Technical amendment. This provision is a holdover from an earlier draft; rights are not specified in the final bill.

Topic: Certification of Resource Center availability
(AB-133 page 602, line 23 through page 603, line 5)

Hospitals should be added to the list of entities to whom the Secretary certifies that a Resource Center is available for purposes of providing functional and financial screens.

Explanation:
The bill includes requirements for hospitals to refer certain patients to the Resource Center. They should be included in the list of entities to be notified when these requirements are effective.

Topic: Resource Center requirements for screening
(AB-133 page 608, lines 9-12)

Amend s.46.283 (4) (g) to read:

(g) Provide a functional and financial screen to any person seeking admission to a nursing home, community-based residential facility, residential care apartment complex or adult family home if the secretary has certified that the resource center is available to the person and the facility and the person is determined by the resource center to have a condition expected to last at least 90 days that would require care, assistance or supervision.

Explanation:
As drafted, this provision would require the Resource Center to conduct a functional and financial screen for every admission to a long-term care facility, whether or not the person had a long-term care need. The proposed amendment would allow the Resource Center to judge whether the person is likely to need long-term care and to provide the screen only in appropriate cases.

Topic: Family Care District
(AB-133, page 626, line 13 through page 627, line 21)

Amend s. 46.2895 (3) (b) 2. to read:

2. The family care district board appointed under par. (a) 2. shall consist of 15 persons, plus ~~one~~ two additional member for each county in excess of 2, all of whom are residents of the area of jurisdiction of the family care district. At least one-fourth of the

members shall be representative of the client group or groups whom it is the family care district's primary purpose to serve or those clients' family members, guardians or other advocates.

Explanation:
For a three-county or a five-county consortium, adding one member for each county in excess of two would result in an even number of members; adding two members would always result in an odd number of members.

Amend s. 46.2895 (3) (c) to read:

(c) The members of the family care district board appointed under par. (a) shall serve 3-year terms. No member may serve more than 2 consecutive terms. Of the members first appointed, 5 shall be appointed for 3 years; 5 shall be appointed for 4 years; and 5, or, in the case of a board appointed under par. (b) 2., the remainder, shall be appointed for 5 years. A member shall serve until his or her successor is appointed, unless removed for cause under s. 17.13.

Explanation:
Intended to clarify that a member removed for cause does not serve until his or her successor is appointed.

Topic: Subrogation rights for CMOs

Further amend ss. 49.89 (2), (3), (3m) and (9), 803.03 (2) and 814.03 (3) by adding the double underlined language below:

49.89 (2) SUBROGATION. The department of health and family services, the department of workforce development, a county or an elected tribal governing body that provides any public assistance under this chapter or under s. 46.284 or s. 253.05 as a result if the occurrence of an injury, sickness or death that creates a claim or cause of action, whether in tort or contract, on the part of a public assistance recipient or beneficiary or the estate of a recipient or beneficiary against a 3rd party, including an insurer, is subrogated to the rights of the recipient, beneficiary or estate and may make a claim or maintain an action or intervene in a claim or action by the recipient, beneficiary or estate against the 3rd party.

Subrogation under this subsection because of the provision of medical assistance under subch. IV or the provision of the family care benefit under s. 46.284 (5) constitutes a lien, equal to the amount of the medical assistance or the family care benefit provided as a result of the injury, sickness or death that gave rise to the claim. The lien is on any lump sum payment resulting from a judgment or settlement that may be due the obligor. A lien under this subsection continues until it is released and discharged by the department of health and family services.

49.89 (3) ASSIGNMENT OF ACTIONS. By applying for assistance under this chapter or under, s. 46.284 (5) or s. 253.05, an applicant assigns to the state department, the county department or the tribal governing body that provided the assistance the right to make a claim to recover an indemnity from a 3rd party, including an insurer, if the assistance is provided as a result of the occurrence of injury, sickness or death that results in a possible recovery of an indemnity from the 3rd party.

49.89 (3m) NOTICE REQUIREMENTS. (a) An attorney retained to represent a current or former recipient of assistance under this chapter or under s. 46.284 (5), or the recipient's estate, in asserting a claim that is subrogated under sub. (2) or assigned under sub. (3) shall provide notice under par. (c).

49.89 (3m) (b) If no attorney is retained to represent a current or former recipient of assistance under this chapter or under s. 46.284 (5), or the recipient's estate, in asserting a claim that is subrogated under sub. (2) or assigned under sub. (3), the current or former recipient or his or her guardian or, if the recipient is deceased, the personal representative of the recipient's estate, shall provide notice under par. (c).

49.89 (3m) (bm) A person against whom a claim that is subrogated under sub. (2) or assigned under sub. (3) is made, or that person's attorney or insurer, shall provide notice under par. (c), if that person, attorney or insurer knows, or could reasonably determine, that the claimant is a recipient or former recipient of medical assistance under subch. IV or

of the family care benefit under s. 46.284 (5), or is the estate of a former recipient of medical assistance under subch. IV or of the family care benefit under s. 46.284 (5).

49.89 (7) (c) The incentive payment shall be an amount equal to 15% of the amount recovered because of benefits paid under s. 46.284, 49.19, 49.20, 49.30 or 253.05. The incentive payment shall be taken from the state share of the sum recovered, except that the incentive payment for an amount because of benefits paid under s. 49.19 shall be considered an administrative cost under s. 49.19 for the purpose of claiming federal funding.

49.89 (9) (intro.) POWERS OF HEALTH MAINTENANCE ORGANIZATIONS. A health maintenance organization, care management organization under s. 46.284 or other prepaid health care plan has the powers of the department of health and family services under subs. (2) to (5) to recover the costs which the organization or plan incurs in treating an individual if all of the following circumstances are present:

49.89(9) (b) The costs result from an occurrence of an injury or sickness of an individual who is a recipient of medical assistance or a recipient of the family care benefit under s. 46.284(5).

803.03 (2) (bm) *Joinders because of implication of medical assistance or family care.* If the department of health and family services is joined as a party pursuant to par. (a) and s. 49.89 (2) because of the provision of benefits under subch. IV of ch. 49 or under s. 46.284 (5), the department of health and family services need not sign a waiver of the right to participate in order to have its interests represented by the party that caused the joinder. If the department of health and family services makes no selection under par. (b), the party causing the joinder shall represent the interests of the department of health and family services and the department of health and family services shall be bound by the judgment in the action. Regardless of whether the department of health and family services joins in prosecuting the claim, the portion of the proceeds of the claim that represents benefits paid

under subch. IV of ch. 49 or under s. 46.284 (5) as a result of the occurrence of injury, sickness or death for which the claim arose shall be paid to the department of health and family services pursuant to s. 49.89 (5).

814.03 (3) Notwithstanding subs. (1) and (2), where the department of health and family services or a county is joined as a plaintiff pursuant to ss. 49.89 (2) and 803.03 (2) (a) because of the provision of benefits under subch. IV of ch. 49 or under s. 46.284 (5)~~, and where the interests of the department of health and family services or of the county are represented under s. 803.03 (2) (b) by the party who caused the joinder~~, the department of health and family services or the county shall not be liable for costs to any prevailing defendant.

