LRB-0032

2003 DRAFTING REQUEST

Bill

Received: **09/13/2002**

Received By: **pkahler**

Wanted: **Soon**

Identical to LRB:

For: **Administration-Budget 7-9546**

By/Representing: **Jablonsky**

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

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - misc**

Extra Copies:

Submit via email: **YES**

Requester's email:

Carbon copy (CC:) to:

Pre Topic:

DOA:.....Jablonsky - BB0004

Topic:

Various cost control provisions for chronic disease aids program

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 09/18/2002	kgilfoy 09/18/2002		_____ _____			State
/P1			pgreensl 09/19/2002	_____ _____	sbasford 09/19/2002		State
/P2	pkahler	kgilfoy	jfrantze	_____	sbasford		

LRB-0032

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	10/14/2002	10/14/2002	10/15/2002	_____	10/15/2002		

FE Sent For:

<END>

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10/15

FE Sent For:

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By/Representing: **Jablonsky**

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May Contact:

Addl. Drafters:

Subject: **Public Assistance - comm. aids**

Extra Copies:

Submit via email: **YES**

Requester's email:

Carbon copy (CC:) to:

Pre Topic:

DOA:..... -

Topic:

Various cost control provisions for chronic disease aids program

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
FE Sent For:		1/1 - 9/18 KMG	9/19 PS	9/19 <END> PS/PS			

Sue Jablonsky

DRAFT

DHFS

Department of Health and Family Services
2003-2005 Biennial Budget Statutory Language Request
August 27, 2002

Modify Chronic Disease Aids Program

Current Language

s.49.68, s.49.682, s.49.683, s.49.685, s. 49.687

Proposed Change

1. Amend s.49.68 (Chronic Renal aids), s. 49.683 (Cystic Fibrosis aids), s.49.685 (Hemophilia treatment services), and s.49.687 (patient financial and liability requirements for Disease Aids) to require potential clients of these program to apply for other state-funded health insurance programs, including Medicaid, before applying for assistance from the Disease Aids program. Provide that "other programs" be defined in rule and include Medicaid, Badger Care and Senior Care. presc. drug

2. Amend s.49.68 (3)(e) to delete the requirement that state aids for services in the Chronic Renal program must be equal to the allowable charges under the Medicare program. In addition, amend the statute to prevent providers from billing any balance of the costs to clients.

3. Amend s.49.687 to allow the program to adopt managed care methods of cost containment.

Effect of the Change

All of the changes would provide the Department the authority to implement cost control measures for the Chronic Disease Aids program. By allowing the Department to set its own pricing guidelines, potential costs to the program will be reduced. Preventing providers from billing any difference between the actual price of services and the amount paid by the Department to patients will ensure that patients do not bear the burden of decreased reimbursement.

Rationale for the Change

Although the Department adopted patient cost sharing and deductible amounts in 1993, it has been difficult to control costs in the Chronic Disease program. Costs for this program, as for all

health care programs, have risen, particularly for drugs. Cost containment measures will be necessary in order to limit expenditures and maintain an equitable level of services for clients of the program.

Desired Effective Date:	Upon passage of bill
Agency:	DHFS
Agency Contact:	Ellen Hadidian
Phone:	266-8155

State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–0032/2
PJK:

DOA:....., – Various cost control provisions for chronic disease aids program

FOR 2003–05 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** changes to the chronic disease aids programs.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under the chronic disease aids program in current law, DHFS provides financial assistance for the cost of medical care for the treatment of chronic kidney disease, cystic fibrosis, and hemophilia to persons with those conditions. This bill makes three changes to the chronic disease aids program for cost control purposes. The bill authorizes DHFS to use managed care methods of cost containment for the chronic disease aids program. The bill eliminates the requirement that the rates paid by DHFS for services provided for the treatment of chronic kidney disease be equal to the allowable charges under the federal medicare program and prohibits a provider of a service for the treatment of chronic kidney disease from billing a patient for any difference between the amount the state pays under the chronic disease aids program and the provider's charge for the service. Finally, the bill provides that a person may not receive benefits under the chronic disease aids program unless, before applying for benefits under that program, the person applies for benefits under other state–funded health care coverage programs for which he or she reasonably may be eligible. DHFS must promulgate rules specifying other state–funded health care coverage programs for which a person must apply, including the medical assistance program, the badger care health care program, and the prescription drug assistance for elderly persons program.

