State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0905/P2
PJK:jld:nwn

DOA:.....Pink, BB0185 – BadgerCare Plus

FOR 2007-09 BUDGET -- NOT READY FOR INTRODUCTION

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

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

This is a preliminary draft. An analysis will be provided in a later version.

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

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

SECTION 1. 49.46 (1) (a) 5. of the statutes is amended to read:

49.46 **(1)** (a) 5. Any child in an adoption assistance, foster care, ~~kinship care, long-term kinship care,~~ treatment foster care, or subsidized guardianship placement under ch. 48 or 938, as determined by the department.

SECTION 2. 49.~~474~~ 471 of the statutes is created to read:

49.474 BadgerCare Plus. (1) DEFINITIONS. In this section, unless the context requires otherwise:

(a) "BadgerCare Plus" means the Medical Assistance program described in this section.

(b) "Child" ~~includes~~ means a person ~~from the time of conception until it is born alive.~~ who is born and who is under the age of 19

(c) "Recipient" means an individual receiving benefits under this section.

****NOTE: Do we need to define "caretaker relative" or any other terms?

****NOTE: I didn't define "family." The term only seems to be used as part of "family income." See how I treated it in proposed s. 49.474 (12) (c).

(2) WAIVER. The department shall request a waiver from, and submit ~~an~~ amendments to the state Medical Assistance plan to, the secretary of the federal department of health and human services to implement BadgerCare Plus. If the state plan amendments ~~is~~ are approved and a waiver that is consistent with all of the provisions of this section is granted and in effect, the department shall implement BadgerCare Plus beginning on January 1, 2008, the effective date of the state plan amendments ~~which is approved~~, or the effective date of the waiver, whichever is latest. If the state plan amendments are not approved or if a waiver that is consistent with all of the provisions of this section is not granted, BadgerCare Plus may not be implemented. If the state plan amendments are approved but approval is not continued or if a waiver that is consistent with all of the provisions of this section is granted but not continued in effect, BadgerCare Plus shall be discontinued.

(3) INELIGIBILITY FOR OTHER MEDICAL ASSISTANCE BENEFITS. (a) 1. Notwithstanding ss. 49.46 (1), 49.465, 49.47 (4), and 49.665 (4), if the amendments to the state plan under sub. (2) are approved and a waiver that is consistent with all of the provisions of this section under sub. (2) is granted and in effect, an individual described in sub. (4) (a) or (b) or (5) is not eligible under s. 49.46, 49.465, 49.47, or 49.665 for Medical

Assistance or BC benefits. The eligibility of an individual described in sub. (4) (a) or (b) or (5) for Medical Assistance benefits shall first be determined under this section.

(b) 1. If an individual over 18 years of age who is eligible for and receiving Medical Assistance benefits under s. 49.46, 49.47, or 49.665 in the month before BadgerCare Plus is implemented loses that eligibility solely due to the implementation of BadgerCare Plus and, because of his or her income, is not eligible for BadgerCare Plus, the individual shall continue receiving for 18 consecutive months the medical assistance he or she was receiving before the implementation of BadgerCare Plus if all of the following are satisfied:

a. The individual's eligibility for the Medical Assistance benefits in the month before the implementation of BadgerCare Plus was based on an application filed before the implementation of BadgerCare Plus.

b. The individual continues to pay any premium that he or she was required to pay for the Medical Assistance coverage in the same amount as the amount that was due in the month before the implementation of BadgerCare Plus.

c. The individual continues to meet all nonfinancial eligibility requirements for the coverage that he or she had in the month before the implementation of BadgerCare Plus.

d. The individual continues to be ineligible for BadgerCare Plus because of his or her income.

2. Notwithstanding subd. 1., if at any time during an individual's 18-month eligibility extension under subd. 1. any criterion under subd. 1. a. to d. is not satisfied, the individual's eligibility for the extended coverage is terminated and any time remaining in the eligibility period is lost.

(4) ~~FINANCIAL~~ ELIGIBILITY CRITERIA; APPLICABLE BENEFITS. (a) Except as otherwise provided in this section, all of the following individuals are eligible for the benefits described in s. 49.46 (2) (a) and (b):

1. A pregnant woman whose family income does not exceed 200 percent of the poverty line.

2. A child who is under one year of age, whose mother was ~~determined to be~~ eligible under subd. 1., and who lives with his or her mother in this state.

3. A child under 19 years of age whose family income does not exceed 200 percent of the poverty line.

4. Unless the individual is eligible under par. (b) 4., an individual who is a parent of a child under 19 years of age and whose family income, calculated as provided in sub. (7) (a), does not exceed 200 percent of the poverty line. If there is no child under 19 years of age in the individual's home because all of the individual's children under 19 years of age have been removed from the home, the individual is eligible under this subdivision only if he or she is working toward unifying the family by complying with a permanency plan under s. 48.38.

5. Unless the individual is eligible under par. (b) 5., an individual who is a caretaker relative of a child under 19 years of age and whose family income, calculated as provided in sub. (7) (a), does not exceed 200 percent of the poverty line.

6. An individual who, regardless of family income, is 18 years of age and who, on his or her 18th birthday, was in a foster care or treatment foster care placement under ch. 48 or 938, as determined by the department.

****NOTE: This is part of the out-of-home youths phase-in, assuming the first year affects only 18-year-olds.

(b) Except as otherwise provided in this section, all of the following individuals are eligible for the benefits described in sub. (11):

1. A pregnant woman whose family income exceeds 200 percent but does not exceed 300 percent of the poverty line.

2. A child who is under one year of age, whose mother was determined to be eligible under subd. 1., and who lives with his or her mother in this state.

3. A child under 19 years of age whose family income exceeds 200 percent but does not exceed 300 of the poverty line.

4. Unless the individual is eligible under par. (a) 4., an individual who is a parent of a child under 19 years of age and whose family income, calculated as provided in sub. (7) (a), does not exceed 200 percent of the poverty line. If there is no child under 19 years of age in the individual's home because all of the individual's children under 19 years of age have been removed from the home, the individual is eligible under this subdivision only if he or she is working toward unifying the family by complying with a permanency plan under s. 48.38.

