1999 DRAFTING REQUEST

Bill

Received: **09/22/98**

Received By: **yacketa**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget**

By/Representing: **Fossum**

This file may be shown to any legislator: **NO**

Drafter: **yacketa**

May Contact: **Thomas Hamilton, DHFS**

Alt. Drafters: **kahlepj**

Subject: **Public Assistance - med. assist.**
Insurance - health

Extra Copies: **DAK**

Topic:

DOA:.....Fossum - Pathways to independence

Instructions:

See Attached

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May Contact: **Thomas Hamilton, DHFS**
Karen Tritz - 602361

Alt. Drafters: **kahlepj**

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DHFS

Department of Health and Family Services
1999-2001 Biennial Budget Statutory Language Request
September 11, 1998

Pathways to Independence Medicaid Assistance Plan

Current Language

Current statutes establish eligibility for Medicaid (s.46.45) and for the Health Insurance Risk-Sharing Pool (Ch. 149).

Proposed Changes

Revise the statutes to provide Medicaid eligibility for certain individuals who are engaged in paid employment or participate in a work-related health care management system under section 4733 of the 1997 Budget Adjustment Bill and Section 1902(r)2 of the Social Security Act; and establish protocols for Medicaid and HIRSP programs to work together for such individuals, as follows:

Definitions:

- *Exempt Assets*- Exempt assets are those specified by the Supplemental Security Income program rules (42 U.S.C. 1382b) and those deposited in an "Independence Account" approved by the Department, except that the Department may establish a higher exemption value for a vehicle used by the individual for transportation to the site of paid employment. Spousal impoverishment protection applies in calculating the amount of exempt assets.

- *Exempt Income*- Exempt income includes (a) a basic living allowance established by the Department which is not less than the medically needy income limit, (b) medical and remedial expenses paid by the individual and other expenses normally exempted for purposes of Medicaid eligibility determinations, (c) an exceptional housing needs allowance established by the Department, not to exceed 50% of the basic living allowance and (d) interest, dividends or capital gains accrued within an Independence Account.

- *Independence Account*: An Independence Account is a designated account approved by the Department which consists entirely of savings, and dividends or other gains from those savings, which have been derived solely from income earned from paid employment after the initial date an individual began participating in the Pathways Medicaid Assistance Plan.

- *Disability*: defined under 42 USC 1382c (a) (3).

- *Work-Related Health Care Management Program*: Any program approved by the Department to work with people with disabilities for the purpose of securing and sustaining paid employment with continuity of health coverage, including Pathways to Independence and programs established under s. 46.27, 46.275, 46.278.

- *Pathways to Independence*: A program established to work with people with disabilities for the purpose of securing and sustaining paid employment with continuity of health and long term care coverage pursuant to a grant from the Robert Wood Johnson Foundation received September 1, 1998.

- *Pathways Medicaid Assistance Plan ("the Plan"):* A plan established under provisions of the federal Balanced Budget Act of 1997 (P.L. 105-33, Section 4733) and section 1902(r)2 of the Social Security Act to remove employment barriers by enabling people with substantial disabilities to purchase health and long term care coverage at affordable rates, and disregarding earned and unearned income for initial eligibility determination in lieu of sliding scale premiums.

Department Duties and Authority:

- Submit for federal approval amendments to the Medicaid State Plan and any necessary waivers to implement the Pathways Medicaid Assistance Plan, and implement the program no later than January 1, 2000 or within 3 months of federal approval, whichever is later.

- Amend section 47.27 and all Wisconsin MA waivers under s. 1915(c) of the Social Security Act to include PMAP participants as an eligible medical status group, and require that such programs pay the entry premium for any person who has been determined eligible for Community Options or a s. 1915(c) waiver at the time the person elects to participate in the Pathways Medical Assistance Plan.

- Submit federal waivers or Medicaid State Plan amendments that would increase the availability or affordability of Medicare coverage for persons whose acute care, home health, or physician care would otherwise be paid by Medicaid under this plan.

- Promulgate rules for the operation of the plan, including appeal and grievance procedures.

- Purchase or pay premiums for individual coverage offered by employers under circumstances in which the department determines that purchasing that coverage would not be more costly than providing coverage under this section. Maximize the availability of coverage under private insurance or Medicare. Pay Medicare Part A and Part B premiums for persons eligible under the plan.

- Determine eligibility of persons for the plan, collect premiums, provide quality assurance, and perform any other duties necessary for the proper and effective administration of the plan.

- Establish methods by which Plan participants who are engaged in paid employment but later become ineligible for the Plan are able to achieve continuity of health care coverage.

County Duties:

- Provide information to prospective applicants, determine eligibility under contract with the department, and work with the Department and Plan participant to ensure continuity of health coverage for any Plan participant who later loses eligibility for coverage under the Plan.

Eligibility

All of the following criteria must be met:

- The family's net income does not exceed 250% of the federal poverty line as defined under provisions of the federal Balanced Budget Act of 1997 (P.L. 105-33, Section 4733) and section 1902(r)2 of the Social Security Act, unless the Department has established a higher limit. In accordance with the Balanced Budget Act, net income will be determined using the SSI-disregards including disregarding $65 plus 1/2 of all earned income, $20 of unearned income, and all impairment related work expenses as defined by the Social Security Administration. After 18 months of operation, the department may set higher income thresholds (under 1902(r)(2) of the U.S. Social Security Act) if the department judges such higher levels to be cost-effective and the federal government has approved federal financial participation.

- The individual does not have over $20,000 in non-exempt assets. Assets accumulated in Independence Accounts are also disregarded before determining eligibility. The Department may raise the level of non-exempt assets after 18 months of program operation if it judges such an increase to be necessary for meeting the employment goals of the department and is within existing fiscal resources.

- When resources and substantial gainful activity (SGA) are ignored, the individual meets the non-financial criteria for SSI-disabled (42 U.S.C.1382c).

- The individual is legally eligible for paid employment in Wisconsin.

- For individuals under age 18, the deeming of parental income and assets will apply when determining eligibility.

- The individual maintains premium payments, or enters into an agreement with the Department for the gradual recovery of missed payments.

- The individual meets all other requirements established by the department by rule, including evidence of earned income or participation in a work-related health care management program.

Monthly Premium

The department may assess monthly premiums based on the following criteria:

- Monthly premiums will be reduced by 25% for individuals who are also covered by private health insurance as an incentive for maintaining their private coverage.

- Monthly premiums will be the sum of the following:

    - Earned Income: 3 to 3.5 percent of an individual's earned income and
    - Unearned Income: 100% of an individual's non-exempt unearned income.

  The department may use premium bands of earned income so that small changes to income do not result in burdensome changes in premiums.

- Monthly premiums calculated to be below $10.00 may be waived for administrative cost-efficiency.

- For individuals under age 18, the deeming of parental income and assets will apply when determining monthly premiums.

- If permitted by federal law, the Department also increase the monthly premium by a sliding fee schedule based on the sum of non-exempt assets which exceeds a level established by the department. The

Entry Premium

The department may assess a one-time entry premium based on sliding scale calibrated to the amount of an individual's gross income, except that parental income shall be deemed available in the case of a person under age 18. The Department may treat earned and unearned income differently for purposes of calculating the entry premium amount Example:

Gross Monthly Income for an Individual	Entry Premium
$0 - $800	$0
$801-$1000	$25
$1001-$1200	$150
$1201-$1500	$250
$1501-$2000	$500
$2001-$2500	$1000
$2501+	$1500

The department may raise or lower the entry premium in order to meet the program intent. The department may waive all or part of the entry premium for an applicant or extend the payment schedule for the entry premium based on application of uniform, objective criteria which results in a department finding that: undue hardship would result which is injurious to the program's intent, cost-effectiveness of the program would be reduced, or the public interest would not be served.