For further information see the ***state*** 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. 49.68 (3) (a) of the statutes is amended to read:

49.68 **(3)** (a) ~~Any~~ Subject to s. 49.687 (1m), any permanent resident of this state who suffers from chronic renal disease may be accepted into the dialysis treatment phase of the renal disease control program if the resident meets standards set by rule under sub. (2) and s. 49.687.

History: 1973 c. 308; 1975 c. 39; 1977 c. 29; 1981 c. 314; 1983 a. 27; 1985 a. 332 s. 251 (1); 1989 a. 311; 1991 a. 316; 1993 a. 16, 449, 491; 1995 a. 27 ss. 3035 to 3044; Stats. 1995 s. 49.68; 2001 a. 16.

SECTION 2. 49.68 (3) (e) of the statutes is amended to read:

49.68 **(3)** (e) State aids for services provided under this section ~~shall be equal to~~ may not exceed the allowable charges under the federal medicare program. In no case shall state rates for individual service elements exceed the federally defined allowable costs. The rate of charges for services not covered by public and private insurance shall not exceed the reasonable charges as established by medicare fee determination procedures. A person that provides to a patient a service for which aid is provided under this section shall accept the amount paid under this section for the service as payment in full and may not bill the patient for any amount by which the charge for the service exceeds the amount paid for the service under this section. The state may not pay for the cost of travel, lodging, or meals for persons who must travel to receive inpatient and outpatient dialysis treatment for kidney disease. This paragraph shall not apply to donor related costs as defined in par. (b).

History: 1973 c. 308; 1975 c. 39; 1977 c. 29; 1981 c. 314; 1983 a. 27; 1985 a. 332 s. 251 (1); 1989 a. 311; 1991 a. 316; 1993 a. 16, 449, 491; 1995 a. 27 ss. 3035 to 3044; Stats. 1995 s. 49.68; 2001 a. 16.

****NOTE: With the amendments that were added to this provision, it may not be accurate to state that the entire paragraph does not apply to donor related costs. Let me know if this paragraph needs to be broken down into subunits and if only one or more of those subunits do not apply to donor related costs.

Also, the instruction just said to delete the requirement that state aids be equal to the allowable charges under Medicare. I assume, however, that the requirement that the state aids not exceed the allowable charges should be retained.

SECTION 3. 49.683 (1) of the statutes is amended to read:

49.683 **(1)** ~~The~~ Subject to s. 49.687 (1m), the department may provide financial assistance for costs of medical care of persons over the age of 18 years with the diagnosis of cystic fibrosis who meet financial requirements established by the department by rule under s. 49.687 (1).

History: 1973 c. 300; Stats. 1973 s. 146.35; 1973 c. 336 s. 55; Stats. 1973 s. 146.36; 1975 c. 39; 1979 c. 34 s. 2102 (43) (a); 1983 a. 27 s. 1562; Stats. 1983 s. 49.483; 1993 a. 16, 449; 1995 a. 27 ss. 3045, 3046, 3047; Stats. 1995 s. 49.683; 1997 a. 27; 1999 a. 9; 2001 a. 16.

SECTION 4. 49.687 (title) of the statutes is amended to read:

49.687 (title) **Disease aids; patient requirements; rebate agreements; cost containment.**

History: 1983 a. 27; 1989 a. 56; 1991 a. 39; 1993 a. 16, 449; 1995 a. 27 ss. 3063 to 3065; Stats. 1995 s. 49.687; 1997 a. 27; 1999 a. 9; 2001 a. 16.

SECTION 5. 49.687 (1m) of the statutes is created to read:

49.687 **(1m)** (a) A person is not eligible to receive benefits under s. 49.68, 49.683, or 49.685 unless, before the person applies for benefits under s. 49.68, 49.683, or 49.685, the person first applies for benefits under all other health care coverage programs specified by the department by rule under par. (b) for which the person reasonably may be eligible.

(b) The department shall promulgate rules that specify other health care coverage programs for which the state provides funding and for which a person must apply before applying for benefits under s. 49.68, 49.683, or 49.685. The programs specified by rule must include the medical assistance program under subch. IV, the badger care health care program under s. 49.665, and the prescription drug assistance for elderly persons program under s. 49.688.

****NOTE: Do we need to specify that the person may receive benefits only if he or she was determined not to be eligible under any of those other health care coverage programs for benefits provided under s. 49.68, 49.683, or 49.685? Another approach would be to say that a person who is eligible for the same or similar benefits under any

of the other state–funded programs specified by DHFS by rule is not eligible for benefits under a program under s. 49.68, 49.683, or 49.685. That way it is implied that he or she must apply to those other programs first and you do not have to say additionally that he or she was determined not to be eligible after first applying to those other programs.