→ Insert 4-15

5. Unless the individual is eligible under par. (a) 5., an individual who is a caretaker relative of a child under 19 years of age and whose family income, calculated as provided in sub. (7) (a), does not exceed 200 percent of the poverty line.

Insert 5-15

(c) Except as otherwise provided in this section, a child under 19 years of age who does not have health insurance coverage and whose family income exceeds 300 percent of the poverty line is eligible to purchase coverage of the benefits described in sub. (11), at the full per member per month cost of the child's coverage.

***NOTE: Should this specifically be the insurance coverage under sub. (8) (b) 1.?

(5) PRESUMPTIVE ELIGIBILITY. (a) In this subsection:

1. "Qualified entity" means an entity that satisfies the requirements under 42 USC 1396r-1a (b) (3) (A), as determined by the department.

2. "Qualified provider" means a provider that satisfies the requirements under 42 USC 1396r-1 (b) (2), as determined by the department.

(b) 1. Except as provided in sub. (6) (a), a pregnant woman is eligible for the benefits specified in par. (c) during the period beginning on the day on which a qualified provider determines, on the basis of preliminary information, that the woman's family income does not exceed 300 percent of the poverty line and ending on the applicable day specified in subd. 3.

2. Except as provided in sub. (6) (a), a child under 19 years of age is eligible for the benefits described in s. 49.46 (2) (a) and (b) during the period beginning on the day on which a qualified entity determines, on the basis of preliminary information, that the child's family income does not exceed 150 percent of the poverty line and ending on the applicable day specified in subd. 3.

3. a. If the woman or child applies for benefits under sub. (4) within the time required under par. (d), the benefits specified in subd. 1. or 2., whichever is applicable, end on the day on which the department or the county department under s. 46.215, 46.22, or 46.23 determines whether the woman or child is eligible for benefits under sub. (4).

b. If the woman or child does not apply for benefits under sub. (4) within the time required under par. (d), the benefits specified in subd. 1. or 2., whichever is applicable, end on the last day of the month following the month in which the provider or entity makes the determination under this paragraph.

(c) On behalf of a woman under par. (b) 1., the department shall audit and pay allowable charges to a provider certified under s. 49.45 (2) (a) 11. only for ambulatory prenatal care services under the benefits under sub. (11).

(d) A woman or child who is determined to be eligible under par. (b) shall apply for benefits under sub. (4) on or before the last day of the month following the month in which the qualified provider or entity makes the eligibility determination.

(e) A qualified provider or entity that determines that a woman or child is eligible under par. (b) shall do all of the following:

1. Notify the department of that determination within 5 working days after the day on which the determination is made.

2. Notify the woman or child of the requirement under par. (d).

(f) The department shall provide qualified providers and qualified entities with application forms for the benefits under sub. (4) and information on how to assist women and children in completing the forms.

(6) MISCELLANEOUS ELIGIBILITY AND BENEFIT PROVISIONS. (a) Any pregnant woman, child, or parent whose family income is less than 150 percent of the poverty line is eligible for medical assistance under this section for any of the 3 months prior to the month of application if the individual met the eligibility criteria under this section ~~during those months.~~

insert 7-16

insert 7-19

****NOTE: Should this include or exclude those eligible under presumptive eligibility?

(b) A pregnant woman who is determined to be eligible for benefits under sub. (4) remains eligible for benefits under sub. (4) for the balance of the pregnancy and to the last day of the month in which the 60th day after the last day of the pregnancy falls without regard to any change in the woman's family income.

(c) If a child who is eligible for benefits under sub. (4) is receiving inpatient services covered under sub. (4) on the day before his or her 19th birthday and, but for attaining 19 years of age, the child would remain eligible for benefits under sub. (4), the child remains eligible for benefits until the end of the stay for which the inpatient services are being furnished.

(d) If an application under this section shows that an individual is an essential person, the individual shall be provided the benefits specified under sub. (4) (a) or (b), regardless of whether the individual requests the benefits.

(e) The medical assistance eligibility extensions under s. 49.46 (1) (c), (cg), and (co) for individuals who lose eligibility due to increased income do not apply to BadgerCare Plus.

(f) The medical assistance eligibility provisions for migrant workers and their dependents under s. 49.47 (4) (av) apply to BadgerCare Plus.

(g) All of the following apply to BadgerCare Plus in the same respect as they apply under s. 49.46:

1. Section 49.46 (2) (c) and (cm), relating to benefits for individuals who are eligible for Medicare.

2. Section 49.46 (2) (d), relating to prohibiting payments for any part of any service payable through 3rd-party liability or any governmental or private benefit system.

3. Section 49.46 (2) (dm), relating to prohibiting payment for services to residents of institutions for mental diseases.

4. Section 49.46 (2) (f), relating to prohibiting payment for gastric bypass or stapling surgery.

(7) SPECIAL INCOME PROVISIONS. (a) In the calculation of family income for purposes of determining the eligibility of a parent or caretaker relative under sub. (4) (a) 4. or 5. or (b) 4. or 5., if the parent or caretaker relative has self-employment income the department shall allow all deductions allowed under federal and state tax law, except for depreciation. If a parent's or caretaker relative's family income without deducting depreciation does not exceed 200 percent of the poverty line, the parent or caretaker relative is eligible under sub. (4) (a) 4. or 5. If family income without deducting depreciation equals or exceeds 200 percent of the poverty line, however, the parent or caretaker relative is eligible under sub. (4) (b) 4. or 5. if his or her family income does not exceed 200 percent of the poverty line after depreciation is deducted.

(b) To meet the eligibility requirements under this section, the department shall allow all of the following to obligate or expend income for medical care or for any other type of remedial care recognized under state law or for personal health insurance premiums or both:

1. A pregnant woman, to meet the family income limit under sub. (4) (b) 1.

2. A child who has the health insurance coverage specified in sub. (8) (b) 1., so that his or her family income does not exceed 150 percent of the poverty line.

****NOTE: It would seem that such a child would be eligible for "regular MA" benefits if their family income went down to below 150 percent of poverty.