For individuals under age 18, the deeming of parental income and assets will apply when determining entry premiums

Community Options Program Participants:

- Participants in the Community Options Program who are not participating in a Medicaid waiver under s. 1915(c), but who would be eligible for the Medicaid Purchase Plan, will be required to participate in this program and would become Waiver participants. The department may make an exception to this requirement if it judges that a strict application would result in undue hardship or would not be cost-effective in terms of state costs.

- Individuals subject to the above waiver mandate who were participating on the regular Community Options Program under 46.27(7) but later lost eligibility under the Plan will have top priority on any wait list for an opening under s.46.27(7).

- The Community Options Program shall pay the entry premium for individuals who were in the Community Options Program and transferred to the Medicaid Purchase Plan as a result of changes in eligibility requirement. The Community Options Program may pay the monthly premium of COP recipients who become eligible for a Medicaid Purchase Plan.

- The Department may transfer funds from the Community Options appropriation to the Medicaid appropriation and to the Department's administrative expense appropriation. Such transfers are possible because GPR funds will be freed as a result of increased federal financial participation and will be required to defray the expenses under Pathways.

Changes to Chapter 149, HIRSP

- Individuals may be HIRSP-eligible while participating in the Pathways Medicaid Assistance Plan.

- Individuals who are found eligible for the Pathways Medicaid Assistance Plan but are also enrolled under HIRSP shall be retained as HIRSP-eligible with dormant HIRSP benefits. An individual who was enrolled in HIRSP within 3 months prior to a successful application for coverage under the Pathways Medicaid Assistance Plan shall be re-enrolled in HIRSP if all other HIRSP eligibility requirements are met, except that previous non-payment of HIRSP premiums shall not be a cause for rejection of re-enrollment.

- HIRSP shall transfer annually to the department's Medicaid General Program Revenue Fund an amount equal to the sum expended by Medicaid for services covered under the HIRSP plan, less net premiums which would have been charged to policyholders.

- Individuals who are dually enrolled for HIRSP and the Pathways Medicaid Plan will be waived from paying HIRSP premiums and deductibles as they will already be paying premiums under the Pathways Medicaid Plan

Community Aids – See Community Aids statutory changes under the Family Care Proposal.

Effect of Change

This initiative accomplishes the following:

- Removes major barriers to employment on the part of people with disabilities,
- Substitutes sliding scale eligibility for Medicaid for certain people who meet the SSI/SSDI disability test instead of the current "all or nothing" eligibility system,
- Reduces the cost of the Department's Family Care initiative by capturing federal financial participation,
- Saves current GPR dollars by capturing FFP to defray insurance or service costs currently paid entirely by GPR funds in the regular Community Options Program, the AIDS-HIV Insurance Subsidy Program, and the Health Insurance Risk-Sharing Pool.

Rationale for the Change

The loss or fear of losing health or long term care coverage is a major impediment to employment on the part of people with significant disabilities. For persons on SSDI who may have Medicare coverage, the inability to access personal care, transportation, or other supports available under Medicaid often make the difference between working and not working. Finally, it is in the state's interest to capture federal financial participation where 100% GPR funds are currently used.

Desired Effective Date: Upon Passage
Agency: DHFS
Agency Contact: Thomas E. Hamilton
Phone: 266-9304

OSF

Department of Health and Family Services
Office of Strategic Finance
PO Box 7850
Madison WI 53707-7850
Phone (608) 266-3816
Fax (608) 267-0358

Date: October 21, 1998

To: Gretchen Fossum
Department of Administration

From: Thomas Hamilton
Center for Delivery Systems Development

Subject: Pathways Medical Assistance Plan Questions

Below are responses to the questions posed to Fredi Bove which cover the Pathways Medical Assistance Plan and Pathways to Independence.

1. Clarification of the population eligible for the Pathways Medical Assistance Plan.

Individuals eligible for the Pathways Medical Assistance Plan must meet the following criteria:

- Meets the SSI-disabled criteria. Includes all disability categories (e.g. physically disabled, mentally ill, blind, etc.);
- Is eligible for paid employment in Wisconsin (ages 14-65). Under the current federal requirements we can not set specific age limits;
- Is working or is enrolled in a work-related health care management program which is approved by the Department (this would include Pathways to Independence, Community Options Program, etc.);
- Meets the financial eligibility criteria.

Enrollment in the Pathways Medical Assistance Plan is voluntary for all groups (including Pathways to Independence participants). However, for Community Options Program recipients the waiver mandate for the current home and community based waiver does apply.

2. Composition of exempt income

Exempt income includes (a) a basic living allowance established by the Department which is not less than the medically needy income limit (our proposal is to set this at the SSI payment level for which the person is eligible), (b) medical and remedial expenses paid by the individual and other expenses normally exempted for purposes of Medicaid eligibility determinations, (c) an exceptional housing needs allowance established by the Department, not to exceed 50% of the basic living allowance and (d) interest, dividends or capital gains accrued within an Independence Account.

3. Types of savings, dividends and capital gains involved in Independence Accounts. Is there an upper dollar limit on these accounts?

The intent of the Independence Account is to create a designated account approved by the department in which individuals could deposit earned income. The upper dollar limit on these accounts would be bound by the total amount of earned income received by the individual over that time period, minus taxes estimated at 10%.

For example, if an individual earned $500 per month, the maximum amount allowed in the account for any one month would be 90% * $500 = $450, plus an IRA or any employer-sponsored retirement accounts. ***Given that earnings will limit the amount available to put into an independence account, there is no separate arbitrary dollar cap.***

Our goal is to create incentives for savings provided the savings comes from employment, and also to avoid creating a large bureaucracy of complex rules or excessive administrative costs around the Independence Account. The Independence Account results will be part of the Pathways evaluation.

4. Why would the department require the counties or the state to pay the entry premium "for any person determined eligible for COP or a s. 1915(c) waiver at the time the person elects to participate in the Pathways Medical Assistance Plan?"

If we could write the MA State Plan Amendment in such a way that regular COP participants will be exempt, that would be great. However, so far HCFA has told us that is not permitted because it treats one class of MA applicants differently than others who apply.

If we pay the entry premium, certain individuals enrolled in regular COP would become MA eligible under the purchase plan and thereby become subject to the MA waiver mandate. This could be COP-W or CIP IB or any other waiver which applies.

5. Why would children be included in the buy-in? Are these working teenagers no longer attending school?

The intent for the Pathways Medical Assistance Plan is to provide access to health care for *adults* with disabilities who want to work. Unfortunately, the law, as written, does not include the ability for states to set specific age requirements. Therefore, we have included statutory language which attempts to target this program to adults; specifically, we propose to limit the program to individuals who are "eligible for paid employment" in Wisconsin. Under these requirements, an individual would need to be over 14. In addition, deeming of parental income and resources would also apply. We therefore expect very few children would meet the eligibility criteria and would participate in the Pathways Medical Assistance Plan.

It is not the intent of this program to include children unless federal law does not permit us to avoid such inclusion. We have tried to build in provisions which follow the intent of federal law (to target to adults) while living with the technical inability to set a specific age level.

6. What is the highest percent of the federal poverty line for family net income that the department will set? Same question for the dollar amount of non-exempt assets.

