participant's representative" means a person designated in writing by the participant to act on behalf of the participant in making decisions about or directing the provision of services received by the participant.

(13) "Primary caregiver" means the person providing the majority of unpaid, informal care to the participant.

(14) "Private non–profit agency" means a nonprofit corporation, as defined in s. 181.0103 (17), Stats., that provides a program of all–inclusive care for the elderly under 42 USC 1395eee or 1396u–4.

(15) "Respite care" means care and supervision to a participant in a homelike environment for purposes of giving the primary caregiver temporary relief, relieving the primary caregiver of the stress of giving continuous support.

(16) "Service provider" means an individual employed to provide supportive home care services to a participant, whether that individual is employed by the participant, the participant's representative, a county department or a vendor agency.

(17) "Supportive home care" means the provision of services except nursing care that are intended to maintain participants in independent or supervised living in the participant's own home or the home of the participant's friends or relatives, which help the participant meet his or her daily living needs, address the participant's needs for social contact, ensure the participant's well being, and reduce the likelihood that the participant will have to move to a nursing home or other alternate living arrangement.

(17m) "Terminally ill" means a medical prognosis that an individual's life expectancy is less than 12 months.

(18) "Vendor agency" means an agency from which a county department purchases supportive home care services for participants.

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93; emerg. cr. (3m) and (8m), eff. 1–1–96; cr. (3m), (8m) and (17m), Register, May, 1996, No. 485, eff. 6–1–96; correction in (6) made under s. 13.92 (4) (b) 6., Stats., Register November 2008 No. 635; **CR 22–026: r. (4), am. (5), (8m), (11), (14) Register May 2023 No. 809, eff. 6–1–23; correction in (14) made under s. 35.17, Stats., Register May 2023 No. 809.**

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

(2) CASE PLAN. The county department shall develop a case plan for non–institutional community services for a person who is assessed and for whom services are feasible, can be financed with available state and federal funds and are preferred to nursing home care by the person or the person's guardian. The case plan shall specify the types and amounts of services to be provided, the manner of service delivery and the assistance to be provided by informal community supports and shall incorporate the participant's preferences to the maximum extent possible.

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register August 2001 No. 548; **CR 22–026: am. (1) Register May 2023 No. 809, eff. 6–1–23.**

DHS 73.06 Development of service agreements. (1) REQUIREMENT FOR NEGOTIATED AGREEMENT. Except when a county department expects services to be provided for less than 30 days, after an assessment and case plan have been completed and within 2 weeks after the initiation of service by the service provider, an agreement or agreements on services to be provided the participant shall be negotiated.

(2) PARTICIPANT EMPLOYMENT OF SERVICE PROVIDER. If the service provider is employed by the participant or participant's representative, there shall be 2 service agreements unless the county department and the participant or participant's representative decide that a single agreement is preferable. A single agreement involving the county department, participant or participant's representative and service provider shall cover all required items in the 2 agreements. If there are 2 agreements, they shall be the following:

(a) A signed agreement between the county department and the participant or participant's representative, which shall set out in writing:

1. The specific services that will be provided;

2. The amount of funds the county department will provide;

3. Procedures for transfer of funds by the county department;

4. A requirement that any service provider employed by the participant or participant's representative shall be qualified on the basis of experience, training or both to perform required tasks, and that any training needed by the service provider shall be completed within 6 months after beginning employment or after February 1, 1993 whichever is later; and

5. That the county department or a vendor for the county department shall act as fiscal agent for the participant or participant's representative for the purpose of performing the tasks required to comply with wage, benefit and tax laws applicable to the employer, unless the participant or participant's representative makes an informed, knowing and voluntary waiver of the use of a fiscal agent; and

(b) Except as provided in sub. (3), a signed agreement between the participant or participant's representative and the service provider, which shall set out in writing:

1. The services the service provider will perform;

2. The service provider's normal schedule of work or a specification of how scheduling will be accomplished;

3. When and how any training needed by the service provider will be furnished and completed;

4. The service provider's rate of compensation; and

5. Verification and payment procedures to be followed consistent with s. DHS 73.09 (1) to (3).

(3) EXEMPTIONS. The service agreement between the participant or participant's representative and service provider under sub. (2) (b) is not required when:

(a) The services provided are limited to household care;

(b) The services are provided by the spouse of the participant or by the parent of a minor participant; or

(c) The services are for the purpose of providing respite care.

(4) COUNTY DEPARTMENT OR VENDOR AGENCY EMPLOYMENT OF SERVICE PROVIDER. (a) If the service provider is employed by the county department or a vendor agency, there shall be either a single signed agreement among the participant or participant's representative, the county department and, where applicable, the vendor agency, or separate signed agreements, one between the participant or participant's representative and the county department and the other between the participant or participant's representative and the vendor agency.

(b) The agreement or agreements required under par. (a) shall contain at least the content specified in sub. (2) (a) 1. to 4. and (b), except that verification and payment procedures under sub. (2) (b) 5. and training arrangements under sub. (2) (b) 3. may be omitted if these do not directly involve the participant and are covered elsewhere either in written policy of the county department or in its contract with the vendor agency.