Explanation:
These changes would assure that the Department and CMOs have subrogation rights to recover Family Care costs for non-Medicaid eligibles as well as Medicaid-eligibles. This was a part of our original drafting request, but technical questions could not be resolved in time for the bill. Some changes to the subrogation statutes, unrelated to Family Care, are already proposed in the budget bill. It is the double-underlined material above that would be added through the proposed Family Care amendments.

Topic: Typographical errors

Page 1472, line 10: The second "on" should be "or."

Page 767, line 16: "(a)" should be deleted.

Corrections and additions: Family Care technical amendments

1. Correction to requested changes regarding hearings:

Amend **s. 46.287 (2) (b)** to read:

(b) An enrollee may contest ~~a~~ any decision, omission or action of a care management organization ~~regarding the type, amount or quality of the enrollee's services under the family care benefit,~~ other than those specified in par. (a) ~~1. d. to f., or may contest the choice of service provider~~. In these instances, the enrollee shall first send a written request for review by the unit of the department that monitors care management organization contracts. This unit shall review and attempt to resolve the dispute. If the dispute is not resolved to the satisfaction of the enrollee, he or she may request a hearing under the procedures specified in par. (a) 1. (intro.).

Explanation of change from original request:
The requested deletions (strike-throughs) were omitted in the original request.

Explanation of intended change to language in bill:
As written, the language appears to limit the rights of enrollees to request a fair hearing, after review by the Department's contract monitors, to only certain kinds of CMO decisions. It would not appear to cover, for example, a CMO's failure to provide required notification of rights or release of confidential information without informed consent. The proposed amendment is meant to clarify this language.

2. Addition to eligibility/entitlement language:

Add to **s. 46.286 (3) (b)**:

3. The department or its designee determines that the person no longer meets eligibility criteria under sub. (1).

Explanation:
S. 46.286 (3) (b) describes the limited circumstances under which a person may be involuntarily disenrolled from a CMO. A provision to cover the circumstance in which a person is no longer eligible (functionally or financially) should be added.

3. Addition of Family Care to provisions covering recovery of incorrect payments:

Amend **s. 49.497** to read:

49.497 Recovery of incorrect medical assistance payments.

(1) The department may recover any payment made incorrectly for benefits specified under s. 46.284, 49.46, 49.468 or 49.47 if the incorrect payment results from any misstatement or omission of fact by a person supplying information in an application for benefits under s. 46.284, 49.46, 49.468 or 49.47. The department may also recover if a medical assistance recipient or a recipient of the family care benefit or any other person responsible for giving information on the recipient's behalf fails to report the receipt of income or assets in an amount that would have affected the recipient's eligibility for benefits. The department's right of recovery is against any medical assistance or family care recipient to whom or on whose behalf the incorrect payment was made. The extent of recovery is limited to the amount of the benefits incorrectly granted. The county department under s. 46.215 or 46.22 or the governing body of a federally recognized American Indian tribe administering medical assistance shall begin recovery actions on behalf of the department according to rules promulgated by the department.

(2) A county or governing body of a federally recognized American Indian tribe may retain 15% of benefits distributed under s. 46.284, 49.46, 49.468 or 49.47 that are recovered under sub. (1) due to the efforts of an employe or officer of the county or tribe.

(3) Cash assets of medical assistance or family care recipients that exceed asset limitations shall be applied against the cost of medical assistance or family care benefits provided.

Explanation:
This section of the statutes provides for recovery of Medical Assistance payments that are made on behalf of a person whose misstatement or omission of financial information results in an incorrect finding of eligibility. The proposed amendments would extend this provision to cover non-Medicaid payments under Family Care.

Rationale for a Technical Amendment to the Statutory Language Proposed in the Medical Assistance Purchase Plan

Proposed Technical Change to Governor's Budget	Explanation
s. 49.472 **(3)** ELIGIBILITY. Except as provided in sub. (6) (a), an individual is eligible for and shall receive medical assistance under this section if all of the following conditions are met: ~~(a) The individual's net income, including income that would be deemed to the individual under 20 CFR 416.1160, is less than 250% of the poverty line for a family the size of the individual's family. In calculating the net income, the department shall disregard the income specified under 42 USC 1382a (b).~~ As prescribed by federal requirements, the family's net combined income is less than 250 % of the federal poverty level for a family of the size involved. Net income is calculated by applying all appropriate SSI disregards and exemptions(specified under 42 USC 1382a (b)) to the family's total income.	Section (3)(a) as written does not follow the federal requirements for family net income determinations particularly as it relates to the treatment of spouse's income. The rewritten portion conforms to the federal procedure outlined by the Health Care Financing Administration.
(c) The individual would be eligible for supplemental security income for purposes of receiving medical assistance but for evidence of work, attainment of the substantial gainful activity level, earned income in excess of the limit established under 42 USC 1396d (q) (2) (13) and unearned income which under this section is disregarded as permitted by 42 USC 1396a(r)(2).	ERRONEOUS CONSTRUCTION: All unearned income is to be disregarded for eligibility determinations; later, the premium takes all unearned income except for certain deductions specified in sub (4). As written, this provision disregards the deductions!! (I,e the .unearned income that is outlined in sub.(4) which refers to the setting of a premium). As written, the provision creates a tautology.

(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 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 after the deductions specified in subd. 2.	
2. In determining an individual's unearned income under subd. 1., the department shall disregard all of the following: a. A maintenance allowance established by the department by rule. The maintenance allowance may not be less than the sum of $20, the federal supplemental security income payment level determined under 42 USC 1382 (b) and the state supplemental payment determined under s. 49.77 (2m). b. Medical and remedial expenses and impairment-related work expenses. c. Deductions listed in 2a or 2b in excess of the individual's total unearned income will be subtracted from the gross monthly earned income before applying the earned income premium calculation under 1 a.	This enables someone who has little or no unearned income to be afforded a personal maintenance allowance credited against their earned income. We did not submit language providing a personal maintenance allowance (or medical deductions) as a deduction from earned income on the theory that excess deductions from unearned income would roll up to earned income. We did not want the deduction to show up in both places separately because then people might get the deduction twice; therefore we put the deduction only in the unearned category with a cross-reference to earned income.

(5) COMMUNITY OPTIONS PARTICIPANTS. From the appropriation under s. 20.435(7) (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~~ the medical assistance purchase plan under ~~s. 46.27 (11)~~ this section and who pays a monthly premium calculated under sub. (4)(a) may be required to pay a ~~monthly premium calculated under sub. (4) (a) if the individual pays the amount calculated~~ cost-share under s. 46.27 (6u) (c) 2.	As written, the language violates federal regulation and requires the reverse of what HCFA would permit. HCFA has stated that individuals participating in both the Purchase Plan and the community waivers would pay only the premium under the Purchase Plan. Post eligibility treatment of income (cost-sharing) applies to individuals who are eligible for waiver services via the special income limit. It can not apply to individuals receiving home and community based waiver services under eligibility categories such as SSI recipients or enrollees in the Pathways Medicaid Purchase Plan.