The highest percent of the federal poverty line for family net income is 250%. According to federal law, this is applied to net income after SSI disregards are applied (e.g. medical and remedial expenses incurred by the person, half of paid earnings, etc.) We propose to exclude employment related work expenses and similar costs.

While we propose authority to allow individualized exemptions to the income eligibility level if an individual needing supports provided by this program would have to otherwise quit working, our understanding is that such authority will require a waiver. If the waiver were granted, we would do an individualized cost-effectiveness test; that is, if an exception to the 250% limit were granted then the state would have to make a finding that it would cost the state less to do so than would otherwise be the case. We would need to promulgate an administrative rule with the specific criteria for this.

7. Can an existing COP regular client be mandated into the buy-in?

Under the waiver mandate in the current home and community based waiver rules, if a COP regular client becomes eligible for Medicaid they would no longer eligible for COP if they refused MA waiver participation. In case there is any ambiguity here, we did include a reference to theis in the proposed *Pathways* statutory language for the drafter.

8. How is gross monthly income defined for the purpose of the one-time entry premium? Why allow the department to treat earned and unearned income differently for this purpose?

Gross monthly income for the purposes of the one-time entry premium is defined as including 1) All earned income 2) all unearned income (e.g. SSI, SSDI, dividends, interest, pension, etc.) 3) Income from self-employment.

For the one-time entry premium, the department does not treat earned and unearned income differently. The entry premium is based on gross monthly income.

The monthly premium does, however, treat earned and unearned income differently. This was done to avoid having too many people with minimal employment from wanting to come in to the program. Hence we propose to take the same amount of unearned income that the present system requires under existing medically needy criteria, and then take a smaller percentage of earned income. We want to target to people who can and will work at a substantial level. Treating earned and unearned income differently also allows the department to build in the proper emphasis and incentives for working nto the premium structure.

Another reason this is necessary is that the federal BBA is written in a way which does not permit us explicitly to require that people work! Therefore, we want to make it prohibitive for non-working persons to even begin to think about coming in to the buy-in program. We also wanted to discourage people from transferring from the medically-needy group to PMAP unless they will begin to work or increase their hours.

9. For the purpose of calculating the monthly premiums, what is the basis for the 3 to 3.5 percent of an individual's earned income?

The rate for an individual's earned income is taken from the Department's proposed BadgerCare premium structure including a 3 to 3.5% of earned income and a rate band in which small changes in earnings do not create burdensome administrative recalculations. Because it would consume excessive administrative dollars, we also propose to waiver premiums which are less than $7.50 per month.

10. Throughout the description of the buy-in statutory language request, reference is made to cost-effectiveness. Mention is also made that the buy-in will reduce the cost of Family Care. However, your summary sheet in the cost model (line 93) shows a GPR upper beginning in FY02.

Two reasons. First, the Pathways Medicaid Purchase Plan generates excess revenue in the first two years. Second if the Pathways Plan did not exist, most of these people would be eligible for Family Care and would be funded with 100% GPR (similar to people on regular COP).

In the first two years we estimate that revenues will exceed expenses by These savings result from immediate conversion of GPR-funded regular COP and Community Aids recipients, and the gradual enrollment of all others. By the third and fourth years we expect to reach the same type of plateau that Massachusetts experienced to be close to break-even with a small GPR cost.

If the Pathways Medicaid Purchase Plan did not exist, we expect that most of the individuals would be eligible for Family Care. Because they would not be Medicaid-eligible, the state would pay 100% GPR. This would include more than 700 people now receiving 100% GPR via regular COP because they do not quite meet current Medicaid eligibility standards.

Appendix A

PUBLIC LAW 105-33, BALANCED BUDGET ACT OF 1997

SEC. 4733. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended--

(1) in subclause (XI), by striking `or' at the end;

(2) in subclause (XII), by adding `or' at the end; and

(3) by adding at the end the following:

`(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

agent or contract with a fiscal intermediary to serve as a fiscal agent for that individual for the purposes of performing the responsibilities and protecting the interests of the individual under the unemployment insurance law. The county department or aging unit may elect to act as a fiscal agent or contract with a fiscal intermediary to serve as a fiscal agent for an individual who is provided long–term support services under s. 46.275, 46.277, 46.278, 46.495, 51.42 or 51.437. The fiscal agent under this paragraph is responsible for remitting any federal unemployment compensation taxes or state unemployment insurance contributions owed by the individual, including any interest and penalties which are owed by the individual; for serving as the representative of the individual in any investigation, meeting, hearing or appeal involving ch. 108 or the federal unemployment tax act (26 USC 3301 to 3311) in which the individual is a party; and for receiving, reviewing, completing and returning all forms, reports and other documents required under ch. 108 or the federal unemployment tax act on behalf of the individual. An individual may make an informed, knowing and voluntary election to waive the right to a fiscal agent. The waiver may be as to all or any portion of the fiscal agent's responsibilities. The waiver may be rescinded in whole or in part at any time.

(6) ASSESSMENTS. (a) 1. Within the limits of state and federal funds allocated under sub. (7) and within the limits of fees collected, an assessment shall be conducted for any person identified in sub. (5) (e) or who is seeking admission to or is about to be admitted to a nursing home. A fee may be charged, unless prohibited, for the assessment.

1m. Each assessment shall determine the person's functional abilities, disabilities and need for medical and social long–term community support services. Each assessment shall include an investigation of long–term community support services that could serve as alternatives to institutional care in a nursing home. The assessment shall include an explanation of the potential community alternatives to the person being assessed and the person's family or guardian.

2. Subdivision 1. does not apply to:

a. Any person or facility that is excluded because of gradual implementation of the program under sub. (3) (c).

b. Emergency admissions, as determined by a physician, but shall be applied within 10 days of admission.

c. Private pay patients seeking admission to or about to be admitted to a facility under subd. 1. who are informed about the program but waive the assessment, unless the patient will be eligible for medical assistance within 6 months of assessment.

cm. Persons seeking admission to or about to be admitted to the Wisconsin veterans home at King under subd. 1. who are informed about the program but waive the assessment.

d. Any person who is readmitted to a nursing home from a hospital within 6 months after being assessed.

e. Current residents of a nursing home who are eligible for an assessment under sub. (5) (e) and subd. 3., but who waive the assessment.

f. A person who enters a nursing home for recuperative care.

g. A person who enters a nursing home for respite care.

h. A person who is admitted to a nursing home from another nursing home, unless the person requests an assessment and funds allocated for assessments under sub. (7) (am) are available to the county.

3. In each participating county, except in counties where a pilot project under s. 46.271 (2m) is established, assessments shall be conducted for those persons and in accordance with the procedures described in the county's community options plan. The county may elect to establish assessment priorities for persons in target groups identified by the county in its plan regarding gradual implementation. If a person who is already admitted to a nursing home requests an assessment and if funds allocated for assessments under sub. (7) (am) are available, the county shall conduct the assessment.

(b) Within the limits of state and federal funds allocated under sub. (7) and within the limits of fees collected unless prohibited, a community services case plan shall be developed for any person with chronic disabilities:

1. Who is assessed under par. (a); and

2. For whom noninstitutional community services are feasible, financially viable and preferred by the person or the person's guardian. In this subdivision, noninstitutional community services are financially viable if they can be financed by state or federal funds allocated under sub. (7).

(c) The amount of any fee charged for conduct of an assessment under par. (a) or for development of a case plan under par. (b) shall be in accordance with a sliding scale formula established by the department by rule under sub. (12) (c). A fee may not be charged if prohibited under 42 USC 1396 to 1396v or under regulations under 42 USC 1396 to 1396v.