Note that s. 49.68 (3) (d) 1. says that no aid may be granted under s. 49.68 unless the recipient has no other form of aid available from Medicare or private insurance. Should that be expanded to include the other health care coverage programs specified by rule under s. 49.687 (1m)? See also s. 49.685 (6) (b). Perhaps something similar to that language, in conjunction with requiring the person to first apply to those other programs specified by DHFS, should be added to both ss. 49.68 and 49.683. (I assume "contract" or "any other contractual arrangement" includes private insurance.)

SECTION 6. 49.687 (4) of the statutes is created to read:

49.687 **(4)** The department may adopt managed care methods of cost containment for the programs under ss. 49.68, 49.683, and 49.685.

SECTION 9324. Initial applicability; health and family services.

(1) APPLYING FOR CHRONIC DISEASE AIDS PROGRAM. The treatment of sections 49.68 (3) (a), 49.683 (1), and 49.687 (1m) of the statutes first applies to persons who apply for benefits under section 49.68, 49.683, or 49.685 of the statutes on the effective date of this subsection.

SECTION 9424. Effective dates; health and family services.

(1) APPLYING FOR CHRONIC DISEASE AIDS PROGRAM. The treatment of sections 49.68 (3) (a), 49.683 (1), and 49.687 (1m) (a) of the statutes and SECTION 9324 (1) of this act take effect on the first day of the 13th month beginning after the effective date of this subsection.

****NOTE: These initial applicability and effective date provisions provide some time for DHFS to promulgate rules specifying the other programs for which a person must first apply. Do you want to provide a different amount of time or a date certain? Do you want to require DHFS to submit proposed rules within a certain time?

(END)

Kahler, Pam

From: Jablonsky, Sue
Sent: Monday, October 14, 2002 9:28 AM
To: Kahler, Pam
Subject: FW: LRB 0032

Comments on LRB 0032.doc

-----Original Message-----
From: Hadidian, Ellen
Sent: Friday, October 11, 2002 8:46 AM
To: Jablonsky, Sue
Subject: LRB 0032

Sue,

Attached are comments from program staff about LRB 0032, Chronic Disease language. We appreciate the careful work done by the drafter and the questions raised about the direction the stat. language should take. If you agree with the comments, could you forward to LRB? thanks

Comments on LRB 0032, Wisconsin Chronic Disease Program (WCDP) Statutory Language

Drafter's note, p. 2 – No, does not need to be broken down more.

Drafter's note, top of p. 3 – Assumption is correct, state aids should not exceed allowable charges.

P. 3, line 16. Please eliminate "for which the state provides funding," because DHFS does not want to limit this provision to state-funded health insurance only. Disease Aids is meant to be payer of last resort for all programs where that is possible. There is some discussion about whether that is possible with Senior Care, since the federal government has indicated that that program is intended to be the payer of last resort.

DHFS would prefer not to have the application of this policy wait until the rule can be promulgated – is there a way to avoid this? then must specify programs in statu

Drafter's note, p. 3. No, we do not want to specify that someone is not eligible for WCDP if he or she is eligible for another state-funded program, because there is concern that someone might be found eligible for another program but be put on a waiting list for that program. The person would be in need of health care, not able to get it from the program he's wait-listed on, but then could not get benefits from WCDP if we add this provision.

Drafter's note, p. 4, top of page. Yes, language should be expanded to include other health care coverage programs specified under s.49.687 (1m), and language specifying that should be added to ss.49.68 and 49.683.

Drafter's note, p. 4, bottom of page. The Department would like the changes to be effective on the day of publication of the Act, if that is possible. Other changes that might become necessary would be accomplished upon implementation of administrative rules. If possible, DHFS would like to have emergency rule authority to add other programs to which an applicant must apply before becoming eligible for WCDP. This language would be similar to the language of the HIRSP program.

State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–0032/P2
PJK:kmg:pg

DOA:.....Jablonsky – Various cost control provisions for chronic disease aids program

FOR 2003–05 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** changes to the chronic disease aids programs.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

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including the medical assistance program, the badger care health care program, and the prescription drug assistance for elderly persons program.