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

Tuberculosis Statutory Language
DIN 5101

Description of Change

1. Section 2416 of the budget bill renumbers s.252.08(3) of the statutes to s.252.07(10). It is necessary to have a reference to s.252.07(10) in the appropriation language in order to make payments for this program.

2. Section 2414 to 2419 of the budget bill proposes to repeal several subsections of s.252.08 and to renumber the remaining unrepealed subsection. It should also be specified that the title of s.252.08 is repealed.

Explanation

1. The budget bill splits the current Disease Aids appropriation, creating a separate Disease Aids appropriation for tuberculosis-related costs in the Division of Public Health. The current appropriation, also called Disease Aids, which includes funding for other diseases, remains in the Division of Health Care Financing. The intent of this section is to create separate funding for the TB program. The new s.252.07(10) is a part of the TB program related to inpatient care for TB patients and should be included as one of the programs that can be reimbursed from the new Disease Aids appropriation in the Division of Public Health.

2. If this change is not made, the old title of s.252.08 might be deemed to remain as a section having no provisions of substance within it.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
0	0	0	0		

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
April 13, 1999

Supervised Release for Sexually Violent Persons

Description of Change

Sections 3228 and 3238 of the budget bill contains the following language for ss. 980.06 (2)(cr):

. . . If the court finds that the plan provides **either** adequate treatment and services to the person **or** adequate protection to the community, the court shall, except as provided in par. (ct), issue a written decision and order approving the plan and placing the person on supervised release in the county that prepared the plan.

This language should be amended to say "both . . and" rather than "either . . or."

Explanation

As the current language reads, if the supervised release plan provided adequate treatment and services but failed to provide adequate community protection, the court would be required to approve the plan. The intent of the Department is that a supervised release placement must include both adequate treatment and community protection.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
0	0	0	0		

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

Mental Health Services Contracting

Description of Change

Make changes to section 1000 in the budget bill, as follows:

1. Delete the underlined material in the following provision:

s.46.043(3)(a) Except as provided in pars. (b) and (c), services under this section are governed by all of the following:

2. Delete the underlined material in the following provisions:

s.46.043(3)(b) In the event of a conflict between par.(a)1.and2.or3., the services shall comply with the contractual, statutory or rules provision that is most protective of the service recipient's health, safety, welfare or rights, as determined by the mental health institute.

3. Revise s.46.043(3)(c) to read:

Services offered under this section, including the facilities in which such services are provided, are not subject to any statutes or rules other than those enumerated under par.(a) 2., including but not limited to ss.46.03(18), 46.10, 51.15(2), 51.20(13)(c)1. and 51.42(3)(as), or to zoning or any other ordinances or regulations of the county or municipality in which the services are provided or the facility is located.

Explanation

1. The only exception to the provisions under 46.043(3)(a) are given in paragraph (b), not paragraph (c).

2. Protective provisions may derive from other sources than the mental health institutes.

3. Th e intent of this paragraph is to provide that the services authorized are not subject to other statutes or rules, with certain exceptions. This revised language provides a more specific listing of these exceptions.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
0	0	0	0		

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget Request
April 13, 1999

DIN Title IMD Funding Transfer

DIN Number 5610

Description of Change

Amend s. 46.266(3) to allow payments for specialized services to made for all residents of the IMD, rather than only those residents who occupy beds that were decertified for Medical Assistance funding in 1989.

Explanation

The Governor's Budget transfers GPR funding for specialized services for all three IMDs in the state from the Medical Assistance (MA) appropriation to the IMD GPR appropriation in the Division of Supportive Living. This IMD appropriation funds a portion of the care of residents who occupy IMD beds that were decertified for MA reimbursement in 1989. The amount transferred to DSL is equal to the actual amount that MA paid for specialized services for eligible people in the three institutions in FY 98. The Governor's Budget recommends transferring the funds because the Trempealeau County IMD was completely decertified for MA funding in September 1998 and therefore can no longer receive specialized services funding from the MA appropriation. The intent of the transfer is to continue funding specialized services for all beds on an ongoing basis regardless of whether the institution was decertified.

The current language in the statute (s. 46.266) that governs the IMD GPR appropriation limits the number of IMD residents the Department can fund from the appropriation in two ways. First, under par. (1), it defines eligible persons as those who a) were residents of the facility in 1989 and whose care is disallowed for MA reimbursement, b) a non elderly adult who has replaced one of the people in (a), and c) people relocated to the community who return to the IMD within 6 months. Second, under par. (3), it limits the total number of beds that can be funded from the appropriation at any time to the number of beds that were originally occupied by people under (1)(a) minus the number of beds that have closed since then.

Under this language, with the transferred funds, the Department would be able to fund specialized services for 63 IMD beds at Trempealeau that were decertified in 1989 and similar beds at the other two IMDs. However, it would not allow the Department to fund services for the other 13 beds at Trempealeau that were MA certified until last summer or for beds at the other IMDs that remain MA certified.

The governor's budget bill partially solves this problem by expanding the eligible persons under (1) to include any resident of the facility determined to require specialized services. However, it does not amend (3) to increase the number of beds we can fund services for above the number decertified in 1989.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
April 9, 1999

Prostate Cancer Non-Statutory Language
DIN 5105

Description of Change

Add a non-statutory provision to the budget bill providing that, notwithstanding s.50.135 (2)(c), $50,000 of the licensing and approval fees for inpatient health care facilities in FY 01 may be allocated to the prostate cancer prevention program in the Division of Public Health.

Explanation

The Department requested $50,000 GPR in FY 01 to set up an advisory committee to draft guidelines for the care and treatment of prostate cancer in Wisconsin. In the Governor's budget, funding for this was to be provided from licensing and approval fees for inpatient health care facilities (s.50.135). Due to an oversight, non-statutory language that would allow the Department to use these fees for this purpose was omitted from the budget request.

The Governor's budget request included the prostate cancer prevention program. This technical change will allow licensing and approval fees to be used for this prevention initiative.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
0		0			

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
April 13, 1999

DIN Title NA

DIN Number NA (statutory language change)

Description of Change

Change sections 996, 1023 and 1091 to replace "Before July 1, 2006" with Before July 1, 2005.

Explanation

The Department's budget request and the narrative description in the Executive Budget propose the creation of a statutory provision requiring the Department to establish, and the counties to implement, a statewide automated child welfare information system before July 1, 2005. The budget bill inadvertently establishes the date as July 1, 2006.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget Request
March 19, 1999

DIN Title 2% State Operations Lapse Reductions

DIN Number 4000

Description of Change

Increase appropriation 604 by $232,400 GPR in FY 00 and FY 01.

Increase the position authority in 690 by .5 FTE.

Explanation

Because of an error in implementing the 2% state operations reduction for the Division of Supportive Living, the Governor's Budget reduces the SSI administration budget by $232,400 too much and inadvertently deletes .5 FTE.