(d) If the county, through an assessment, determines that a community arrangement is not feasible, the county department or aging unit administering the program shall explain the reasons to the person and his or her family or guardian. The county department or aging unit administering the program shall maintain records sufficient to provide the county long–term support planning committee and the department with a periodic review of the reasons community arrangements were not feasible in order to assist future program planning.

(e) The department shall encourage counties to use public health nurses who meet the requirements of s. 250.06 (1) to conduct assessments under this subsection.

(6d) CARE MANAGEMENT REQUIREMENTS. (a) The department, after consulting with representatives of counties, hospitals, and individuals who receive services under this section, shall do all of the following:

1. Establish minimum requirements for the provision of care management services, as defined by the department, including standards for care, times for performance of duties, and size of caseloads.

2. Specify a reasonable schedule for phasing in the requirements established under subd. 1.

3. Provide technical consultation and assistance to the administrator of the program, as designated under sub. (3) (b), with respect to the requirements established under subd. 1.

(b) The department need not promulgate as rules under ch. 227 the requirements under par. (a) 1. or the schedule under par. (a) 2.

(6g) FISCAL RESPONSIBILITY. Except as provided in s. 51.40, and within the limitations under sub. (7) (b), the fiscal responsibility of a county for an assessment, unless the assessment is performed by an entity under s. 46.271 (2m), case plan or services provided to a person under this section is as follows:

(a) For a person seeking admission to or about to be admitted to a nursing home, the county in which the person has residence is the county of fiscal responsibility.

(b) For a person residing in a nursing home, except a state–operated long–term care facility, the county in which the nursing home is located is the county of fiscal responsibility.

(c) For a person living in a nursing home, except a state–operated long–term care facility, whose legal residence is established in another county, the county in which the legal residence is established is the county of fiscal responsibility.

(d) For a person residing in a state–operated long–term care facility, or for a person protectively placed under ch. 55, the county in which the person has residence before he or she enters the state–operated long–term care facility or is protectively placed is the county of fiscal responsibility.

(6r) ELIGIBILITY. No county may use funds received under sub. (7) (b) to pay for long–term community support services provided to any of the following:

(a) A person who is initially eligible for services under sub. (7) (b), for whom home and community–based services are available

under sub. (11) or s. 46.275, 46.277 or 46.278 that require less total expenditure of state funds than do comparable services under sub. (7) (b) and who is eligible for and offered the home and community–based services under sub. (11) or s. 46.275, 46.277 or 46.278, but who declines the offer, except that a county may use funds received under sub. (7) (b) to pay for long–term community support services for the person for a period of up to 90 days during which an application for services under sub. (11) or s. 46.275, 46.277 or 46.278 for the person is processed.

(b) A person who initially receives services under this section after December 31, 1985, unless one of the following applies:

1. The person meets the level of care requirements under s. 49.45 (6m) (i) for reimbursement of nursing home care under the medical assistance program.

1m. The person meets the requirements under s. 46.266 (1) (a), (b) or (c) for receipt of care in an institution for mental diseases.

2. The person has chronic mental illness, as defined under s. 51.01 (3g), affecting mental health to the extent that long–term or repeated hospitalization is likely unless the person receives long–term community support services.

3. The person receives medical assistance, resides in a nursing home immediately prior to receiving services under this section and is identified through the inspection of patient care under 42 USC 1396a (a) (31) as a person for whom community care is appropriate.

4. The person has been diagnosed by a physician as having Alzheimer's disease and requires a level of care equivalent to either of the following:

a. Noninstitutional personal care, including personal assistance, supervision and protection, and periodic medical services and consultation with a registered nurse, or periodic observation and consultation for physical, emotional, social or restorative needs, but not regular nursing care.

b. Care, including social services and activity therapy, in a residential facility under the daily supervision of a licensed nurse with consultation from a registered nurse at least 4 hours per week.

(c) A person who resides or intends to reside in a community–based residential facility and who is initially applying for long–term community support services, if the projected cost of services for the person, plus the cost of services for existing participants, would cause the county to exceed the limitation under sub. (3) (f), unless the department grants an exception to the requirement under this paragraph, under the conditions specified by rule, to avoid hardship to the person.

(e) A person who has not resided in this state for at least 180 consecutive days before applying for or receiving long–term community support services that are funded under sub. (7) (b).

(6u) FINANCIAL ELIGIBILITY AND COST–SHARING REQUIREMENTS. (a) In this subsection, "assets" has the meaning given in s. 49.453 (1) (a).

(b) The county department or aging unit selected to administer the program shall require all persons applying for long–term community support services that are funded under sub. (7) or (11) and, annually, all persons receiving the services to provide the following information:

1. For persons applying for or receiving services under sub. (7), a declaration of assets, on a form prescribed by the department. The declaration shall include any assets that the person applying for or receiving the services, or his or her spouse, has, after August 12, 1993, transferred to another for less than fair market value at any time within the 36–month period, or with respect to payments from a trust or portions of a trust that would be treated as assets transferred by an individual under s. 49.454 (2) (c) or (3) (b), within the 60–month period, immediately before the date of the declaration.

2. For persons applying for or receiving services under sub. (11), a declaration of income, on a form prescribed by the department.

(c) From the information obtained under par. (b), the county department or aging unit shall:

1. Determine the financial eligibility of the applicant or recipient of services to receive assistance for long–term community support services under the program. A person is financially eligible under this subdivision if he or she is one of the following:

a. Eligible for medical assistance under s. 49.46, 49.468 or 49.47.

b. A person whom the county department or aging unit finds is likely to become medically indigent within 6 months by spending excess assets for medical or remedial care.

2. For a person who is determined to be financially eligible under subd. 1. calculate, by use of the uniform fee system under s. 46.03 (18), the amount of cost sharing required for receipt of long–term community support services provided under sub. (5) (b). The county department or aging unit shall require payment by the person of 100% of the amount calculated under this subdivision.

3. Bill persons not determined under subd. 1. to be financially eligible for the full cost of long–term community support services received.

4. Use funds received under subds. 2. and 3. to pay for long–term community support services for persons who are eligible under sub. (6) (b).

(d) In determining financial eligibility under par. (c) 1. and in calculating the amount under par. (c) 2., the county department or aging unit shall include as the assets for any person, except those persons who are eligible for medical assistance under s. 49.46, 49.468 or 49.47, any portion of assets that the person or the person's spouse has, after August 12, 1993, transferred to another as specified in par. (b), unless one of the following conditions applies:

1. The transferred asset has no current value.

2. The county department or aging unit determines that undue hardship would result to the person or to his or her family from a denial of financial eligibility or from including all or a portion of a transferred asset in the calculation of the amount of cost sharing required.

(7) FUNDING. (am) From the appropriation under s. 20.435 (7) (bd), the department shall allocate funds to each county or private nonprofit agency with which the department contracts to pay assessment and case plan costs under sub. (6) not otherwise paid by fee or under s. 49.33 (2) or 49.45. The department shall reimburse counties for the cost of assessing persons eligible for medical assistance under s. 49.46, 49.468 or 49.47 as part of the administrative services of medical assistance, payable under s. 49.45 (3) (a). Counties may use unspent funds allocated under this paragraph to pay the cost of long–term community support services.