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SECTION 2. 49.68 (3) (e) of the statutes is amended to read:

49.68 **(3)** (e) State aids for services provided under this section ~~shall be equal to~~ may not exceed the allowable charges under the federal medicare program. In no case shall state rates for individual service elements exceed the federally defined allowable costs. The rate of charges for services not covered by public and private insurance shall not exceed the reasonable charges as established by medicare fee determination procedures. A person that provides to a patient a service for which aid is provided under this section shall accept the amount paid under this section for the service as payment in full and may not bill the patient for any amount by which the charge for the service exceeds the amount paid for the service under this section. The state may not pay for the cost of travel, lodging, or meals for persons who must travel to receive inpatient and outpatient dialysis treatment for kidney disease. This paragraph shall not apply to donor related costs as defined in par. (b).

***NOTE: With the amendments that were added to this provision, it may not be accurate to state that the entire paragraph does not apply to donor–related costs. Let me know if this paragraph needs to be broken down into subunits and if only one or more of those subunits do not apply to donor–related costs.

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49.687 (title) **Disease aids; patient requirements; rebate agreements; cost containment.**

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49.687 **(1m)** (a) A person is not eligible to receive benefits under s. 49.68, 49.683, or 49.685 unless, before the person applies for benefits under s. 49.68, 49.683, or 49.685, the person first applies for benefits under all other health care coverage programs specified by the department by rule under par. (b) for which the person reasonably may be eligible.

(b) The department shall promulgate rules that specify other health care coverage programs for which ~~medical assistance is available and for which~~ a person must apply before applying for benefits under s. 49.68, 49.683, or 49.685. The programs specified by rule must include the medical assistance program under subch. IV, the badger care health care program under s. 49.665, and the prescription drug assistance for elderly persons program under s. 49.688.

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must apply to those other programs first and you do not have to say additionally that he or she was determined not to be eligible after first applying to those other programs.

Note that s. 49.68 (3) (d) 1. says that no aid may be granted under s. 49.68 unless the recipient has no other form of aid available from Medicare or private insurance. Should that be expanded to include the other health care coverage programs specified by rule under s. 49.687 (1m)? See also s. 49.685 (6) (b). Perhaps something similar to that language, in conjunction with requiring the person to first apply to those other programs specified by DHFS, should be added to both ss. 49.68 and 49.683. (I assume "contract" or "any other contractual arrangement" includes private insurance.)

Insert 4-1

SECTION 6. 49.687 (4) of the statutes is created to read:

49.687 **(4)** The department may adopt managed care methods of cost containment for the programs under ss. 49.68, 49.683, and 49.685.

SECTION 9324. Initial applicability; health and family services.

(1) APPLYING FOR CHRONIC DISEASE AIDS PROGRAM. The treatment of sections 49.68 (3) (a) and (d) 1., 49.683 (1), and 49.687 (1m) of the statutes first applies to persons who apply for benefits under section 49.68, 49.683, or 49.685 of the statutes on the effective date of this subsection.

SECTION 9424. Effective dates; health and family services.

(1) APPLYING FOR CHRONIC DISEASE AIDS PROGRAM. The treatment of sections 49.68 (3) (a), 49.683 (1), and 49.687 (1m) (a) of the statutes and SECTION 9324 (1) of this act take effect on the first day of the 13th month beginning after the effective date of this subsection.

****NOTE: These initial applicability and effective date provisions provide some time for DHFS to promulgate rules specifying the other programs for which a person must first apply. Do you want to provide a different amount of time or a date certain? Do you want to require DHFS to submit proposed rules within a certain time?

(END)

INSERT 2–5

SECTION 1. 49.68 (3) (d) 1. of the statutes is amended to read:

49.68 **(3)** (d) 1. No aid may be granted under this subsection unless the recipient has no other form of aid available from the federal medicare program ~~or~~, from private health, accident, sickness, medical, and hospital insurance coverage, or from other health care coverage specified by rule under s. 49.687 (1m) (b). If insufficient aid is available from other sources and if the recipient has paid an amount equal to the annual medicare deductible amount specified in subd. 2., the state shall pay the difference in cost to a qualified recipient. If at any time sufficient federal or private insurance aid or other health care coverage becomes available during the treatment period, state aid under this subsection shall be terminated or appropriately reduced. Any patient who is eligible for the federal medicare program shall register and pay the premium for medicare medical insurance coverage where permitted, and shall pay an amount equal to the annual medicare deductible amounts required under 42 USC 1395e and 1395L (b), prior to becoming eligible for state aid under this subsection.

History: 1973 c. 308; 1975 c. 39; 1977 c. 29; 1981 c. 314; 1983 a. 27; 1985 a. 332 s. 251 (1); 1989 a. 311; 1991 a. 316; 1993 a. 16, 449, 491; 1995 a. 27 ss. 3035 to 3044; Stats. 1995 s. 49.68; 2001 a. 16.