In its original 2% reduction plan included in its 99-01 Biennial Budget Request, the Department recommended that $305,000 GPR of the SSI administration budget be replaced with an equal amount of TANF funds, on the grounds that a portion of the administrative expenses are related to the costs of making Caretaker Supplement Payments to SSI parents with dependent children. A portion of the Caretaker Supplement (C-Supp) benefits are funded with TANF.

DOA concluded that only $75,000 of the SSI administration budget could be attributed to C-Supp and asked DHFS to produce a plan for saving the remaining $230,000 GPR. In November, the Department submitted a plan that involved transferring an additional $45,000 GPR of the SSI administrative budget to federal Medical Assistance funding and transferring 3.11 FTE from GPR to PR funding. Most of this plan was implemented in the Governor's budget. However, the original $305,000 reduction to the SSI administration budget was not removed. In addition, while 3.11 FTE GPR were deleted, only 2.61 FTE PR positions were created, resulting in a net reduction of .5 FTE.

If the reduction to the SSI administration budget is not restored, the Department will not have sufficient funds to make monthly SSI state supplement and C-Supp payments to approximately 100,000 disabled and elderly individuals in the state. If the .5 FTE position is not restored, the Department will be unable to perform important functions related to administering $23 million in state substance abuse treatment and prevention programs.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
232,400	.5	232,400	.5	(6)(ee) (6)(mc)	604 690

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

2% State Operations Reductions
DIN 4000

Description of Change

Modify the GPR reduction in the Division of Public Health. Maintain the same GPR dollar reduction, but delete 1.24 GPR FTE instead of the 0.5 GPR FTE in the bill. Also, provide an additional .24 FED FTE as an offset to the .24 GPR FTE reduction.

Explanation

The Division of Public Health's 0.5 GPR FTE reduction was part of a chief medical officer (CMO) position. This was not the Division's intent. Instead, the Division has determined that it wishes to substitute alternative GPR position reductions and maintain the CMO, whose prevention functions are statutorily mandated. This proposal deletes additional GPR position authority compared to the Governor's budget, but the GPR dollar reduction stays the same. This is due to the differences in salary and fringe costs for the CMO versus the other positions identified for reduction.

This proposal would: 1) restore 0.5 GPR FTE from position #18570 (the CMO); 2) delete 1.0 GPR vacant position #40866. This is a fiscal liaison position whose duties will be absorbed by other DPH staff; 3) switch funding for .24 FTE on position #316628 (a public health educator) from GPR to FED (Prevention Block Grant).

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
$0	(0.74)	$0	(0.74)	1(a)	101
$18,800	.24	$18,800	.24	1(mc)	190

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

AIDS/HIV Insurance Program
DIN 5103

Description of Change

Restore $327,200 GPR in FY 00 and $121,500 GPR in FY 01 for the AIDS/HIV Insurance Premium Subsidy Program.

Explanation

The Governor's budget contains a technical error where the amount of GPR reduction needed to fund the AIDS/HIV Insurance program was double-counted. Funding needs to be restored to cover estimated insurance program expenditures in 1999-01.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
$327,200		$121,500		5(am)	515

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

TANF Funded WIC Administration

Description of Change

Provide $500,000 PR expenditure authority in DHFS to allow for the transfer of new TANF WIC-related administration funding in DWD to be distributed through existing DHFS WIC contracts.

Explanation

The Governor's budget provides $500,000 TANF annually (Section 1326) for local agencies that administer the women, infants and children (WIC) program. Discussions with DWD staff have indicated that they would be supportive of entering into an MOU with DHFS to transfer this funding to DHFS so that the funds could be distributed to local agencies through the existing consolidated WIC contracts that DHFS administers.

This change will allow for the most efficient distribution of the new TANF funds.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
$500,000		$500,000		5(kz)	569

Agency: DHFS
Agency Contact: Ellen Hadidian
Phone: 266-8155

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

MA Estate Recovery Changes
DIN 8202

Description of Change

Decrease the amount of recoveries (increase expenditure authority) due to changes in the State's Estate Recovery Program (ERP) by $357,600 AF ($147,400 GPR, $210,200 FED) in SFY00 and $476,700 AF ($196,600 GPR, $280,100 FED) in SFY01.

Explanation

The savings estimates currently in the Governor's budget reflect a programmatic provision (Expansion of the Definition of Estate) that was not included in the statutory language of the Governor's budget. In addition, the estimated savings of the proposed statutory changes have been re-estimated. These revised figures more accurately reflect estimated amount of recoveries due to the proposed statutory changes by in the Estate Recovery Program in the Governor's budget.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
147,400		196,600		(4) (b)	404
210,200		280,100		(4) (o)	453

Agency: DHFS
Agency Contact: Richard T. Chao
Phone: 267-0356

DHFS

Department of Health and Family Services
1999-2001 Technical Adjustment Bill
March 19, 1999

Account for DCTF Project Position Cuts as CIP Cuts

DIN Title: Remove Noncontinuing Elements from Base

DIN Number: 3002

Description of Change

Provide $52,500 PR in FY00 and $123,800 PR in FY01 to restore funding for 2.0 FTE in FY00 and 4.00 FTE in FY01. The restored funding will be used toward the amount of lapse required for CIP placements. Position authority need not be restored; the positions will not be refilled when the project period ends.

Explanation

The DHFS budget request deleted the above amounts and FTE in DIN 3002, and requested the funds be restored and the positions converted to permanent status in DIN 4525, Extend/convert project positions. This request was denied; however, in the past DHFS has used funds related to ending project positions toward the CIP cut amount.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Fund Source
$52,500	0.00	$123,800	0.00	(2)(gk)	PR

Agency: DHFS
Agency Contact: Cindy Daggett
Phone: 266-5380

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
March 19, 1999

DIN Title Brighter Futures

DIN Number 5312

Description of Change

1. The budget bill transfers $200,000 from appropriation (7)(mb), numeric 744, in the Division of Supported Living (DSL), to appropriation (3)(nL), numeric 398, in the Division of Children and Family Services. The funding should be transferred back to appropriation (7)(mb).

2. The budget bill requires the Department to use a competitive process to award funds to the Tribes. Section 1122, under 46.99 (2)(c) should be amended to exclude the Tribes from the competitive process.

3. The amount identified for Milwaukee county in section 1122, under 46.99 (2)(a), should be increased from $1,250,600 to $1,355,700, and the amount identified for non-Milwaukee counties should be decreased from $1,109,300 to $1,004,200.

Explanation

1. The budget bill places $200,000 of funding for programs for adults and youth, currently administered by DSL, in the Brighter Futures proposal. Currently, these funds are allocated to four inner city councils who use the funds for both youth and adults and for both treatment services and prevention. Brighter Futures is intended to be a prevention program and the target group is youth. Therefore, the $200,000 should remain in the Division of Supported Living.

2. The grants currently received by the Tribes from the funding included in the Brighter Futures proposal are awarded to the Tribes through a consolidated grant process. In other words, they already receive several sources of funds in one contract, a major feature of the Brighter Futures proposal. The Department specifically excluded the Tribes from the Brighter Futures proposal, mainly for this reason.

