November 4, 2025

Sen. LeMahieu
Wisconsin State Capitol, Rm 211 S
Madison WI 53707

Sen. Hesselbein
Wisconsin State Capitol, Rm 206 S
Madison WI 53707

Speaker Vos
Wisconsin State Capitol, Rm 217 W
Madison WI 53708

Rep. Neubauer
Wisconsin State Capitol, Rm 201 W
Madison WI 53708

Re: Patient's Representative bill (SB 578/AB 598)

Distinguished members of the State Legislature:

Aging, disability, legal, and patient advocates have significant concerns that the Patient's Representative bill (SB 578/AB 598) as drafted does not resolve the issue it seeks to address, creates new legal and operational issues, and increases risks for patients and families. This bill is substantively the same as last sessions' bill and does not resolve the concerns raised by patient advocates last session.

Wisconsin has deliberately designed its statutes and regulations to safeguard the rights of individuals; this bill bypasses those protections.

While other states have Next of Kin laws, those laws are not as expansive as what is being proposing in SB 578/AB 598 (e.g. those laws – do not authorize financial expenditures, are time limited, do not authorize admission into long-term care facility, contains safeguards, etc.). Wisconsin also has requirements for Protective Placement which other states do not have and has a more explicit process under Wis. Stats. 50.06 that allows for a surrogate to admit an incapacitated person to a post-acute care facility (many states with next-of-kin laws are often silent on admission authority).

The authority given to Patient's Representatives in SB 578/AB 598 is fundamentally different from the existing authority and patient protections included in the Health Care Power of Attorney Statutes (Wis. Stats. Ch 155). They differ in consequential ways and would lead to incongruency in patient rights and powers given to decision makers. We have appended a comparison chart to this memo.

Family members, friends, and legal representatives are the most common people involved in allegations of financial exploitation or abuse (APS, BOALTC data) and in complaints regarding care quality and rights violations (BAL State of Assisted Living - Source of Complaint CY 2024). While the family involvement can be protective, that closeness gives them power. When that power goes unchecked, it risks causing significant harm, especially to vulnerable individuals. We know the system already depends heavily on families, and while we can take proactive steps to help families understand patient rights, their roles, and responsibilities as representatives, we also need policies/oversight mechanisms that protect individuals from relationships that go awry.

SB 578/AB 598 bill DOES NOT:

- Provide a mechanism for decision-making for incapacitated individuals who remain in inpatient care.
- Require any screening or background checks to prevent individuals with financial motives or history of abuse from being appointed as a patient representative.
- Establish a process for contesting the appointment of a patient representative whose decisions or priorities conflict with those of the individual.
- Sets no limits on how long a patient representative can make decisions on behalf of the individual.
- Require that the finding of incapacity – or the appointment of a patient representative – be communicated to the individual. As a result, a person may lose their right to make their own decisions without knowing who is acting for them and why.
- Provide a mechanism for the individual to object to decisions made by the patient representative (other than the decision to admit)
- Ensure oversight of health care decisions. Instead, the bill grants the patient representative decision-making authority that is equivalent to that of a guardian of person, but without any court oversight. That would allow patient representatives to override the individual's wishes and authorize involuntary care (with some exceptions). Agents authorized under a Health Care Power of Attorney do not have that authority, and Guardians of the Person are subject to court oversight.
- Specify when or whether an incapacitated individual must be re-evaluated for capacity, who can/must perform the evaluation, or who is responsible for ensuring it occurs.
- Provide any requirements or timelines for a court to hear a petition reviewing the patient representative's conduct.
- Authorize a court to remove the patient representative.
- Provide a process for patient representative to resign, and does not address what happens if the representative becomes incapacitated or dies.
- Define what is included in "health care expenditures."
- Clarify whether a patient representative can liquidate assets (including real estate) on limits of the PR's ability to liquidate assets (including real estate) to privately pay for placement and/or to spenddown to be eligible for Medicaid.
- Clearly authorize a patient representative to access bank accounts, retirement accounts, life insurance policies, and other financial information used to verify Medicaid eligibility.
- Speak to what happens when a patient is transferred to a different facility or between facilities.
- Specify who in the hospital must notify corporation counsel or Adult Protective Services, set timelines for such notification, or outline consequences if notice is not provided.
- Address what happens if the individual has no known county of legal residence or if their most recent residence was in another state.

The bill does not address root causes of Hospital discharge delays.

SB 578/AB 598 is based on the claim that individuals who have been evaluated and declared medically incapacitated and do not have a Power of Attorney or Guardian remain hospitalized longer than necessary because the guardianship process is lengthy and costly. However, the bill fails to consider other root causes and contributing factors that result in discharge and placement delays.

In the experience of the Long-term Care Ombudsman and other advocates, hospital discharge delays are often caused by the following factors that the bill does not address:

- **Facility Acceptance Issues:** It can be challenging to find a nursing home or assisted living facility with an available bed with the staffing needed to accommodate the patient's level of care needs, especially if the patient does not have a known funding source to pay for their post-inpatient care. Hospitals frequently send referrals to multiple facilities, casting a wide net, hoping one will accept.