(c) When calculating an individual's family income, the department shall do all of the following:

1. Deduct from family income any payments made by the individual for court-ordered child or family support.

****NOTE: Do we need to define "support" to include everything in s. 49.854 (1) (f)?

2. Disregard earnings of children under 18 years of age.

3. Determine separately the family incomes of caretaker relatives and the children for whom they are caring and not legally responsible.

4. Not include in the calculation any income of an individual receiving benefits under s. 49.77 or federal Title XVI.

(8) HEALTH INSURANCE COVERAGE AND ELIGIBILITY. (a) 1. Except as provided in subd. 2., any individual who is otherwise eligible under this section and who is eligible for enrollment in a group health plan shall, as a condition of eligibility for medical assistance and if the department determines that it is cost-effective to do so, apply for enrollment in the group health plan, except that, for a minor, the parent of the minor shall apply on the minor's behalf.

2. If a parent of a minor fails to enroll the minor in a group health plan in accordance with subd. 1., the failure does not affect the minor's eligibility under this section.

(b) Except as provided in pars. (c) and (d), an individual whose family income that exceeds 150 percent of the poverty line is not eligible for BadgerCare Plus if any of the following applies:

1. The individual has individual or family health insurance coverage that is any of the following:

a. Coverage provided by an employer and for which the employer pays at least 80 percent of the premium.

b. Coverage under the state employee health plan under s. 40.51 (6).

2. The individual, in the 12 months before applying, had access to the health insurance coverage specified in subd. 1.

3. Access to the health insurance coverage specified in subd. 1. will become available to the individual in the month in which the individual applies for coverage under this section or in any of the next 3 calendar months.

(d) 1. Except as provided in subd. 2., ~~a pregnant woman~~, regardless of family income, is ~~not~~ ineligible for BadgerCare Plus by reason of having health insurance coverage or access to health insurance coverage.

(e) If a pregnant woman has health insurance coverage and her family income exceeds 200 percent of the poverty line, the woman is required, as a condition of eligibility, to maintain the health insurance coverage.

(f) If an individual with a family income that exceeds 150 percent of the poverty line had the health insurance coverage specified in par. (b) 1. and lost the coverage, or if a pregnant woman specified in par. (e) 2. has health insurance coverage and does not maintain the coverage, the individual or pregnant woman is not eligible for BadgerCare Plus for the 3 calendar months following the month in which the insurance coverage ended without a good cause reason specified in par. (g).

(g) Any of the following is a good cause reason for purposes of par. (f):

1. The individual or pregnant woman was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber's employment ended for a reason other than voluntary termination, unless the voluntary termination was a result of the incapacitation of the subscriber or because of an immediate family member's health condition.

2. The individual or pregnant woman was covered by a group health insurance plan that was provided by a subscriber through his or her employer, the subscriber changed employers, and the new employer does not offer ~~family~~ health insurance coverage.

3. The individual or pregnant woman was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber's employer discontinued health plan coverage for all employees.

4. The individual's or pregnant woman's coverage was continuation coverage and the continuation coverage was exhausted in accordance with 29 CFR 2590.701-2 (4).

~~4.~~ 5. The individual's or pregnant woman's coverage terminated due to the death or change in marital status of the subscriber.

~~5.~~ 6. Any other reason determined by the department to be a good cause reason.

(9) EMPLOYER VERIFICATION OF INSURANCE COVERAGE. (a) For an applicant or recipient with a family income that exceeds 150 percent of the poverty line, except for an applicant or recipient who is a pregnant woman, the department shall verify insurance coverage and access information directly with the employer through which the applicant or recipient may have health insurance coverage or access to coverage.

(b) An employer that receives a request from the department for insurance coverage and access to coverage information shall supply the information requested by the department within 30 calendar days after receiving a request regarding an individual who is an applicant and within 10 calendar days after receiving a request regarding an individual who is a recipient.

(c) 1. Subject to subd. 2., an employer that does not comply with the requirements under par. (b) shall be required to pay a penalty equal to the full per member per month cost of coverage under BadgerCare Plus for the individual about whom the information is requested for each month in which the individual was covered before the employer provides the information.

2. An employer with fewer than 250 employees may not be required to pay more than $1,000 in penalties under this paragraph in any 6-month period. An employer with 250 or more employees may not be required to pay more than $15,000 in penalties under this paragraph in any 6-month period.

3. All penalty assessments collected under subd. 2. shall be credited to the appropriation account under s. 20.435 ( ) ( ) and (jz)

****NOTE: Further information needed on appropriation or fund in which penalties are deposited.

(d) An employer may contest a penalty assessment under par. (c) by sending a written request for hearing to the division of hearings and appeals in the department of administration. Proceedings before the division are governed by ch. 227.

****NOTE: This provision was included in BadgerCare. Do you want it in BadgerCare Plus, too?

(10) COST SHARING. (a) Except as provided in s. 49.45 (18)(an) all cost-sharing provisions under s. 49.45 (18) apply to a recipient with coverage of the benefits described in s. 49.46 (2) (a) and (b) to the same extent as they apply to a person eligible for medical assistance under s. 49.46, 49.468, or 49.47.

(b) A recipient who is an adult, who is not a pregnant woman, and whose family income is greater than 150 percent but not greater than 200 percent of the poverty line shall pay a premium for coverage under BadgerCare Plus that does not exceed 5 percent of his or her family income. If the recipient has self-employment income and is eligible under sub. (4) (b) 4. or 5., the premium may not exceed 5 percent of family income calculated before depreciation was deducted.

(c) A recipient who is an unborn child, or a pregnant woman whose family income is greater than 200 percent of the poverty line shall pay a premium for coverage of the benefits eligible under sub. (4)(b)1.

described in sub. (11) that does not exceed the full per member per month cost of coverage for an adult with a family income of 300 percent of the poverty line.

(d) 1. Except as provided in subd. 2. and par. (c), a recipient who is a child whose family income is greater than 200 percent of the poverty line shall pay a premium for coverage of the benefits described in sub. (11) that does not exceed the full per member per month cost of coverage for a child with a family income of 300 percent of the poverty line.

a. A child who is a Native American or an Alaskan Native with a family income that does not exceed 300 percent of the poverty line may not be required to pay a premium.