3. The bill specifies the amount of funding to be awarded to non-Milwaukee counties, in Milwaukee County, and to the Tribes. The amounts specified were intended to represent the amounts currently awarded under the separate categorical programs which

have been combined into the Brighter Futures appropriation in the bill. The Department inadvertently included $105,100, currently provided to agencies in Milwaukee County, in the amounts specified for non-Milwaukee counties.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
$200,000		$200,000		(7)(mb)	744
(-$200,000)		(-$200,000)		(3)(nL)	398

DHFS

Department of Health and Family Services
Technicals to 1999-2001 Biennial Budget
April 13, 1999

DIN Title Milwaukee Child Protective Services

DIN Number **5310**

Description of Change

Increase funding in the salary line by $13,600 in FY 00 and by $12,000 in FY 01 in appropriation (3)(cw), numeric 314, and decrease the salary line by the same amounts in appropriation (3)(mw), numeric 352. Increase funding in the fringe line by $32,200 in FY 00 and by $33,600 in FY 01 in appropriation (3)(cw), numeric 314, and increase funding by $12,800 in FY 00 and by $11,500 in FY 01 in appropriation (3)(mw), numeric 352.

In appropriation (3)(cw), numeric 314, increase funding in the supplies and services line by $214,700 and decrease funding in the salary line by $158,600 and decrease funding in the fringe line by $56,100 to correct a coding error related to overtime.

In appropriation (3)(cw), numeric 314, increase funding in the internal DP line by $113,600 in FY 00 and by $119,300 in FY 01 to correct a coding error.

Explanation

These adjustments are needed to correct coding errors in the Governor's budget.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Numeric
159,400		164,900		(3)(cw)	314
(800)		(500)		(3)(mw)	352

DHFS

Department of Health and Family Services
1999-2001 Technical Adjustment Bill
April 16, 1999

Social Worker and Vocational Rehabilitation Counselor Pay Increases

Description of Change

Provide $282,300 GPR, $116,700 PR and $105,700 PRF in DHFS appropriations to fund recently negotiated pay increases for social workers and vocational rehabilitation counselor positions.

Explanation

The Department of Employment Relations has negotiated contracts with WSEU to assign certain specified classifications to higher levels. The reassignments result in higher individual salaries of approximately $1.11 per hour. These wage increases, when multiplied by the number of DHFS employes and annualized result in costs that cannot be absorbed by DHFS within existing budget levels.

FY 00		FY 01		Appropriation	
$	FTE	$	FTE	Alpha	Fund Source
SW's, VRCs					
$282,300		**$282,300**		**Various**	**GPR**
$116,700		**$116,700**		**Various**	**PR**
$105,700		**$105,700**		**Various**	**PRF**

Agency: DHFS
Agency Contact: Cindy Daggett
Phone: 266-5380

Impact on DHFS of DER Negotiated Wage Settlements

Social Workers	
201	$50,100
202	$20,800
203	$20,800
301	$600
314	$171,500
GPR Total	$263,800
228 (PR)	$56,800
229 (PR)	$35,100
237 (PR)	$2,300
267 (PR)	$6,900
PR Total	$101,100
352 (PRF)	$45,600
355 (PRF)	$33,500
392 (PRF) may be a GPR cost since SSBG cannot absorb	$26,600
PRF Total	$105,700
All Funds Total	$470,600
Vocational Rehabilitation Counselors	
601 GPR	$18,500
667 PR	$15,600
All Funds Total	$34,100
GPR Total for All Classes	$282,300
PR Total for All Classes	$116,700
PRF Total for All Classes	$105,700
Grand Total	$504,700

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

April 29, 1999

The Honorable Brian Burke
Senate Co-Chair, Joint Committee on Finance
Room 316 S, State Capitol
Madison, WI 53702

The Honorable John Gard
Assembly Co-Chair, Joint Committee on Finance
Room 315 N, State Capitol
Madison, WI 53702

Dear Senator Burke and Representative Gard:

As noted in my March 24 testimony, I am submitting with the concurrence of the Department of Administration a number of statutory language changes for the Family Care budget item. These changes are based on developments since completion of the Governor's budget. These developments include recent discussions between Department staff and federal officials, comments received from stakeholder groups, and discussion between Department staff and staff in the pilot county sites regarding operational aspects of Family Care. I would appreciate the Joint Finance Committee's favorable consideration of these proposals.

Sincerely,

Joe Leean
Secretary

cc Bob Lang, LFB
Charlie Morgan, LFB
Richard Megna, LFB
Mark Bugher, DOA
Jennifer Kraus, DOA
Gretchen Fossum, DOA

DHFS proposed substantive amendments to Family Care legislation

Topic: Limiting Family Care pilots

Amend s. 46.281 (1) (d) and (e) to read:

(d) Before July 1, 2001, in geographic areas of the state whose total eligible Family Care population does not exceed 29% of the state's total eligible Family Care population:

1. Establish~~, in geographic areas determined by the department,~~ a pilot project under which the department may contract with a county, a family care district, a tribe or band or the Great Lakes inter-tribal council, inc., or with any 2 or more of these entities under a joint application, to operate a resource center.

2. Contract with counties or tribes or bands under a pilot project to demonstrate the ability of counties or tribes or bands to manage all long-term care programs and administer the family care benefit as care management organizations.

(e) 1. Before November 1, 2000, prepare and submit to the Governor, as part of the Department's biennial budget request for 2001-2003, a report describing the implementation and outcomes of the pilot projects under par. (d) and recommendations on whether resource centers, care management organizations and the family care benefit should be continued and expanded.

2. After June 30, 2001, subject to the approval of necessary funding, contract with one or more entities certified as meeting requirements under s. 46.284 (3) for services of the entity as a care management organization and one or more entities for services specified under s. 46.283 (3) and (4), in those areas of the state as authorized by the legislature.

Explanation:
Many stakeholders are concerned that this legislation authorizes the expansion statewide of the Family Care program, regardless of the findings of evaluation of the pilots. The proposed revisions are intended to explicitly condition the continuation and further expansion of Family Care on the approval of the Governor and Legislature.

Topic: Phase-in of requirement for separation

Amend s. 46.285 (intro) and add a sub. (4) as follows:

46.285 (intro) ~~In~~ Except as provided in sub. (4), in order to meet federal requirements and assure federal financial participation in funding of the family care benefit, a county, a tribe or band, a family care district or an organization, including a private, nonprofit corporation, may not directly operate both a resource center and a care management organization. ~~All~~ Unless the department approves a different method of achieving necessary separation, all of the following apply to operation of both a resource center and a care management organization:

46.285 (4) A county or tribe operating pilots under s.46.281 (1) (d) 1. and 2. shall achieve separation between operation of a resource center and a care management organization within a time frame established by the department as allowed under federal requirements.

Explanation:
Creation of a Family Care District is not the only way that counties and tribes can achieve necessary separation between the Resource Center and the CMO; the suggested amendment is intended to clarify this point. In addition, the amendment would allow a phase-in period for the initial pilot counties to achieve requirements for separation between the Resource Center and the CMO. It will take some time for them to create new units of government or otherwise achieve the necessary separation. HCFA has given informal advice that these entities need not be separate until consumers may access Medicaid home and community waiver services only through the Family Care benefit.