(b) 1m. From the appropriations under s. 20.435 (7) (bd) and (im), the department shall allocate funds to each county to pay the cost of providing long–term community support services under sub. (5) (b) not otherwise paid under s. 49.45 to persons eligible for medical assistance under s. 49.46 or 49.47 or to persons whom the county department or aging unit administering the program finds likely to become medically indigent within 6 months by spending excess income or assets for medical or remedial care. The average per person reimbursement under this paragraph may not exceed the state share of the average per person payment rate the department expects under s. 49.45 (6m). The county department or aging unit administering the program may spend funds received under this paragraph only in accordance with the case plan and service contract created for each person receiving long–term community support services.

State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–0266/P1
TAY

DOA:.....Fossum – Pathways to independence

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, a person is eligible for medical assistance (MA) if the person meets certain income and asset limits and other nonfinancial criteria. Certain people are eligible for MA because of substantial medical needs that consume so much of their income as to qualify them as "low–income." This category of MA recipient is commonly referred to as "medically needy." Other people are eligible for MA by virtue of their receipt of other federal assistance, such as supplemental security income (SSI). This category of people is commonly referred to as "categorically needy."

This bill directs the department of health and family services (DHFS) to seek federal approval of an amendment to the state MA plan and to request any necessary waivers from the secretary of the federal department of health and human services and from the commissioner of the social security administration to expand MA eligibility to disabled persons who would qualify for SSI but for excess income and assets. Under the bill, a disabled person whose family's income is less than 250% of the federal poverty line and whose assets do not exceed $20,000 is eligible to receive MA if the person pays a monthly premium and a one–time initial premium (buy–in) established by DHFS. The bill directs DHFS, however, to pay the monthly premium for a person who is eligible for the buy–in and who is receiving services under the

community options program (COP). The bill also authorizes DHFS to pay for that person's one–time entry premium.

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

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

SECTION 1. 20.435 (7) (bd) of the statutes is amended to read:

20.435 **(7)** (bd) *Community options program and long–term support pilot projects.* The amounts in the schedule for assessments, case planning, services and administration under s. 46.27 ~~and~~, for pilot projects under s. 46.271 (1) ~~and~~ for the payment of premiums under s. 49.472 (5) ~~that the department is required or has opted to pay~~, and the amounts carried forward under 1997 Wisconsin Act 27, section 9123 (2), for the pilot project under s. 46.271 (2m). If the department transfers funds to this appropriation from the appropriation account under sub. (5) (b), the amounts in the schedule for the fiscal year for which the transfer is made are increased by the amount of the transfer for the purposes specified in s. 49.45 (6v). Notwithstanding ss. 20.001 (3) (a) and 20.002 (1), the department may under this paragraph transfer moneys between fiscal years. Except for moneys authorized for transfer under this appropriation, under s. 46.27 (7) (fm) or (g) or under 1997 Wisconsin Act 27, section 9123 (2), all moneys under this appropriation that are allocated under s. 46.27 and are not spent or encumbered by counties or by the department by December 31 of each year shall lapse to the general fund on the succeeding January 1 unless transferred to the next calendar year by the joint committee on finance.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55), 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

SECTION 2. 46.27 (6u) (c) 2. of the statutes is amended to read:

46.27 **(6u)** (c) 2. For a person who is determined to be financially eligible under subd. 1. calculate, by use of the uniform fee system under s. 46.03 (18), the amount of cost sharing required for receipt of long–term community support services provided under sub. (5) (b). The county department or aging unit shall require payment by the person of 100% of the amount calculated under this subdivision, unless the person pays the premiums established under s. 49.472 (4).

History: 1981 c. 20; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 192, 239; 1985 a. 29 ss. 876s to 896am, 3200 (56); 1985 a. 120, 176; 1987 a. 27, 399; 1989 a. 31, 77, 336, 359; 1991 a. 32, 39, 235, 274; 1993 a. 16, 27, 437; 1995 a. 27; 1997 a. 13, 27, 39, 79, 237.

SECTION 3. 49.43 (8) of the statutes is amended to read:

49.43 **(8)** "Medical assistance" means any services or items under ss. 49.45 to 49.47 49.472 and 49.49 to 49.497, or any payment or reimbursement made for such services or items.

History: 1977 c. 29 ss. 583m, 591; 1977 c. 418 s. 929 (18); 1979 c. 221; 1981 c. 20 s. 2202 (20) (m); 1981 c. 93; 1983 a. 189; 1987 a. 27; 1987 a. 403 s. 256; 1987 a. 413; 1991 a. 39; 1993 a. 27, 99, 112, 437; 1995 s. 27 ss. 2649, 2661, 2943 to 2946, 9126 (19).

SECTION 4. 49.472 of the statutes is created to read:

49.472 Medical assistance buy–in. (1) DEFINITIONS. In this section:

(a) "Health insurance" means surgical, medical, hospital, major medical or other health service coverage, including a self–insured health plan, but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time or accident benefits.

(b) "Independence account" means an account approved by the department that consists solely of savings, and dividends or other gains derived from those savings, from income earned from paid employment after the initial date that an individual began receiving medical assistance under this section.

(c) "Medical assistance buy–in" means a category of medical assistance eligibility that is determined under this section.

(2) WAIVERS AND AMENDMENTS. The department shall submit to the federal department of health and human services an amendment to the state medical assistance plan, and shall request any necessary waivers from the secretary of the federal department of health and human services ~~and from the commissioner of the federal social security administration~~, to permit the department to expand medical assistance eligibility as provided in this section. If the state plan amendment and all necessary waivers are approved and in effect, the department shall implement the medical assistance eligibility expansion under this section not later than January 1, 2000, or 3 months after full federal approval, whichever is later.

(3) ELIGIBILITY. ~~An~~ individual is eligible for and shall receive medical assistance under this section if all of the following conditions are met:

(a) The net income of the individual's family is less than 250% of the poverty line for a family the size of the individual's family. After the first 18 months of administration of this section, the department may set a higher income level if the department has determined that a higher level would be cost–effective and has received assurance of federal financial participation from the federal government at that higher level. In calculating the net income, the department shall disregard the income specified under 42 USC 1382a (b).

(b) The individual's assets do not exceed $20,000. In determining assets, the department may not include assets that are excluded from the resource calculation under 42 USC 1382b (a) or assets accumulated in an independence account. The department may also exclude from the asset calculation, in whole or in part, the value of a vehicle used by the individual for transportation to paid employment. After the first 18 months of administration of this section, the department may set a higher asset level if the department has determined that a higher level would be

cost–effective and has received assurance from the federal government of federal financial participation.

(c) The individual would be considered to be receiving supplemental security income for purposes of receiving medical assistance but for earnings in excess of the limit established under 42 USC 1396d (q) (2) (B).

(d) The individual is physically disabled, as defined in s. 46.27 (11) (a).

(e) The individual is legally able to work in all employment settings without a permit under s. 103.70.

(f) The individual maintains premium payments calculated by the department in accordance with sub. (4), unless the individual is exempted from premium payments under sub. (4) (b) or (5).

(g) The individual meets all other requirements established by the department by rule.

(4) PREMIUMS. (a) Except as provided in par. (b) and sub. (5), an individual who is eligible for medical assistance under sub. (3) and receives medical assistance shall pay a monthly premium to the department. The department shall establish the monthly premiums by rule in accordance with the following guidelines:

1. The premium for any individual may not exceed the sum of the following:

a. Three and one-half percent of the individual's earned income.

b. One hundred percent of the individual's unearned income.

2. The department shall reduce the premium by 25% for an individual who is covered by private health insurance.

(b) The department may waive monthly premiums that are calculated to be below $10 per month.