(e) If a recipient who is required to pay a premium under this subsection or under sub. (4) (c) does not pay a premium when due, the recipient's coverage terminates and the recipient is not eligible for BadgerCare Plus for 6 calendar months following the date on which the recipient's coverage terminated.

(11) BENCHMARK PLAN BENEFITS AND COPAYMENTS. Recipients who are not eligible for the benefits described in s. 49.46 (2) (a) and (b) shall have coverage of the following benefits and pay the following copayments:

(a) Prescription drugs bearing only a generic name, as defined in s. 450.12 (1) (b), with a copayment of no more than $5 per prescription. Insert 14-19

****NOTE: I need the correct terminology for the BadgerCareRx(?) discounts, if that language is still necessary.

(b) Physicians' services, including one annual routine physical examination, with a copayment of no more than $15 per visit.

Insert 14-4

(c) Inpatient hospital services as medically necessary, with a copayment of $100 for medical and surgical services and a copayment of no more than $50 per admission for psychiatric services.

(d) Outpatient hospital services, with a copayment of no more than $15, except that nonemergency use of emergency room services shall require a copayment of no more than $75.

Insert 15-5

****NOTE: Do we need a definition for "emergency medical condition," as was suggested in the drafting instructions, or can the department determine whether the emergency room use was for a nonemergency purpose?

(e) Laboratory and X-ray services, including mammography.

(f) Home health services, limited to 60 visits per year.

(g) Skilled nursing home services, limited to 30 days per year.

(h) Inpatient rehabilitation services, limited to 60 days per year.

(i) Physical, occupational, and speech therapy, limited to 20 visits per year for each type of therapy, with a copayment of no more than $15 per visit.

(j) Cardiac rehabilitation, limited to 36 visits per year, with a copayment of no more than $15 per visit.

(k) Outpatient and transitional treatment for nervous or mental disorders and alcoholism and other drug abuse problems, with a copayment of no more than $15 per visit and coverage limits that are the same as those under the state employee health plan under s. 40.51 (6).

inpatient,

****NOTE: Are inpatient services not covered? I assumed you did not want to specify the current limits, in case they change under the state plan.

(L) Durable medical equipment, limited to $2,500 per year, with a copayment of no more than $5.

(m) Transportation to obtain emergency medical care only, as medically necessary, with a copayment of no more than $5.

(n) One refractive eye examination every 2 years, with a copayment of no more than $15 per visit.

(o) Fifty percent of allowable charges for preventive and basic dental services, including services for accidental injury and for the diagnosis and treatment of temporomandibular disorders. The coverage under this paragraph is limited to $750 per year, applies only to pregnant women and children under 19 years of age, and requires an annual deductible of $200 and a copayment of no more than $15 per visit.

(p) Early childhood developmental services, for children under 6 years of age.

(q) Smoking cessation treatment, for pregnant women only.

(r) Prenatal care coordination, for pregnant women at high risk only.

(12) ~~ADMINISTRATIVE PROVISIONS.~~ RULES. (a) Except for an individual under sub. (4) (a) 6., the department shall verify the income information provided by every applicant and recipient (for whom there is no data match).

****NOTE: The drafting instructions contained the language in parentheses, but wouldn't "verifying" include checking data matches?

(b) A recipient shall report to the department any change that might affect his or her eligibility within 10 days after the change occurs.

(c) For purposes of determining eligibility and family income, the department shall include a family member who is temporarily absent from the home for not more than 6 months, as determined by the department.

(d) 1. The department may promulgate any rules necessary for and consistent with its administrative responsibilities under this section, including additional eligibility criteria.

2. The department may promulgate emergency rules under s. 227.24 for the administration of this section for the period before the effective date of any

NOTICE OF EFFECTIVE DATE

permanent rules promulgated under subd. 1., 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 this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subdivision.

(7) (b) If the amendment to the state plan submitted under sub. (2) is approved and a waiver that is consistent with all of the provisions of this section is granted and in effect, the department shall publish a notice in the Wisconsin Administrative Register that states the date on which BadgerCare Plus is implemented.

****NOTE: This last paragraph may not be needed in the end, but I've included it in case we need an effective date for some provision that is dependent on the effective date of BadgerCare Plus. We don't have an actual effective date since it could be any of three different ones.

SECTION 3. 49.474 (4) (a) 6. of the statutes, as created by 2007 Wisconsin Act .... (this act), is amended to read:

49.474 (4) (a) 6. An individual who, regardless of family income, is at least 18 years of age but less than 20 years of age and who, on his or her 18th birthday, was in a foster care or treatment foster care placement under ch. 48 or 938, as determined by the department.

SECTION 4. 49.474 (4) (a) 6. of the statutes, as affected by 2007 Wisconsin Act .... (this act), section 3, is amended to read:

49.474 (4) (a) 6. An individual who, regardless of family income, is at least 18 years of age but less than ~~20~~ 21 years of age and who, on his or her 18th birthday, was in a foster care or treatment foster care placement under ch. 48 or 938, as determined by the department.

SECTION 5. 49.665 (4) (ap) 2. of the statutes is repealed.

Insert 17-23

Keep

Insert 17-4

SECTION 6. 49.665 (7) (a) 1. of the statutes is amended to read:

49.665 **(7)** (a) 1. Notwithstanding sub. (4) (a) 3m. ~~and (ap) 2.~~, the department shall mail information verification forms to the employers of the individuals required to provide the verifications under sub. (4) (a) 3m. ~~and (ap) 2.~~ to obtain the information specified.

SECTION 7. 49.785 (1) (intro.) of the statutes is amended to read:

49.785 **(1)** (intro.) Except as provided in sub. (1m), if any recipient ~~of benefits under s. 49.148, 49.46 or 49.77, or under 42 USC 1381 to 1385 in effect on May 8, 1980,~~ specified in sub. (1c) dies and the estate of the deceased recipient is insufficient to pay the funeral, burial, and cemetery expenses of the deceased recipient, the county or applicable tribal governing body or organization responsible for burial of the recipient shall pay, to the person designated by the county department under s. 46.215, 46.22, or 46.23 or applicable tribal governing body or organization responsible for the burial of the recipient, all of the following:

SECTION 8. 49.785 (1c) of the statutes is created to read:

49.785 **(1c)** All of the following are eligible recipients under this section:

(a) A recipient of benefits under s. 49.148, 49.46, or 49.77, or under 42 USC 1381 to 1385 in effect on May 8, 1980.