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93.

DHS 73.08 Supervisory review of payment decisions. (1) The county department shall develop and implement written procedures for supervisory review of staff decisions regarding the competence of a participant to receive funds to pay a service provider and appropriateness of the levels of funds based upon the needs identified in the participant's assessment and services authorized in the case plan for the participant.

(2) In conducting a review of a case in which a participant or participant's representative receives funds, the supervisor shall examine:

(a) The capability of the participant or participant's representative to manage funds and act as employer of the service provider;

(b) The adequacy of the funds provided compared to the level of need identified in the participant's assessment; and

(c) The adequacy of any training provided to the participant or the participant's representative to enable the participant or participant's representative to manage funds and serve as an employer.

(3) The supervisor's review shall occur within 3 months after the initial disbursement of funds to a participant who receives funds for the first time on or after February 1, 1993 and within 9 months after February 1, 1993 for a participant who was receiving payments prior to February 1, 1993, and thereafter whenever there is a substantial change to the participant's condition or need for services. Alternatively, the county department may conduct a supervisor's review on a random sample of at least 10% of cases or 25 cases, whichever is greater, in which a participant receives

funds. County departments with fewer that 25 cases shall review all cases. This review shall be completed within 12 months after February 1, 1993 and within every 12 months thereafter.

(4) A county department may contract with a third party for supervisory review under this section.

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93.

DHS 73.09 Documentation that services have been provided. (1) If a participant or the participant's representative employs a service provider, the county department shall verify the type and amount of service for which reimbursement is sought. A verification form developed and available from the county department shall either be submitted to the county department by the participant or participant's representative or be reviewed by the case manager at the participant's residence at least every 6 months.

(2) The completed verification form shall include the following information:

(a) The type or types of services provided;

(b) The number of hours of service provided in the past month or, if the service provider lives in the residence of the participant, the number of days of service provided in the past month;

(c) The total dollar amount paid for the services;

(d) The month in which the services were provided;

(e) The dated signature of the participant or participant's representative; and

(f) The dated signature of the service provider.

(3) The county department may provide in the form under sub. (2) that the information in sub. (2) (b) does not have to be maintained or reported if:

(a) The services provided are limited to household care;

(b) The services are for the purpose of providing respite care; or

(c) The services are provided by the spouse of the participant or by the parent of a minor participant.

(4) If a county department directly provides services or purchases services from a vendor agency, the county department and vendor agency, if any, shall establish procedures sufficient to document the amount of services provided to each participant each month.

History: Cr. Register, January, 1993, No. 445, eff. 2–1–93.

DHS 73.10 Individual hardship exceptions to limits on funding for CBRF care. (1) LIMITATION ON FUNDING. Each county shall annually establish limits on spending for services for persons who reside in CBRFs from the allocations received under s. 46.277 (5), Stats., for community long–term support services.

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

History: Emerg. cr. eff. 1–1–96; cr. Register, May, 1996, No. 485, eff. 6–1–96; CR 00–056: am. (1), Register August 2001 No. 548, eff. 9–1–01; **CR 22–026: am. (1), (2), r. (3) Register May 2023 No. 809, eff. 6–1–23.**

DHS 73.11 Criteria for determination of the infeasibility of in–home services. (1) A county may use long–term support funds under s. 46.277, Stats., to provide services to a person residing in a CBRF if the county department or aging unit has determined that all 5 conditions under s. 46.277 (5) (d) 1n., Stats., have been met.

Note: The five conditions are: the completion of an assessment before the person's admission; determination of the infeasibility of in–home care; determination that the CBRF is the person's preferred residence; determination that the CBRF provides a quality environment and quality care services; and determination that the CBRF is cost–effective when compared to other residential options.

(2) To determine in–home care is infeasible, the county department or aging unit shall document in writing that all of the following have occurred:

(a) A change has occurred in the individual's condition, functioning, living situation or supports so that arrangements that were in place and adequate to maintain the individual's health, safety and well–being are no longer sufficient to provide or ensure the provision of what the individual needs.

Note: Examples include, but are not limited to, when a spouse or other family member who has been a major caregiver dies or for some other reason can no longer provide care, or when there is a major change in the medical condition of a program participant such as a stroke or heart attack and there is need for more care and support but the additional funds or needed caregivers are for some reason not available.

(b) Options for supporting the individual in his or her own home and community have been explored or attempted but have either failed or been found to be unavailable or not possible.

Note: Examples of efforts include, but are not limited to, other relatives, friends, neighbors or volunteers have been contacted; professional workers from a home health agency have been recruited and have attempted unsuccessfully to work with the individual in his or her home; and other options such as modifying the home and providing adaptations and aids to enable the individual to be more independent or obtaining nutritional services, adult day care and transportation are not available, feasible or cost–effective.

History: CR 00–056: cr. Register August 2001 No. 548 eff. 9–1–01; **CR 22–026: am. (1) Register May 2023 No. 809, eff. 6–1–23.**