(c) The department shall assess a one–time entry premium based on a sliding scale established by the department by rule and according to an individual's gross income. In calculating an individual's gross income, the department may treat earned and unearned income differently. The department may waive all or part of the entry premium for an individual if the department determines that any of the following is true:

1. Assessment of the premium would impose an undue hardship on the individual.

2. Assessment of the premium would reduce the cost–effectiveness of the medical assistance buy–in under this section.

(5) COMMUNITY OPTIONS PARTICIPANTS. From the appropriation under s. 20.435 (7) (bd), the department shall pay the entry premium established under sub. (4) (c), and may pay the monthly premium calculated under sub. (4) (a), for an individual who is a participant in the community options program under s. 46.27 (11). No individual who is a participant in the community options program under 46.27 (11) may be required to pay a monthly premium calculated under sub. (4) (a) if the individual pays the amount calculated under s. 46.27 (6u) (c) 2.

(6) INSURED PERSONS. (a) From the appropriation under s. 20.435 (5) (b), the department shall, on the part of an individual who is eligible for medical assistance under sub. (3), pay premiums for or purchase individual coverage offered by the individual's employer if the department determines that paying the premiums for or purchasing the coverage will not be more costly than providing medical assistance.

(b) From the appropriation under s. 20.435 (5) (b), the department shall pay medicare Part A and Part B premiums for individuals who are eligible for medicare and for medical assistance under sub. (3).

(6) DEPARTMENT DUTIES. The department shall do all of the following:

(a) Determine eligibility, or contract with a county department, as defined in 49.45 (6c) (a) 3., to determine eligibility, of individuals for the medical assistance buy–in in accordance with sub. (3).

(b) Notwithstanding s. 49.45 (5), establish by rule an appeal and grievance procedure under the medical assistance buy–in.

(c) Ensure, to the extent practicable, continuity of care for a medical assistance recipient under this section who is engaged in paid employment and who becomes ineligible for medical assistance.

(END)

1999–2000 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

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OTHER HEALTH AND HUMAN SERVICES

The health insurance risk–sharing plan (HIRSP) under current law, which is administered primarily by DHFS, provides major medical health insurance coverage for persons who are covered under medicare because they are disabled, persons who have tested positive for HIV and persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. Also eligible for coverage are persons (called "eligible individuals") who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage for at least 18 months in the past. Persons who are eligible for MA are not eligible for HIRSP. If a person with coverage under HIRSP terminates the coverage, the person may not be reenrolled in HIRSP for 12 months after terminating the coverage, unless the termination is due to eligibility for MA.

Under the bill, a person with coverage under HIRSP who becomes eligible for MA by reason of the amendment to MA that is established under the bill for disabled persons with incomes too high for SSI may receive MA without losing HIRSP eligibility. If the person chooses to receive MA, his or her HIRSP coverage is merely suspended and he or she does not pay any premiums or deductibles to HIRSP. If the person, or any person who has the MA coverage established in the bill and who had coverage under HIRSP within 3 months of applying for the MA coverage, terminates or loses eligibility for the MA coverage, the person is eligible for immediate reenrollment in HIRSP, without the 12–month waiting period or any preexisting condition limitation or exclusion. Annually, DHFS must transfer from two general purpose revenue appropriations for HIRSP to an appropriation that pays MA benefits the amount that would have been paid under HIRSP in the previous year for health care costs and premium and deductible subsidies on behalf of all of the persons with coverage under HIRSP who received MA in that year.

(END OF INSERT A-2)

INSERT 2-1

SECTION #. 20.435 (5) (af) of the statutes is amended to read:

20.435 **(5)** (af) *Health insurance risk–sharing plan; costs.* The amounts in the schedule for paying a portion of the operating costs of the health insurance risk–sharing plan under ch. 149 and for making the transfer under s. 149.167.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322, 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27,

76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

SECTION 4. 20.435 (5) (ah) of the statutes is amended to read:

20.435 **(5)** (ah) *Health insurance risk–sharing plan; premium and deductible reduction subsidy.* Biennially, the amounts in the schedule for the purpose of subsidizing premium reductions under s. 149.165 and deductible reductions under s. 149.14 (5) (a) and for making the transfer under s. 149.167.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

INSERT 2-1E

SECTION 5. 20.435 (5) (kp) of the statutes is created to read:

20.435 **(5)** (kp) *Medical assistance benefits; transfer from the health insurance risk–sharing plan.* All moneys transferred under s. 149.167 from the appropriation accounts under pars. (af) and (ah), for the purpose of providing the state share of medical assistance program benefits administered under s. 49.45, for providing medical assistance program benefits administered under s. 49.45 that are not also provided under par. (o) and for funding the pilot project under s. 46.27 (9) and (10).

*** NOTE: bold

(END OF INSERT 2–1)

INSERT 7–9

SECTION 6. 149.12 (2) (b) 1. of the statutes is amended to read:

149.12 **(2)** (b) 1. Except as provided in subd. 2. and in sub. (4) (c), no person who is covered under the plan and who voluntarily terminates the coverage under the plan is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage under the plan.

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12.

SECTION 7. 149.12 (2) (f) of the statutes is amended to read:

149.12 **(2)** (f) ~~No~~ Except for a person who is eligible for medical assistance under s. 49.472, no person who is eligible for medical assistance is eligible for coverage under the plan.

History: 1979 c. 313; 1983 a. 27, 215; 1985 a. 29, 73; 1987 a. 27, 70, 239; 1989 a. 201 s. 36; 1989 a. 332, 359; 1991 a. 39, 250; 1993 a. 27; 1995 a. 27, 407; 1997 a. 27 ss. 3025f, 4826 to 4831e; Stats. 1997 s. 149.12.

SECTION . 149.12 (3) (br) of the statutes is created to read:

149.12 **(3)** (br) Persons for whom premium payments are paid, subsidized, waived or reduced under s. 49.472 (4)(b) or (5) are not ineligible for coverage under the plan by reason of such payments.

SECTION . 149.12 (4) of the statutes is created to read:

149.12 **(4)** (a) If a person with coverage under the plan becomes eligible for and receives medical assistance under s. 49.472, the person's coverage under the plan does not terminate by reason of his or her eligibility for and receipt of medical assistance but is merely suspended during the time that the person is receiving medical assistance under s. 49.472.

(b) A person with suspended coverage under the plan who is receiving medical assistance under s. 49.472 shall not pay any premiums or deductibles for coverage under the plan during the time that he or she is receiving medical assistance under s. 49.472.

(c) 1. If a person who is receiving medical assistance under s. 49.472 has suspended coverage under the plan, or had coverage under the plan at any time within 3 months before he or she successfully applied for medical assistance under s. 49.472, terminates the medical assistance coverage or loses eligibility for the medical assistance coverage, the person shall be eligible for immediate reenrollment in the plan if the person continues to satisfy all other eligibility requirements. The waiting period under sub. (2) (b) 1. and the preexisting condition exclusionary period

under s. 149.14 (6) (a) do not apply to person who reenrolls in the plan under this paragraph.

SECTION #. 149.167 of the statutes is created to read:

149.167 Transfer for eligible persons receiving medical assistance. Annually, the department shall transfer from the appropriation accounts under s. 20.435 (5) (af) and (ah) to the appropriation account under s. 20.435 (5) (kp) the amount that would have been paid under the plan from these appropriations in health care costs on behalf of all persons with coverage under the plan who received medical assistance under s. 49.472 during the preceding year, including any premium and deductible subsidies that would have been paid on behalf of those persons, reduced by the premium and deductible amounts that those persons would have paid to the plan in that preceding year.