(b) A recipient of benefits under s. 49.~~47~~471 who is any of the following:

1. A pregnant woman or a child under 6 years of age with a family income not exceeding 185 percent of the poverty line at the time of death.

2. A child at least 6 years of age but less than 19 years of age with a family income not exceeding 100 percent of the poverty line at the time of death.

****NOTE: The drafting instruction said "a child between the ages of 5 and 19" but I changed this to "at least 6 but less than 19" or there would be a conflict between subds. 1. and 2. For example, one wouldn't know whether a 5-year-old with a family income of

120 percent of the poverty line would be eligible under subd. 1. or ineligible under subd. 2.

3. A parent or caretaker relative with a family income not exceeding 50 percent of the poverty line at the time of death.

SECTION 9. 49.82 (2) of the statutes is amended to read:

49.82 **(2)** ELIGIBILITY VERIFICATION. Proof shall be provided for each person included in an application for public assistance under this chapter, except for a child who is eligible for medical assistance under s. 49.46 ~~or~~, 49.47, or 49.471 because of 42 USC 1396a (e) (4) or an unborn child who is eligible for coverage under s. 49.471 or the Badger Care health care program under s. 49.665 (4) (ap), of his or her social security number or that an application for a social security number has been made.

(END)

insert 19-2

insert 19-9

471

49.46 — 49.47

16.009 (2) (j)
46.206 (1) (bm)
46.22 (1) (b) 1. d.
46.27 (6u) (c) 1. a.
(6u) (d) (intro.)
(7) (am)
(7) (b)
46.275 (1m) (a)
46.277 (1m) (a)
46.278 (1m) (b)
46.283 (3) (k)
46.40 (9) (c)
46.485 (3g)
48.195 (5)
48.57 (3m) (e)
(3n) (e)
49.19 (1) (c) 1.
49.22 (2m) (a)
(2m) (b)
(2m) (c) 3. → (6)
49.43 (8)
49.45 (2) (a) 1.
(2) (a) 3.
(2) (b) 3., 7. (intro.)
(3) (b) 1.
(3) (b) 2.
(3) (dm) (3)(f)2.
(3) (L) 2.
(6c) (d) 1.
(6c) (d) 2.
(8) (a) 4.
(9) — (8m)(intro.)
(10)
(18) (ac), (6)3.
(29)
(35) (38) (48) (51)(a)

49.455 (2)
49.465 (2) (a)
(2) (c)
(4)
(6)
49.468 (1) (b)
(1) (c)
(1m) (a)
(2) (a)
49.473 (2) (a)
49.49 (3m) (a) (intro.), 1., 2.
49.665 (4) (ap) (intro.)
49.688 (5) (a) (intro.)
49.785 (1) (intro.)
49.81 (4)
49.82 (2)
49.89 (7) (b) — 51.04 51.038
59.53 (5) (a)
66.0137 (3)
149.12 (2) (f) 2. d. — 253.10(3)(d)1. why only 49.
302.38 (3)
302.386 (1) — 449.17 (8)
632.746 (7m) (b) 1.
814.61 (13)
885.01 (5)

seems to be already disabled

16.09 (2) (j) – ?
46.206 (1) (bm) – yes
46.27 (6u) (c) 1. a. – ?
(6u) (d) (intro.) ?
(7) (am) ?
(7) (b) ?
46.275 (1m) (a) ?
46.277 (1m) (a) ?
46.278 (1m) (b) ?
46.283 (3) (k) ?
46.40 (9) (c) no
46.485 (3g) no (?)
48.195 (5) ?
49.19 (1) (c) 1. no ?
49.22 (2m) (a) yes ✓
(2m) (b) yes ✓
(2m) (c) 3. yes ✓
49.45 (2) (a) 3. yes
(3) (b) 1. yes
(3) (b) 2. yes
(3) (dm) yes – medicine ?
(3) (L) 2. ?
(6c) (d) 1. yes ??
(6c) (d) 2. yes ??
(8) (a) 4. yes ?
(9) yes ?
(10) no ?
(18) (ac) yes – both "plans" or just regular MA?
(29) yes
(35) yes – ltd to the spend down elig ?

49.455 (2) no ?
49.465 (2) (a) no
(2) (c) no
(4) no
(6) no
presumptive elig
49.468 (1) (b)
(1) (c)
(1m) (a)
(2) (a)
? but could be caretaker relative?
49.473 (2) (a) yes
49.665 (4) (ap) (intro.) no ?
49.688 (5) (a) (intro.) yes ?
49.785 (1) (intro.) – already added
49.81 (4) yes ?
49.82 (2) – already added
49.89 (7) (b) – yes ?
59.53 (5) (a) yes ?
66.0137 (3) yes
149.12 (2) (f) 2. d. no ?
302.38 (3) ?
302.386 (1) ?
632.746 (7m) (b) 1. ?
814.61 (13) yes ?
885.01 (5) yes

will be part of MA under subch

Whole thing ⇒ waiver & State plan amdt (both)

keep current stats as is

buy in — Benchmark PMPM
full cost of coverage

"uninsured kids" ⇒ no crowd out rule

youths existing (18* or 18 or 19 yr old as of 1-1-08)

newborn ⇒ regardless of income for the yr coverage is obtained, even was receiving unless mom goes from BM to MA

presumptive kids ⇒ reg MA

determine
good cause — by rule? ✳
↳ in stat ←

emp verification: keep (7)(b)3. ✳

open door ⇒ preg women, to Benchmark
children, to (don't know yet)

temp absence ⇒ 6 months or less (child or parent)

unborn child is ~~a~~ a child under 19

✳ BM copays shall be "up to"

49.45 (18) cost sharing

drugs w/ discounted cost (will get info to me)

appropriations → Michelle Reinke
not new + separate

49.46 (1) (d) does not apply (reg MA)

(e) → essential person part still applies
~ BCT

(so part of (e) would be relevant for BCT)

(j) applies

(k) ~~applies but not 1. (instead of 18)~~
2. applies but not 1.