Topic: Family Care District Board Membership

Amend **s. 46.2895 (3) (b) 3.** to read:

3. Membership of the family care district board under subd. 1. or 2. shall reflect the ethnic and economic diversity of the area of jurisdiction of the family care district. ~~No member~~ Not more than 25% of the members of the board may be ~~an~~ elected or appointed officials or ~~an employe~~ employes of the county or counties that created the family care district. No member of the board may have a private financial interest in or profit directly or indirectly from any contract or other business of the family care district.

Explanation:
A complete prohibition on overlap between the board of the Family Care District and the County Board of Supervisors that created it may be too severe. County boards are reluctant to create an entity with which it has no direct connection and the Department believes that the federal Health Care Financing Administration will accept some overlap.

Topic: Clarifying jurisdiction and possible roles of Family Care Districts

Amend **s. 46.2895 (1) (a) 1. b.** to read:

b. Specifies the family care district's primary purpose, which shall be to operate, under contract with the department, either a resource center to perform all or part of the functions under s. 46.283 or a care management organization under s. 46.284, but not both.

Amend **s. 46.2895 (1) (b)** to read:

The county boards of supervisors of 2 or more ~~contiguous~~ counties may together create a family care district with the attributes specified in par. (a) (intro) on a multicounty basis within the counties if the county boards of supervisors comply with the requirements of par. (a) 1. and 2.

Amend **s. 46.2895 (3) (a) 2.** to read:

The county boards of supervisors of 2 or more ~~contiguous~~ counties shall appoint the members of the family care district board, which is the governing board of the family care district under sub. (1) (b). Each county board shall appoint members in the same proportion that the county's population represents to the total population of all of the counties that constitute the jurisdiction of the family care district.

Explanation:
These amendments would clarify that a Family Care District could be formed to perform only part of the Resource Center functions (e.g., functional and financial screens and eligibility determination and enrollment counseling), and that two or more counties can form a multicounty district whether or not they are contiguous. These amendments are intended to provide additional options for counties to provide the separation between the CMO and those particular functions of the Resource Center that is necessary to prevent conflicts of interest.

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

May 4, 1999

The Honorable Brian Burke
Senate Co-Chair, Joint Committee on Finance
Room 316 S, State Capitol
Madison, WI 53702

The Honorable John Gard
Assembly Co-Chair, Joint Committee on Finance
Room 315 N, State Capitol
Madison, WI 53702

Dear Senator Burke and Representative Gard:

As noted in my March 24 testimony, I am submitting with the concurrence of the Department of Administration a number of statutory language changes for the Health Insurance Risk Sharing Plan (HIRSP). It is expected that these changes will increase fiscal accountability, reduce plan complexity for policyholders, and increase provider satisfaction with the program. The HIRSP Board of Governors has approved all of the proposed changes in concept. I would appreciate the Joint Finance Committee's favorable consideration of these proposals.

Sincerely,

Joe Leean
Secretary

cc Bob Lang, LFB
Charlie Morgan, LFB
Amie Goldman, LFB
Mark Bugher, DOA
Jennifer Kraus, DOA
Sue Jablonsky, DOA

DHFS

Department of Health and Family Services
1999-01 Biennial Budget Statutory Language Request
May 5, 1999

HIRSP PROGRAM RESTRUCTURING

Current Language

Created by the legislature in 1980, the Health Insurance Risk-Sharing Plan (HIRSP) provides health insurance coverage for the state's medically uninsurable population or those unable to obtain affordable coverage in the private market because of their health conditions.

Effective 01/01/98 the administration of HIRSP was transferred from the Office of the Commissioner of Insurance to the Department. Payment for the operating and administrative costs of the plan are funded through policyholder premiums, insurance assessments, provider payment rate reductions, and state GPR.

Proposed Changes

Section 20.435

1. Modify s. 20.435 (8) (k) to add 0.5 FTE and corresponding annual expenditure authority of $40,500. Support for this appropriation will be transferred from s. 20.435 (4) (u).

2. Modify s. 20.435 (4) (u) Health insurance risk-sharing plan; administration:
   - Change the appropriation to a biennial SEG appropriation.
   - To fund a total of 3.5 FTE and 1.0 project positions.
   - To include administrative expenses for the plan administrator (EDS).
   - Annual expenditure authority for this appropriation shall be $3,805,000.
   - Support for this appropriation will be transferred in the amounts as stated in the schedule from the HIRSP Fund as described in s.149.125.

3. S. 20.435 (4) (gh) is renumbered to s. 20.435 (4) (uu) and amended as stated below:
   - Rename the appropriation, Health Insurance Risk-sharing plan; program benefits funding.
   - This will be a SEG, continuing, appropriation to be funded in the amounts in the schedule from the HIRSP Fund as described in s. 149.125.
   - This appropriation would be used to fund program expenditures for the HIRSP program with annual expenditure authority of $46,668,500.

- Revenue sources for the appropriation include:
  - In a separate numeric, the amount in schedule from HIRSP Fund as described in s. 149.125, to be used as specified in s. 149.143 (1) (b) 1.b. (policyholder premium support).
    - ✓ This numeric will be funded from monies received from the plan administrator under s. 149.143 (2) (a) 1.c.
    - ✓ Amend provisions that these monies can be only for the following purposes:
      1. Relief of policyholder premiums as before.
      2. Permit the Department to use these monies for other policyholder needs such as subsidizing copayment for pharmacy, with majority approval by the HIRSP Board.
  - In a separate numeric from the above stated funds for policyholder premium support, the amount in schedule from HIRSP Fund as described in s. 149.125 to be used to support program benefits.

Chapter 25

State that the State of Wisconsin Investment Board may invest the monies from the HIRSP Fund as described in s. 149.125

Section 149.125

Modify the HIRSP Fund, which will be comprised of:
- All monies received from s. 20.435 (4) (af).
- All monies received from s. 20.435 (4) (ah).
- All monies received from the plan administrator under s. 149.143 (2) (a) 1.c.
- All monies received from premiums from eligible persons with coverage under s. 149.14.
- Insurance assessments as specified in 149.143 (1) 2.a.

State the these segregated funds will be used to support s. 20.435 (4) (u) and s. 20.435 (4) (uu) to support HIRSP administrative and program activities.

Section 149.14 Coverage

Amend statute in this section to comply with the following instructions:

1. Provide DHFS with authority to set HIRSP rates for the various provider groups based on the following guidelines:
   - Each plan year the Department shall examine provider rates and these rates may be adjusted based on changes in the Medicaid rate, projected plan costs, and trend factors.

- Hospitals: The Department will create HIRSP-specific outpatient rates per visit and inpatient DRGs with outlier protections similar to Medicaid.
- Pharmacists: The Department will pay pharmacists Medicaid fee-for service rate for dispensing fees and drug products.
- Physicians and Related Professions: The Department will pay physicians and related professionals an enhanced Medicaid rate, which will be comprised of the Medicaid maximum allowable fee plus an additional rate to be determined by the Department.