(END OF INSERT 7-9)

SECTION #. CR; 149.14 (6) (title)
149.14 (6) (title) Preexisting conditions.

INSERT 2-11

Section #. 20.435 (5) (b) of the statutes is amended to read:

, to pay premiums under s. 49.472 (6)

20.435 **(5)** (b) *Medical assistance program benefits.* Biennially, the amounts in the schedule to provide the state share of medical assistance program benefits administered under s. 49.45, to provide medical assistance program benefits administered under s. 49.45 that are not also provided under par. (o) and to fund the pilot project under s. 46.27 (9) and (10). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation to the appropriation under sub. (7) (kb) funds in the amount of and for the purposes specified in s. 46.485. Notwithstanding ss. 20.001 (3) (b) and 20.002 (1), the department may credit or deposit into this appropriation and may transfer between fiscal years funds that it transfers from the appropriation under sub. (7) (kb) for the purposes specified in s. 46.485 (3r). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation to the appropriation account under sub. (7) (bd) funds in the amount and for the purposes specified in s. 49.45 (6v).

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0266/P1dn
TAY

To Gretchen Fossum:

1. Under current law, certain types of employment are available to minors of any age. Therefore, the department's suggestion to limit eligibility for the medical assistance (MA) buy–in to those who are legally eligible to work would not accomplish its goal and, in fact, is broader than the department may have realized.

I spoke with Gordan Malaise, who drafts in the area of employment law, about what the department was trying to accomplish. His suggestion was to limit MA buy–in eligibility to persons who are legally permitted to work without a permit under s. 103.70, which requires that a permit be obtained from the Department of Workforce Development for employment of a minor. Because there are certain types of employment for which a permit is unnecessary and that are theoretically available to any minor under 18, I have attempted to qualify the requirement. Please review the provision that requires that the individual be eligible to work in any employment setting without a permit under s. 103.70. As drafted, no person under the age of 18 will be eligible for the MA buy–in unless s. 103.70 is amended. Therefore, I did not include references to the income of a minor recipient's parents.

Finally, it is important to note that the requirement may be perceived by the federal government as a thinly disguised effort to thwart the intent of Congress and may therefore be prohibited by HCFA.

2. Should s. 20.435 (5) (b) be amended? 46.22(1)(b) 1. d. or 49.49(3m)(a)

3. An individual who is eligible for MA and for whom a COP slot is available is required under 46.27 (6r) to participate in the COP–waiver in order to receive COP services. By redefining MA to include the MA buy–in provisions, I did not see any reason to amend the COP provisions. As currently written, the COP provisions contemplate only MA eligibility. They do not specify the category of eligibility. I believe the expansion of MA eligibility suffices.

4. I have required the department to seek any necessary waivers from the commissioner of the Social Security Administration. Is this appropriate?

5. One of the eligibility requirements is that the individual be physically disabled, as defined in s. 46.27 (11) (a) ("having a condition that affects one's physical functioning by limiting mobility or the ability to see or hear, that is the result of injury, disease or congenital deficiency and that significantly interferes with or limits at least one major

life activity and the performance of one's major personal or social roles"). Does this effect your intent? Is it too narrow? Is it superfluous in light of the requirement that the person would be considered to be receiving SSI but for excess earnings? Note that I did not define "disability" as it is defined in 42 USC 1382c(a)(3) because there "disability" is defined generally as the inability to engage in substantial gainful employment. Presumably, persons eligible for MA through the buy–in are actually able to engage in substantial gainful employment and therefore would not really meet the federal definition. Thus, if you would like to define "disability," you should define it in such a way as to avoid reference to gainful employment.

5 In determining eligibility, the department must calculate the net income of the applicant's *family*, but the department calculates the assets of the *applicant*, according to the department's instructions. Is that the intent? Or should the assets of the applicant's *family* be calculated? This brings up another issue: should "family" be defined? Should "earned income" and "unearned income" be defined?

6 The department has indicated in its instructions that an entry premium will not be assessed if, among other things, "the public interest would not be served." That seems a bit vague, so I have not included it in this draft. Can you give me an example of how the public interest would not be served (that would not be redundant to the other two reasons for not assessing the premium)? Perhaps an example would give me a better idea of the department's intent.

The department has also used language in its instructions that indicate that the department is authorized but not required to assess an entry premium. Is the entry premium intended to be mandatory unless one of the exceptions applies? Or may the department dispense with it altogether (in which case, why include the exceptions)? I have made it a requirement (with exceptions) to avoid ambiguity. Please let me know if this does not effect the department's intent.

7 In expanding MA to persons who would otherwise be eligible only for COP–R, the department may impede its ability to maintain a waiting list for COP since MA is an entitlement. Does the department envision moving people who are on the waiting list for COP–R and who are eligible for COP–W under this bill into COP–W? Will there be slots for them?

8 Appeal procedures for MA are set forth under s. 49.45 (5). Is it the department's intent to have a different procedure for the MA buy–in?

9 Will the transfer under s. 149.167 affect the formula under s. 149.143 in any way that requires amendment of s. 149.143?

10. I made the transfer from the two HIRSP GPR appropriations. Is this what you want?

11. Should the purpose of s. 20.435 (5) (kp) be limited to providing the state share of benefits administered under s. 49.472? Alternatively, if s. 20.435 (5) (b) is amended on account of s. 49.472 (6) in this draft, should the purpose of s. 20.435 (5) (kp) be expanded in the same manner?

12. Is the language in s. 149.167 accurate? Will the amount that is transferred specifically include any subsidy amounts, as drafted?

~~14~~ 15. Because of s. 149.14 (1) (b), it is possible that all of s. 149.12 (4) is unnecessary. As long as a person who is eligible for MA under s. 49.472 is also eligible for HIRSP under s. 149.12, s. 149.14 (1) (b) seems to address the concern that s. 149.12 (4) (c) is meant to address. The fiction that a person who receives MA under s. 49.472 still has some form of coverage under HIRSP should not be necessary to justify the transfer under s. 149.167. What do you think?

~~15~~ 16. The title of s. 149.14 (6) got eliminated in the renumbering shuffle in the last budget so I added it back in in this draft. Okay?

Tina A. Yacker
Legislative Attorney
261–6927

Pamela J. Kahler
Senior Legislative Attorney
266–2682

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0266/P1dn
TAY&PJK:wlj&kg:lp

November 25, 1998

To Gretchen Fossum:

1. Under current law, certain types of employment are available to minors of any age. Therefore, the department's suggestion to limit eligibility for the medical assistance (MA) buy–in to those who are legally eligible to work would not accomplish its goal and, in fact, is broader than the department may have realized.

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Finally, it is important to note that the requirement may be perceived by the federal government as a thinly disguised effort to thwart the intent of Congress and may therefore be prohibited by HCFA.

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the person would be considered to be receiving SSI but for excess earnings? Note that I did not define "disability" as it is defined in 42 USC 1382c (a) (3) because there "disability" is defined generally as the inability to engage in substantial gainful employment. Presumably, persons eligible for MA through the buy–in are actually able to engage in substantial gainful employment and therefore would not really meet the federal definition. Thus, if you would like to define "disability ", you should define it in such a way as to avoid reference to gainful employment.