SECTION 2. 49.68 (3) (d) 3. of the statutes is created to read:

49.68 **(3)** (d) 3. No payment shall be made under this subsection for any portion of medical treatment costs or other expenses that are payable under any state, federal, or other health care coverage program, including a health care coverage

program specified by rule under s. 49.687 (1m) (b), or under any grant, contract, or other contractual arrangement.

(END OF INSERT 2–5)

INSERT 3–5

SECTION 3. 49.683 (3) of the statutes is created to read:

49.683 **(3)** No payment shall be made under this section for any portion of medical care costs that are payable under any state, federal, or other health care coverage program, including a health care coverage program specified by rule under s. 49.687 (1m) (b), or under any grant, contract, or other contractual arrangement.

SECTION 4. 49.685 (6) (b) of the statutes is amended to read:

49.685 **(6)** (b) Reimbursement shall not be made under this section for any blood products or supplies ~~which~~ that are not purchased from or provided by a comprehensive hemophilia treatment center, or a source approved by the treatment center. Reimbursement shall not be made under this section for any portion of the costs of blood products or supplies ~~which~~ that are payable under any other state ~~or~~, federal ~~program~~, or other health care coverage program, including a health care coverage program specified by rule under s. 49.687 (1m) (b), or under any grant, contract ~~and any~~, or other contractual arrangement.

History: 1977 c. 213; 1979 c. 32; 1983 a. 27; 1983 a. 189 s. 329 (10); 1983 a. 544 s. 47 (1); 1985 a. 29 s. 3202 (23), (46); 1987 a. 27; 1987 a. 312 s. 17; 1993 a. 16, 449; 1995 a. 27 ss. 3048 to 3060; Stats. 1995 s. 49.685; 2001 a. 16.

(END OF INSERT 3–5)

INSERT 4–1

(c) Using the procedure under s. 227.24, the department may promulgate rules under par. (b) for the period before the effective date of any permanent rules promulgated under par. (b), but not to exceed the period authorized under s. 227.24

(1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the department is not required to provide evidence that promulgating a rule under par. (b) as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to make a finding of emergency for promulgating a rule under par. (b) as an emergency rule.

(END OF INSERT 4–1)

State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–0032/P2
PJK:kmg:jf

DOA:.....Jablonsky – BB0004 Various cost control provisions for chronic disease aids program

FOR 2003–05 BUDGET — NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** changes to the chronic disease aids program, granting rule–making authority, and providing an exemption from emergency rule procedures.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under current law, DHFS provides financial assistance for the cost of medical care for the treatment of chronic kidney disease, cystic fibrosis, and hemophilia to persons with those conditions. This assistance is collectively referred to as the chronic disease aids program. This bill makes three changes to the chronic disease aids program for cost control purposes. The bill authorizes DHFS to use managed care methods of cost containment for the chronic disease aids program. The bill eliminates the requirement that the rates paid by DHFS for services provided for the treatment of chronic kidney disease be equal to the allowable charges under the federal Medicare program and prohibits a provider of a service for the treatment of chronic kidney disease from billing a patient for any difference between the amount the state pays under the chronic disease aids program and the provider's charge for the service. Finally, the bill provides that a person may not receive benefits under the chronic disease aids program unless, before applying for benefits under that

program, the person applies for benefits under other health care coverage programs for which he or she reasonably may be eligible. DHFS must promulgate rules specifying other health care coverage programs for which a person must apply, including the Medical Assistance program, the Badger Care health care program, and the prescription drug assistance for elderly persons program.

For further information see the ***state*** 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. 49.68 (3) (a) of the statutes is amended to read:

49.68 **(3)** (a) ~~Any~~ Subject to s. 49.687 (1m), any permanent resident of this state who suffers from chronic renal disease may be accepted into the dialysis treatment phase of the renal disease control program if the resident meets standards set by rule under sub. (2) and s. 49.687.

SECTION 2. 49.68 (3) (d) 1. of the statutes is amended to read:

49.68 **(3)** (d) 1. No aid may be granted under this subsection unless the recipient has no other form of aid available from the federal medicare program ~~or~~, from private health, accident, sickness, medical, and hospital insurance coverage, or from other health care coverage specified by rule under s. 49.687 (1m) (b). If insufficient aid is available from other sources and if the recipient has paid an amount equal to the annual medicare deductible amount specified in subd. 2., the state shall pay the difference in cost to a qualified recipient. If at any time sufficient federal or private insurance aid or other health care coverage becomes available during the treatment period, state aid under this subsection shall be terminated or appropriately reduced. Any patient who is eligible for the federal medicare program shall register and pay the premium for medicare medical insurance coverage where permitted, and shall pay an amount equal to the annual medicare deductible amounts required under 42

USC 1395e and 1395L (b), prior to becoming eligible for state aid under this subsection.