2. Apply the same utilization and control procedures to HIRSP that are applied to Medicaid under HSS 101 – 108, except that HIRSP will not apply the co-payment provisions in s.49.45 (18).

3. Provide authority for DHFS to apply MA service and coverage policies to HIRSP, where MA is more restrictive than HIRSP and where such policies do not conflict with insurance mandates. Retain requirement for HIRSP providers to be Wisconsin Medicaid-certified.

4. Create Section 149.14 (3) (dd). State that the Department may elect to cover and reimburse any or all drugs, only if claims are submitted via direct pharmacy billing to the plan administrator. In addition state that the Department may require any or all participating pharmacies to bill the plan administrator directly for any or all drug reimbursement.

5. Section. 149.14(5)(d) is to be amended to reflect that Medicaid cost containment provisions will be applied to coinsurance.

6. Section 149.14 (5) State that the Department may use copayment amounts for pharmaceuticals toward deductibles.

7. Create Section 149.14 (5c). In this section state:
   - The plan may establish copayment levels, to be determined by the Department, for the use of pharmaceuticals.
   - The Department will determine any maximum copayment level.
   - The Department may count copayment amounts toward deductibles, coinsurance and total out-of-pocket expenses.

Section 149.143 Payment of plan costs.

Retain current formula for determination of costs; however:

1. Modify Section 149.143 (1) (b) 1.b. to refer to specific funds within the appropriate numeric of s. 20.435 (4) (uu) used for policyholder premium support, which has now replaced appropriation 20.435 (4) (gh).

2. Modify Section 149.143 (1) (b) 2.b. to state that the providers' share is an approximate percentage across all provider groups calculated once annually.

3. Create section, which states that the Department will engage in an annual reconciliation process. This process will be based prospectively on the previous calendar year and implemented in the subsequent plan year. This reconciliation process will be completed by April 30th with needed changes in premiums, insurance assessments, and provider rates effective July 1st.

4. Modify Section 149.143 (2) (a) 1. c. to refer to the specific funds in s. 20.435 (4) (uu) instead of s. 20.435 (4) (gh).

Section 149.15 (3)(e) is to be repealed since the application of Medicaid rates makes this section moot.

Effect and Rationale of the Change

Increased plan costs in the HIRSP program have been a problem in recent years. Prior to 1997, these increased costs resulted in higher policyholder premiums, increased insurance assessments, and a sharp decrease in enrollment.

As part of the 1997-99 Governor's biennial budget proposal, the Governor recommended transfer of the HIRSP program from OCI to DHFS and addressed two major concerns. First, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that states pick one of four options with regard to individual insurance market reform or be subject to federal default provisions. In response to that requirement, the state has opted to modify certain statutory provisions of HIRSP as provided for under HIPAA to allow the state to use the HIRSP program as the selected option under HIPAA.

Second, the Governor proposed reducing the costs of the HIRSP program (and thereby the costs to be borne by enrollee premiums and insurer assessments) by paying health care providers who provide services to HIRSP enrollees at rates equivalent to rates paid under the MA program. Services that were currently covered by HIRSP would continue to be covered. However covered expenses under HIRSP would be limited to the allowable charges paid under the MA program.

The final 1997-99 biennial budget (Act 27) did not include the requirement that HIRSP rates be set at Medicaid rates. Instead, the Act provided for payment for the operating and administrative costs of the plan through policyholder premiums, insurance assessments, provider contribution generated through payment rate deductions, and an additional $11.9 million annually in state GPR. However, the complicated funding formula created an administratively complex and cumbersome program and many difficulties in administering the programs still exist.

One area of difficulty is fiscal accountability. Currently, only a small portion of the total program activity is recorded in the state budget. The majority of the program is fiscally

administered "off the books" outside the state accounting system. The proposed changes will permit the entire program to be fiscally recorded in the state accounting system, which will permit better record keeping and clear delineation between program benefits and administrative expenses. In addition, the inclusion of the program in the state accounting system will permit the State of Wisconsin Investment Board (SWIB) to invest program revenues.

Another area of program difficulty is that the current methodology for determining provider discount rate for the various provider groups is inequitable and technically difficult to calculate. As it stands, the current language specifying provider contributions in the form of provider discounts does not adequately address the complexities and differences between and within the different provider groups. The proposed changes will permit the Department to more equitably and accurately determine the level of provider contributions across provider groups.

In addition, the proposed changes also address some of the administrative complexities of the program. Compared to similar programs, the HIRSP program has a high level of administrative activities. For example, in the current system policyholders must individually submit claims for prescription medication. The proposed changes, including authorizing the Department to establish co-payments for the use of pharmaceutical products, creates incentives for the pharmacies rather than the policyholders to submit drug claims. It is expected that this change will reduce plan complexity for the policyholder, increase provider satisfaction and lower overall administrative burden and expenses.

Desired Effective Date:	January 1, 2000
Agency:	DHFS
Agency Contact:	Richard T. Chao
Phone:	267-0356

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

July 23, 1999

The Honorable Brian B. Burke
Co-Chair, Joint Committee on Finance
316 South Capital
Madison, WI 53707

Dear Senator Burke:

The purpose of this letter is to document for your committee the $1,154,000 in excess federal reimbursement which our Department has identified this state fiscal year.

The excess federal reimbursement, and the disposition of these funds as approved by the Department of Administration (DOA), is explained below:

I. AVAILABLE EXCESS FEDERAL REIMBURSEMENT

A. Federal Grant Close Out - $1,154,000

From the FFY97 and 98 final close out of the IV-B Child Welfare Grant, the Department was able to realize $209,300. The Substance Abuse and Community Mental Health Block Grants close out resulted in $944,700 (FFY95 - $4,000, FFY96 - $479,100 and FFY97 - $461,600). These funds were derived from identifying allowable project costs paid from prior year GPR that could be claimed from federal funds during the close out process.

II. DISPOSITION OF EXCESS FEDERAL REIMBURSEMENT

A. Federal Disallowance

DOA has approved reserving $472,800 for the following disallowance:

- Adoption and Foster Care Analysis and Reporting System (AFCARS) - $472,800

The Department was informed that it was not in substantial compliance with the State plan requirements for the title IV-E Social Security Act since it failed to meet the AFCARS data submission standard set forth in 45 CFR 1355.40 (a-d), because Milwaukee County was unable to provide the data in a timely manner. A penalty notification has been received for the period October 1, 1997 – September 30, 1998. The amount of the penalty is calculated at $78,800 per each six month report period. (2 periods x $78,800 = $157,600). The reporting requirements have been successfully implemented in 71 of our 72 counties. However, the collection of missing data for the remaining county, Milwaukee, which accounts for 97.6% of our errors,

will not be completed until December 1999, enabling submission of an acceptable report for the period beginning October 1, 1999. The Department anticipates receiving an additional penalty for the reporting period October 1, 1998 – September 30, 1999. The penalty is increased for this period to a total of $315,200.

B. **GENERAL FUND LAPSE - $681,200**

We are lapsing $681,200 to the state general fund this fiscal year.