(L) no – do not include

(m) yes – provision like it

(are there not to include + that?)

BCT cover medicare prem, deduct., copays
???
yes – 49.46 (2) (c), (cm)

Medicare

49.46 (2) (d) applies
(dm) applies
(f) applies

benefits

search certificate ~ 49.47 (4) (e)

49.47 (4) (av) applies to new elig ↑ migrant workers

(4) (b) doesn't apply
(c) doesn't apply

all the rest are already covered or do not apply

(5) does apply

49.845 also apply

So make this program "medical assistance under subch IV"

~~717~~ → ~~95-884~~ → ~~03-1754~~

05-2884

for cross-refs:

16.09(2)(j)

46.275(1m)(a)
46.277(1m)(a)
46.278(1m)(b)
46.40(9)(c)

(2)(a)
49.468(1)(b), (c), (1m)(a),
49.473(2)(a)
59.53(5)(a)

149.12(2)(f)2.d.
302.38(3)
302.386(1)
632.746(7m)(b)1.

46.206(1)(bm)
46.27(6g)(c)1.a., (d)(intro), (7)(am), (b)
46.283(3)(k)
46.485(3g)
48.195(5)
49.19(1)(c)1.
49.22(2m)(a), (b), (c)3.
49.45(2)(a)3., (3)(b)1., 2., (dm), (L)2., (bc)(d)1., 2., (8)(a)4., (9), (10), (18)(ac), (29), (35)
49.455(2)
49.465(2)(a), (c), (4), (6)
49.665(4)(ap)(intro.),
49.688(5)(a)(intro.)
49.785(1)(intro.)
49.81(4)
49.82(2)
49.89(7)(b)
66.0137(3)
814.61(13)
885.01(5)

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FAX TRANSMITTAL COVER SHEET

(From: LRB–Legal Section–Front Office ... Fax: 608–264–6948)

Date: 12-7-06 Time: 3:30

Total pages transmitted, including this page: 2

Please Deliver This *FAX* To: Jim Jones

Telephone Number: 266-9435

FAX Number: 261-6861

MESSAGE: Jim: Here is the list of sections to check to see if BCT (s.49.474) needs to be added. Thanks!

Senders Name: Pam Kahler 266-2682

options:

income determination:

determining self-employed income + special ones on p6

mandatory verify income

babies born to eligible women (elig'n extra?)

does MA or BM depend on mother's cov?

back dating → eligible for 3 months prior to application

ineligible based on other ins cov:

ineligible:

NWS X, if failure to coop w/ins buy-in

if have certain other ins cov.

not elig for 3 months if lose ins cov w/o good cause

not elig if ~~have access~~ are covered ~~ins cov~~ under or have access to certain ins cov

(adults & child. >150% FPL)

(no access req if <150% or preg)

if access (while) becomes available at any time during month of appl or 3 months after

(what if gets covered & has access = 6th month — ok? doesn't ~~look~~ look BC+ coverage?

So it all depends on when apply??

(title) Elig criteria, applicable benefits

What stats are associated w/ these categories?

(or are they totally new?)

?

2 parts → regular MA benefit Benchmark Plan

only certain categories are contingent on waiver approval?

(some contingent on state plan amdt, too?)

reg MA benefit is also MA benefit?

(b) *Applicability.* 1. A group eligible for BadgerCare with budgetable income at or below 150% of the poverty line is not required to pay a premium toward the cost of the health care coverage.

2. Except as provided in subd. 3. or 4., a group eligible for BadgerCare with budgetable income above 150% of the poverty line shall pay a premium toward the cost of the health care coverage.

3. A BadgerCare applicant group does not owe a premium for the first month of BadgerCare unless a member of the BadgerCare fiscal test group was an MA recipient in the previous month.

4. A BadgerCare applicant group does not owe a premium for the first month of BadgerCare unless a member of the BadgerCare fiscal test group was a BadgerCare recipient in the previous 12 months.

(c) *Amounts.* A group eligible for BadgerCare required under this subsection to pay a premium shall pay the amount indicated in the schedule provided in Table 103.085. Income shall be determined according to s. HFS 103.07.

Table 103.085
BadgerCare Premium Schedule

Monthly Income		Monthly
From	To	Premium
$ 1,000	$ 1,499.99	$ 30
$ 1,500	$ 1,999.99	$ 45
$ 2,000	$ 2,499.99	$ 60
$ 2,500	$ 2,999.99	$ 75
$ 3,000	$ 3,499.99	$ 90
$ 3,500	$ 3,999.99	$105
$ 4,000	$ 4,499.99	$120
$ 4,500	$ 4,999.99	$135
$ 5,000	$ 5,499.99	$150
$ 5,500	$ 5,999.99	$165
$ 6,000	$ 6,499.99	$180
$ 6,500	$ 6,999.99	$195
$ 7,000	$ 7,499.99	$210
$ 7,500	$ 7,999.99	$225
$ 8,000	$ 8,499.99	$240
$ 8,500	$ 8,999.99	$255
$ 9,000	$ 9,499.99	$270
$ 9,500	$ 9,999.99	$285
$10,000	$10,499.99	$300
$10,500	$10,999.99	$315

(d) *Payment.* 1. A group otherwise eligible for BadgerCare that is required to pay a premium under this section shall pay the premium amount in full to the agency before the agency may certify the group's initial eligibility for BadgerCare.

2. Premiums are due by the 10th of the month prior to the month for which the premium is required.

3. If no payment is received by the end of the month for which the premium is required, the department shall terminate the group's eligibility for BadgerCare, effective at the end of the month.

4. The department shall allow a variety of premium payment methods. A group may choose one of the following methods for premium payment:

a. Wage withholding.

b. Electronic funds transfer (EFT).

c. Direct payment by check or money order.

5. A group may pay premiums in advance for more than one month, but only for months in the group's BadgerCare eligibility period.

(e) *Refunds.* The department shall issue a refund for a premium which has been paid in advance when the premium is for one of the following:

1. A month that the group is ineligible for BadgerCare.

2. A month that the group's budgetable income drops to or below 150% of the poverty line and the change in income that brought the group's budgetable income to or below 150% of the poverty line was reported within 10 days of the date the change occurred.