SECTION 3. 49.68 (3) (d) 3. of the statutes is created to read:

49.68 **(3)** (d) 3. No payment shall be made under this subsection for any portion of medical treatment costs or other expenses that are payable under any state, federal, or other health care coverage program, including a health care coverage program specified by rule under s. 49.687 (1m) (b), or under any grant, contract, or other contractual arrangement.

SECTION 4. 49.68 (3) (e) of the statutes is amended to read:

49.68 **(3)** (e) State aids for services provided under this section ~~shall be equal to~~ may not exceed the allowable charges under the federal medicare program. In no case shall state rates for individual service elements exceed the federally defined allowable costs. The rate of charges for services not covered by public and private insurance shall not exceed the reasonable charges as established by medicare fee determination procedures. A person that provides to a patient a service for which aid is provided under this section shall accept the amount paid under this section for the service as payment in full and may not bill the patient for any amount by which the charge for the service exceeds the amount paid for the service under this section. The state may not pay for the cost of travel, lodging, or meals for persons who must travel to receive inpatient and outpatient dialysis treatment for kidney disease. This paragraph shall not apply to donor related costs as defined in par. (b).

SECTION 5. 49.683 (1) of the statutes is amended to read:

49.683 **(1)** ~~The~~ Subject to s. 49.687 (1m), the department may provide financial assistance for costs of medical care of persons over the age of 18 years with the

diagnosis of cystic fibrosis who meet financial requirements established by the department by rule under s. 49.687 (1).

SECTION 6. 49.683 (3) of the statutes is created to read:

49.683 **(3)** No payment shall be made under this section for any portion of medical care costs that are payable under any state, federal, or other health care coverage program, including a health care coverage program specified by rule under s. 49.687 (1m) (b), or under any grant, contract, or other contractual arrangement.

SECTION 7. 49.685 (6) (b) of the statutes is amended to read:

49.685 **(6)** (b) Reimbursement shall not be made under this section for any blood products or supplies ~~which~~ that are not purchased from or provided by a comprehensive hemophilia treatment center, or a source approved by the treatment center. Reimbursement shall not be made under this section for any portion of the costs of blood products or supplies ~~which~~ that are payable under any other state ~~or~~, federal ~~program~~, or other health care coverage program, including a health care coverage program specified by rule under s. 49.687 (1m) (b), or under any grant, contract ~~and any~~, or other contractual arrangement.

SECTION 8. 49.687 (title) of the statutes is amended to read:

49.687 (title) **Disease aids; patient requirements; rebate agreements; cost containment.**

SECTION 9. 49.687 (1m) of the statutes is created to read:

49.687 **(1m)** (a) A person is not eligible to receive benefits under s. 49.68, 49.683, or 49.685 unless, before the person applies for benefits under s. 49.68, 49.683, or 49.685, the person first applies for benefits under all other health care coverage programs specified by the department by rule under par. (b) for which the person reasonably may be eligible.

(b) The department shall promulgate rules that specify other health care coverage programs for which a person must apply before applying for benefits under s. 49.68, 49.683, or 49.685. The programs specified by rule must include the Medical Assistance program under subch. IV, the Badger Care health care program under s. 49.665, and the prescription drug assistance for elderly persons program under s. 49.688.

(c) Using the procedure under s. 227.24, the department may promulgate rules under par. (b) for the period before the effective date of any permanent rules promulgated under par. (b), but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the department is not required to provide evidence that promulgating a rule under par. (b) as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to make a finding of emergency for promulgating a rule under par. (b) as an emergency rule.

SECTION 10. 49.687 (4) of the statutes is created to read:

49.687 **(4)** The department may adopt managed care methods of cost containment for the programs under ss. 49.68, 49.683, and 49.685.

SECTION 9324. Initial applicability; health and family services.

(1) APPLYING FOR CHRONIC DISEASE AIDS PROGRAM. The treatment of sections 49.68 (3) (a) and (d) 1., 49.683 (1), and 49.687 (1m) of the statutes first applies to persons who apply for benefits under section 49.68, 49.683, or 49.685 of the statutes on the effective date of this subsection.

(END)