SUMMARY

CURRENTLY AVAILABLE		DISPOSITION	
Grant Close Out	$1,154,000	Federal Disallowance	$ 472,800
		General Fund	681,200
	$1,154,000		$1,154,000

If you have any questions, or need additional information, please let us know.

Thank you.

Sincerely,

Joe Leean
Secretary

cc: Representative John Gard
Robert Lang, LFB

THE STATE OF WISCONSIN

SENATE CHAIR
BRIAN BURKE

316-S Capitol
P.O. Box 7882
Madison, WI 53707-7882
Phone: (608) 266-8535

ASSEMBLY CHAIR
JOHN GARD

315-N Capitol
P.O. Box 8952
Madison, WI 53708-8952
Phone: (608) 266-2343

JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Brian Burke
Representative John Gard

Date: October 21, 1999

Attached is a copy of a report from the Department of Health and Family Services, pursuant to s. 49.45 (6v) (b) and (c), Stats. The report provides information on the utilization of nursing home beds by Medical Assistance recipients.

The report is being provided for your information only. No formal action is required by the Committee. Please feel free to contact us if you have any questions.

Attachment

BB:JG:dh

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

October 13, 1999

The Honorable Brian Burke
Senate Co-Chair, Joint Committee on Finance
Room 316 S, State Capitol
Madison, WI 53702

The Honorable John Gard
Assembly Co-Chair, Joint Committee on Finance
Room 315 N, State Capitol
Madison, WI 53702

Dear Representative Gard and Senator Burke:

1997 Wisconsin Act 27 directs the Department of Health and Family Services to submit an annual report of the previous fiscal year's utilization of nursing home beds by Medical Assistance (MA) recipients to the Joint Committee on Finance. Wisconsin Statute 49.45(6v)(c) requires that if the report shows a decrease in bed utilization by MA recipients, the Department propose a transfer of funds associated with that decrease from the MA budget to the Community Options Program. Under the methodology adopted by DHFS with concurrence of DOA, the Department proposes a transfer only if such a transfer does not result in a deficit to the overall MA appropriation.

The number of nursing home patient days budgeted for FY 99 was 10,873,873. In FY 99, MA recipients utilized 10,489,173 nursing home patient days, 384,700 days less than budgeted. An analysis of patient days by level of care and the average daily cost for each care level indicated that the patient days under the budgeted amount represented a savings of approximately $28,371,500 (approximately $11.7 mn. GPR).

Although the actual nursing home bed utilization for FY 99 was less than the budgeted amount, the Department does not propose a transfer of any MA funds to the Community Options Program for FY 99. While the nursing home expenditures for FY 99 were below the budgeted level, the overall spending in the MA program for FY 99 exceeded the budgeted level. While several MA services were over the budgeted amount, the largest items were pharmacy ($22.1 mn. GPR), personal care ($8.0 mn. GPR) and waiver programs ($7.1 mn. GPR).

The budget for the 1999-2001 biennium accounts for the deficit incurred in FY 99 and calculates nursing home days based on the lower utilization of days incurred in FY 99. Transferring MA funds from the MA appropriation to COP would create a deficit in the overall MA appropriation which has not been taken into account in the proposed 1999-2001 budget.

Thank you for your attention to this report.

Sincerely,

Joe Leean
Secretary

Attachment

1 West Wilson Street• Post Office Box 7850• Madison, WI 53707-7850• Telephone (608) 266-9622

Budgeted and Actual Nuring Home Patient Days, SFY99

	SNF	ICF1/2	ICF3/4	ICF-MR	IMD<21	IMD>65	Subtotal w/o DD Ctr & King
1. SFY99 Budget Patient Days (A.)	8,559,279	1,583,620	943	702,499		27,532	10,873,873
2. SFY99 Actual Patient Days (B.)	8,233,963	1,475,377	34,313	723,475		22,045	10,489,173
3. SFY99 Actual less SFY99 Budget P.D.	(325,316)	(108,243)	33,370	20,976		(5,487)	(384,700)
4. SFY99 Avg Cost (C.)	79.18	60.80	57.56	123.58		99.23	$79.66
5. Payments over / (under) budget	($25,759,285)	($6,580,780)	$1,920,747	$2,592,284	$0	($544,469)	($28,371,504)

A. LFB worksheet for the 97-99 biennual budget less actual King days from MEDS Report

B. Nursing home accomodation (MEDS) report SFY99, BHCF

C. Report in B. plus financial transation total from BHCF budget monitoring report SFY99

F:act469\SFY99: L. Updike, BHCF 28Sep99

STATE OF WISCONSIN

SENATE CHAIR
BRIAN BURKE

316 South, State Capitol
P.O. Box 7882
Madison, WI 53707-7882
Phone: 266-8535

ASSEMBLY CHAIR
JOHN GARD

315 North, State Capitol
P.O. Box 8952
Madison, WI 53708-8952
Phone: 266-2343

JOINT COMMITTEE ON FINANCE

December 1, 1999

Mr. Joe Leean, Secretary
Department of Health and Family Services
1 West Wilson Street
Madison, WI 53703

Dear Secretary Leean:

On November 24, 1999, the Committee received four requests that you have asked the Committee to address at its December 21 meeting under s. 13.10 of the statutes.

One item requests the transfer of $1 million from the Committee's supplemental GPR appropriation to the Department in 1999-00 to award as a grant to the successor of the Rainbow Clinic in Milwaukee, as provided under s. 9123(9k) of 1999 Wisconsin Act 9. This provision prohibits DHFS from awarding the grant unless the Department submits to the Co-Chairs of the Committee a report that details the amount of the proposed grant and the services that would be provided under the grant by the community health center. The provision also specifies that, if the Co-Chairs of the Committee do not notify the DHFS Secretary within 14 working days after receiving the report that the Committee has scheduled a meeting for the purpose of reviewing the report, DHFS must award the grant. If, within 14 working days after receiving the report, the Co-Chairs notify the DHFS Secretary that the Committee has scheduled a meeting for the purpose of reviewing the report, DHFS may award the grant only if, and to the extent that, it is approved by the Committee.

Your letter indicates that the Department is currently preparing this report. However, the Act 9 provision establishes a 14-day passive review period that will begin once the Department submits the report. Consequently, the Committee will review this request under the procedure set forth in Act 9.

Sincerely,

BRIAN BURKE
Senate Chair

JOHN GARD
Assembly Chair

BB:JG:js

cc: Members, Joint Committee on Finance

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

December 14, 1999

The Honorable Brian Burke
Senate JFC Co-Chair
Wisconsin Senate
Room 316 South, State Capitol
Madison, Wisconsin 53702

Dear Senator Burke:

Section 46.03(26) of the statutes requires the Department of Health and Family Services to report annually on information systems projects under development. The attached report is a summary of the departmental systems currently under development.

Sincerely,

Joe Leean
Secretary

Attachment

cc: Representative John Gard, Assembly JFC Co-Chair
Don Schneider, Senate Chief Clerk
Charles Sanders, Assembly Chief Clerk