  As a result, individuals are sometimes discharged to facilities far from their home and family because those are the only options available. This issue is particularly acute for rural residents living in areas with few providers or that have had facility closures. For individuals with dementia who exhibit challenging behaviors or those with complex behavioral health needs, the availability of facilities equipped to manage these conditions remains limited.

- **Medicaid Eligibility Determinations:** Because facilities may not accept a patient without a known funding source, some patients may not be able to find a bed until a Medicaid application has been approved. Medicaid eligibility can take up to 30 days to determine while county workers verify income, assets, and legal status. These checkpoints help prevent fraud and abuse of the Medicaid system by ensuring that everyone who receives Medicaid benefits is eligible for them, but they can take time to be done correctly. The more complex a person's finances, the longer verification can take. Issues like divestment can lead to denials and further delays.

  If an individual is evaluated for eligibility for home and community-based waiver programs like Family Care and IRIS, a functional screen must first be completed – a process that allows up to 30 days – before the Medicaid application can even begin. As a result, it can take 60 days before both functional and financial eligibility are established, the person is enrolled in a program, and funding for placement in assisted living or home-based services becomes available.

  Even with a legal representative in place, Current DHS policy does not allow an individual's health care agent to sign a Medicaid application on their behalf, which means that if an individual has a valid health care power of attorney but no financial power of attorney, there may be no one who can sign the application. These patients may still need a temporary or permanent guardian of the estate appointed before a Medicaid application can even be

initiated. This bill only addresses situations in which there is no valid *health care* decision-maker—it will not address this need.

- **Coordination with Family Care Managed Care Organizations (MCOs):** Effective discharge planning for Family Care members depends on early and consistent communication with the member's care team. However, hospitals do not always know whether a patient is enrolled in managed care and may rely on patient records, verbal reports, or ADRCs to obtain contact information. Placement and service options are then limited to the MCO's provider network and approved through a resource allocation decision process which emphasizes least restrictive and cost-effective options. Although guidance exists to delineate roles between MCOs and hospital discharge planners, coordination remains inconsistent. In some cases, members have been discharged without the necessary supports in place—and in the most severe cases, individuals experiencing homelessness have been discharged to the streets without care teams being notified.

- **Insufficient Community Services:** Despite some post-pandemic improvements, provider capacity and staffing shortages continue to limit access to home care services. Hospitals may facilitate referrals but follow-through often falls on patients and families. Even when home care is arranged, service start dates can be delayed or provider agencies may be unable to offer enough hours to meet the person's full needs. Private-pay individuals may also struggle to piece together adequate care between agencies and natural support. As a result, some patients who might have been able to discharge to their homes with care and services in place may end up remaining in the hospital longer or needing facility care instead.

- **Relocation Complications:** When an individual cannot return to their previous setting after hospitalization – most often because their condition now requires a higher level of care – discharge planning becomes especially difficult. Affordability, availability, and facility acceptance all play significant roles.

These barriers often compound, making it increasingly complex to arrange a timely and appropriate discharge.

A recent Kaiser Health News article focused on Marshfield Clinic's approach to solving delayed discharge through rehabilitation at home. The article states that patients nationwide are stuck in hospitals because nursing homes and physical rehabilitation facilities are full, which matches the experience of our state long term care Ombudsman and others.

Additionally, there is a growing demographic of people who do not have family or other close relationships that could be tapped to serve as a Patient's Representative (assuming someone was willing to do so).

Case example

The following case example is a common scenario and illustrates how the multiple systemic barriers discussed in the previous section result in prolong hospital stays. **Having a patient representative in place does not address the root causes that kept this person hospitalized longer than desired or necessary.**

Al was an older adult living at home with his spouse and experiencing progressive dementia. As his disease advanced, he became increasingly agitated and sometimes violent. One day, his behavior escalated to the point that his spouse was no longer safe and, exhausted from caregiving, agreed to his hospital admission as an emergency protective placement under Chapter 55.

While the county initiated permanent guardianship and protective placement proceedings, the family worked with the hospital and the ADRC to explore placement options. They knew Al could not return home and would need memory care. The family's financial resources were limited, so they began the Medicaid application process. However, a prior divestment caused a delay in eligibility. The family filed an undue hardship request, which was approved, and Al became eligible for Medicaid.

Once enrolled in Family Care, the managed care organization began seeking placement. Because Al was labeled as having aggressive behavior, finding a facility willing to accept him proved extremely difficult. The entire process took months. Al remained in the hospital throughout that time, where his health declined until he required hospice. Ultimately, the family brought him home, and he passed away just days later.

Sincerely,

Aging and Disability Professionals Association of Wisconsin

Alzheimer's Association – Wisconsin Chapter

Corporate Guardians, Inc.

Disability Rights Wisconsin

Greater Wisconsin Agency on Aging Resources

InControl Wisconsin

Survival Coalition of Wisconsin Disability Organizations

Wisconsin Aging Advocacy Network

Wisconsin Board for People with Developmental Disabilities

Wisconsin Board on Aging and Long Term Care

Wisconsin Coalition of Independent Living Centers

Wisconsin Guardianship Association

Wisconsin Guardianship Support Center

Wisconsin Personal Services Association

WINGS Wisconsin