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Tina A. Yacker
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261–6927

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Pamela J. Kahler
Senior Legislative Attorney
266–2682

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
101 East Wilson Street, Madison, Wisconsin

TOMMY G. THOMPSON
GOVERNOR
MARK D. BUGHER
SECRETARY

Mailing Address:
Post Office Box 7864
Madison, WI 53707-7864

Date: January 11, 1999

To: Tina A. Yacker
Pamela J. Kahler
Legislative Reference Bureau

From: Gretchen A. Fossum
State Budget Office

Subject: LRB Draft 0266/P1

Attached are the changes that the Department of Health and Family Services is requesting regarding LRB draft 0266/P1.

If you have any question, please contact me at 266-2288.

CHANGES TO LRB 0266/P1

To avoid confusion concerning the MA buy-in program proposed in the draft and other programs at the Department of Health and Family Services the buy-in will be referred to as the Medical Assistance Purchase Plan. The draft will need to be amended to reflect this change.

Responses to Tina's drafter's notes:

Drafter note 1.: The department likes the approach used in the draft regarding the employment requirement.

Drafter note 2.: There is no need to amend s. 20.435(5)(b), 46.22(1)(b)1.d. or 49.49(3m)(a).

Drafter note 3.: The department concurs with the approach taken on this issue.

Drafter note 4.: The department responds as follows:

> The eligibility requirement that an individual be physically disabled under s. 46.27(11)(a) is too narrow. We believe it is superfluous because the person would be considered to be receiving SSI but for excess earnings, that is the person needs to meet the functional definition of disability. The department suggests the following:
>
> On page 7 line 4 substitute, "The individual is disabled as defined in 42 USC 1382c but for evidence of work, earned income, or attainment of substantial gainful employment as permitted by 42 USC 1396(a)(10)(A)(ii)(XIII)."
>
> On page 7, line 3 add, at the end of the sentence, "but for unearned income which under this section is disregarded as permitted by 42 USC 1396a (r) (2)."

Drafter note 5.: The department responds as follows:

> Assets/Income. Yes, it is the net *family* income which must be below 250% FPL, and the *individual's* assets which must be below $20,000.
>
> Def. of family etc.- We hope you can use the definitions of family, earned income, and unearned income which are in Medicaid law as they apply to the SSI-Disabled population. Earned income and unearned income should be defined using 42 USC 1382a. *(Section 8 (3)(a) and (b))*

Drafter note 6.: The department responds as follows: "Public interest: It is OK to leave this out. However, in the same section, the draft statute permits the department to waive premiums where they would result in undue hardship. Our original submission was narrower and specified "undue hardship *which is injurious to the program's intent."* We are concerned that without this qualifier anyone who cannot afford the premium could present themselves and claim undue hardship.

The department suggests adding, at the end of the sentence, on page 8 line 5, "and be injurious to the program's intent."

Drafter note 7.: The department responds as follows: Wait-Lists: We do not see a problem here. While Medicaid is an entitlement, eligibility for both regular COP and the 1915c waivers is governed by the availability of slots. Thus, a person who qualifies for the Purchase Plan may obtain MA State Plan services and still be on a waiting list for either regular COP or the waivers. We do expect that this will take some pressure off of regular COP, since some people will by-pass the regular COP program and go directly to the waivers. This is in the state's fiscal interest, since we capture federal match under the waivers but not under regular COP.

Drafter note 8.: Appeal procedures for the Purchase Plan will not be different than the procedures for Medical Assistance under s. 49.45. The department suggests changing lines 4 and 5 on page 9 to read "ensure appeal and grievance procedures under s. 49.45(5)."

Other changes to Tina's sections of the draft:

1. On page 6, lines 10 through 14 delete the sentence "After the first 18 months .... at that higher level." On page 6 delete lines 21 to 24. The intent is to restrict eligibility to 250% of the poverty level and assets not to exceed $20,000.
2. Under s. 49.472(3) add the eligibility requirement: "The individual is engaging in paid employment or is participating in a work and health care management program." Define a work and health care management program as a service delivery program certified by the department which aligns health and employment services in support of a person's employment goals through a comprehensive and integrated action plan.
3. On page 7 line 9, for an individual exempted from the premium payments, add (4)(c).
4. Raising/Lowering Entry Premium: The department is interested in having a procedure by which the department have an expedited rule process when changing the entry premium to maintain the fiscal viability of the program. The department suggests adding the following to s. 49.472(4)(c) on page 7 line 23: "the department may raise or lower the entry premium by a state Medicaid Plan Amendment if the change is less than 50% in any twelve month period, and by rule if the change is greater than 50%."
5. The department requests that the following provision be added to s. 49.472: "the department shall establish by rule consequences for the non-payment of entry or monthly premiums and procedures for the termination of subscriber coverage under medical assistance in the event of continued non-payment of premiums."
6. At the end of the sentence on page 8, line 23 add "if federal financial participation is available."
7. On page 9, line 1: the department would like to be also able to contract with a tribe to determine eligibility for the Purchase Plan.

Changes to Pam's sections of the draft:

The department has changed the way it wants to work HIRSP with the MA Purchase Plan. Below are changes to the draft requested by the department and an explanation for the changes.

In the Bill Analysis

- In the section Other Health and Human Services, second paragraph.: Delete the first two sentences. Change the first part of the third sentence to read: "Any person who has the MA coverage established in the bill...(rest of sentence as drafted). Delete the fourth and final sentence in the paragraph.

In the statutory language

- Sections 1 and 2 (p.2-3): Delete the drafted statutory language changes so that there are no changes to s. 20.435(5)(af) and (ah).
- Delete Section 4 (p.3), so that s. 20.435(5)(kp) is not created.

- Section 10 (p.9): Delete drafted statutory language changes so that there are no changes to s. 149.12(2)(f).

- Delete Section 11 (p.9) so that s. 149.12(3)(br) is not created.

- Section 12 (p.9): Delete section s. 149.12(4)(a) and (b). Change the first part of the first sentence in s. 149.12(4)(c) to read: "If a person who is receiving medical assistance under s.49.472 had coverage under the plan at any time within 3 months..."(rest of sentence as drafted).

- Delete Section 14 (p.10) so that s. 149.167 is not created.

Explanation: Based on further internal staff discussions, DHFS has decided to structure the budgetary linkage between HIRSP and the MA Purchase Plan program in an administratively simpler way. Under the new approach, the Department will project the number of HIRSP clients expected to transfer to the MA Purchase Plan and then decrease the cost to the HIRSP program due to the decrease in this caseload.

As part of its biennial budget submission, the Department will re-estimate downwards the amount of GPR funding in the HIRSP program (in appro. s. 20.435(5)(af)) by the amount of the projected decrease in HIRSP costs due to the decline in HIRSP caseload attributable to projected HIRSP clients transferring to the Purchase Plan. The GPR savings budgeted in the HIRSP program will offset the increased costs in the MA appropriation due to the MA Purchase Plan program.

Under this approach there would not be a year-end reconciliation and transfer process between the HIRSP and MA programs as originally proposed. In addition, under the new approach, there is no need for a HIRSP client who transfers to the MA Purchase Plan to maintain suspended coverage in the HIRSP program. The changes noted above make the statutory provisions consistent with the new approach.

(Note: The new budgetary approach recommended here for the HIRSP program is the same budgetary approach that DHFS is using with respect to the AIDS/HIV program. That is, the GPR funding in the AIDS/HIV program is being re-estimated downwards to reflect the decreased caseload in the AIDS/HIV program to the projected transfer of clients to the Purchase Plan. The savings generated in the AIDS/HIV program offset the increased costs in the MA appropriation due to the MA Purchase Plan.)