3. A month which requires a lower premium amount due to a change in circumstances which was in effect for the entire month so long as the change was reported within 10 days of the date it occurred. In a case where the change was not reported within 10 days of the date it occurred, the effective date of the lower premium amount due is the first day of the month in which the change was reported.

(f) *Consequence of failure to pay BadgerCare premiums.* A group required to pay a premium shall be ineligible for re–enrollment for the period specified in sub. (3) when the group fails to pay its premium within the time specified in par. (d).

(2) QUITTING BADGERCARE. (a) *Termination of benefits.* Except as provided in par. (b), a group eligible for BadgerCare and required under sub. (1) to pay a premium shall be subject to re–enrollment restrictions under sub. (3) when that group voluntarily terminates BadgerCare eligibility.

(b) *Reasons for quitting BadgerCare.* A group that quits BadgerCare shall not be subject to a restrictive re–enrollment period if the group requests termination of BadgerCare for one of the following reasons:

1. The BadgerCare group is moving out of Wisconsin.

2. No one in the BadgerCare group remains non–financially eligible for BadgerCare.

3. A member of the BadgerCare group is starting employment that provides health care benefits.

4. Other health insurance coverage has become available to the BadgerCare group.

5. Any other reason, as determined by the department, not related to payment of the premium.

(3) RE–ENROLLMENT RESTRICTION. (a) *Period of ineligibility.* A BadgerCare group that fails to make a premium payment under sub. (1) or quits BadgerCare under sub. (2) is not eligible for BadgerCare for a period of at least 6 consecutive calendar months following the date that BadgerCare eligibility ends, unless one of the circumstances in par. (b) applies. Eligibility is restored as described in par. (c). After 6 calendar months, the group shall be eligible for BadgerCare only if all past premiums due are paid in full or 12 calendar months have passed after the expiration of BadgerCare eligibility, whichever is sooner.

(b) *Reasons restriction on re–enrollment may not apply.* The restriction on re–enrollment under this section does not apply for either of the following reasons:

1. The failure to pay premiums was due to a circumstance beyond the group's control, provided that all past due premiums have been paid in full. A circumstance beyond the group's control includes any of the following:

a. A problem with an electronic funds transfer from a bank account to the BadgerCare program.

b. A problem with an employer's wage withholding.

c. An administrative error in processing the premium.

d. Any other circumstance affecting payment of the premium which the department determines is beyond the group's control, but not including insufficient funds.

2. A significant change in household composition occurred. A significant change occurs when one of the following events occurs:

a. A parent or a parent's spouse in the group eligible for BadgerCare no longer resides in the home and has not resided in the home for at least 30 consecutive days.

b. A person not in the group eligible for BadgerCare, but who is legally responsible for a group member, no longer resides in the home and has not resided in the home for at least 30 consecutive days.

c. A caretaker relative of a minor in a group eligible for BadgerCare, or the caretaker relative's spouse, no longer resides in the home and has not resided in the home for at least 30 consecutive days.

(c) *Resuming BadgerCare eligibility.* Eligibility for BadgerCare shall resume in the following manner for persons with a re–enrollment restriction that ended due to a reason described in par. (b):

1. For a BadgerCare group with a reason under par. (b) 1. for the re–enrollment restriction not to apply, BadgerCare eligibility shall be restored for any months that the group had been closed during the restriction period, provided that payment of any outstanding premiums owed is made and the group was otherwise eligible for BadgerCare in those months.

2. For a BadgerCare group with a reason under par. (b) 2. for the re–enrollment restriction not to apply, the restriction on re–enrollment shall not apply to the remainder of the 6–month period. Beginning the first of the month after the adult has been out of the home for 30 days, the group may again be eligible for BadgerCare, provided that payment of any outstanding premiums owed is made and the group is otherwise eligible. The BadgerCare group remains ineligible for any prior months when the restriction on re–enrollment was in effect.

(4) ENROLL IN AVAILABLE EMPLOYER–SUBSIDIZED HEALTH PLAN. (a) A BadgerCare recipient is ineligible for BadgerCare when one of the following fail to enroll in an available employer–subsidized health care coverage:

1. The recipient.

2. The recipient's spouse when the spouse is residing with the recipient.

3. The recipient's parent, step–parent or other caretaker relative residing with the recipient, when the recipient is under 19 years of age.

(b) Except as provided in par. (c), the recipient is ineligible for BadgerCare effective on the first day of the month that the employer–subsidized health care coverage would have been in effect for the recipient if the family had been enrolled in the plan. The individual remains ineligible for each month that coverage would have been available up to 19 months from the month the failure to enroll in the plan occurred.

(c) Paragraph (b) does not apply if there was coverage and it ended for a good cause reason. A good cause reason is any of the following:

1. The employment ended for a reason other than voluntary termination.

2. The person changed to a new employer that does not offer family coverage.

3. The person's employer discontinued health plan coverage for all employees.

4. Any other reason determined by the department to be a good cause reason.

(5) COOPERATION WITH BUY–IN TO A GROUP HEALTH INSURANCE PLAN. An adult in a group eligible for BadgerCare shall cooperate when the department determines whether it is cost–effective to purchase coverage for the group in an employer's group health insurance plan under s. HFS 108.02 (13). In this subsection, "cooperation" means providing necessary information in order to determine cost effectiveness, signing up with the plan when requested by the department and cooperating with any other requirements of the health insurance plan. A person who fails or refuses to cooperate with buy–in is not eligible for BadgerCare.

(6) MAXIMUM INCOME. A BadgerCare group remains eligible for BadgerCare while the fiscal test group's income is at or below 200% of the poverty line and the group is otherwise eligible for BadgerCare.

History: Emerg. cr. eff. 7–1–99; cr. Register, March, 2000, No. 531, eff. 4–1–00.

HFS 103.087 Conditions for continuation of eligibility. (1) PREMIUMS. (a) *Authority.* Subject to this section and s. 49.472, Stats., a person eligible for the medicaid purchase plan shall pay a monthly premium.

(b) *Applicability.* 1. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is at or above 150% of the poverty line for the applicable household size shall pay a monthly premium and the applicant shall pay all retroactive premium amounts assessed or other premium payments due.

2. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is below 150% of the poverty line for the applicable household size need not pay a monthly premium.

3. An applicant or recipient eligible for the medicaid purchase plan whose premium, calculated as described in par. (c), is greater than $10.00 shall pay a premium for the cost of the health care coverage offered under the medicaid purchase plan.

(c) *Premium amounts.* 1. An applicant or recipient eligible for the medicaid purchase plan shall pay a monthly premium in accordance with this subsection and the premium schedule in Table 103.087.

2. The county agency shall determine the amount of the premium an applicant shall pay according to the guidelines described in this subsection at the time of application.

3. All earned and unearned sources of income available to the applicant or recipient, except for the interest, dividends or other gains accrued from a recipient's independence account, shall be used in the premium determination.

4. The applicant's or recipient's monthly premium shall be calculated by locating the sum of the monthly adjusted unearned income plus the monthly adjusted earned income on the premium schedule in Table 103.087.

(d) *Calculating the monthly adjusted unearned income.* 1. An applicant's or recipient's monthly adjusted unearned income shall be calculated by subtracting the monthly income disregards in subd. 1. a. to c. from 100% of the applicant's or recipient's gross monthly countable unearned income.

a. The allowance shall be equal to the sum of the monthly federal supplemental security income cash benefit, the monthly state supplemental security cash benefit, and $20, rounded to the nearest dollar.

b. To be claimed as a monthly income disregard, the cost may not have been claimed by the applicant or recipient under any other medicaid purchase plan income disregard.

c. To be claimed as a monthly income disregard, the cost may not have been claimed by the applicant or recipient under any other medicaid purchase plan income disregard.

2. If the applicant or recipient has monthly unearned income equal to $0, the monthly income disregards described in subd. 1. a. to c. apply to the applicant's or recipient's gross monthly earned income. If the applicant or recipient has monthly income disregards greater than his or her monthly unearned income, the difference shall be applied as a deduction to the applicant's or recipient's monthly earned income.

Chapter HFS 103

ELIGIBILITY

Note: Chapter HSS 103 as it existed on February 28, 1986, was repealed and a new chapter HSS 103 was created effective March 1, 1986. Chapter HSS 103 was renumbered Chapter HFS 103 under s. 13.93, Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, January, 1997, No. 493.

HFS 103.01 Introduction. (1) PERSONS ELIGIBLE. (a) Eligibility for medical assistance shall be determined pursuant to ss. 49.455, 49.46 (1), 49.47 (4) and 49.472, Stats., and this chapter, except that medical assistance shall be provided without eligibility determination to persons receiving SSI or those persons who would currently be eligible under the AFDC program that was in place on July 16, 1996 in this state pursuant to s. 49.19, Stats.

(b) Presumptive eligibility for pregnant women shall be determined under s. 49.465, Stats., and this chapter.

(2) SINGULAR ENROLLMENT. No person may be certified eligible in more than one MA case.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; renum. (1) to be (1) (a) and cr. (1) (b), Register, February, 1988, No. 386, eff. 3–1–88; am. (1) (a), Register, March, 1993, No. 447, eff. 4–1–93; emerg. am. (1) (a), eff. 7–1–99; am. (1) (a), Register, March, 2000, No. 531, eff. 4–1–00; am. (1) (a), Register, November, 2000, No. 539, eff. 12–1–00.

HFS 103.03 Non–financial conditions for eligibility. In order to be eligible for MA, a person shall meet both non–financial conditions for eligibility in this section and financial conditions for eligibility under s. HFS 103.04. The non–financial conditions for eligibility are:

(1) AFDC–RELATEDNESS, SSI–RELATEDNESS OR BADGERCARE ELIGIBILITY. (a) *Requirement.* To be non–financially eligible for MA, an applicant shall be AFDC–related, SSI–related or meet the non–financial requirements under par. (f) for BadgerCare.

(b) *AFDC–related persons.* In this subsection, "AFDC–related" means a person who meets one of the following conditions:

1. The person is pregnant and meets the conditions specified in s. 49.46 (1) (a) 1m. or 9., 49.465 or 49.47 (4) (a) 2. or (am) 1., Stats.;

2. The person is a dependent child as defined in s. 49.19 (1) (a), Stats., or is a child who meets the conditions specified in s. 49.46 (1) (a) 10. or 49.47 (4) (a) 1. or (am) 2., Stats.;

3. The person is a caretaker relative; or

4. The person is a foster child under 19 years of age living in a foster home licensed under s. 48.62, Stats., or a group home licensed under s. 48.625, Stats., or is a child in an adoption assistance placement under s. 48.975, Stats.

(c) *SSI–related persons.* In this subsection, "SSI–related person" means a person who meets one of the following conditions:

1. The person is age 65 or over; or

2. The person is blind or disabled.

(d) *Verification of blindness or disability.* Except as provided under par. (e), the blindness or disability claimed under par. (c) 2. shall be verified in one of the following ways:

1. By presentation of a current old age and survivors disability insurance (OASDI) disability award notice;

2. By presentation of a current medicare card indicating blindness or disability; or

3. By receipt of a disability determination made by the department's bureau of social security disability insurance, along with current medical reports.

(e) *Presumption of disability in an emergency.* 1. Under emergency circumstances, a person may be presumed disabled for purposes of demonstrating SSI–relatedness and be eligible for MA without the verification required under par. (d).

2. When an emergency need for MA exists, the department shall make a preliminary disability determination within 7 days of the date a completed disability determination form is received.

3. An emergency need for MA shall exist when the applicant is:

a. A patient in a hospital;

b. Seriously impaired and the attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months;

c. In need of long–term care and the nursing home will not admit the applicant until MA benefits are in effect; or

d. Unable to return home from a nursing home unless in–home service or equipment is available and this cannot be obtained without MA benefits.

Note: Copies of the disability determination form may be obtained from the county or tribal income maintenance agency.

(f) *BadgerCare eligibility.* To be non–financially eligible for BadgerCare, a person shall meet all of the following conditions:

1. The person is under age 19, a custodial parent living with his or her child who is under age 19 or the spouse of a custodial parent if the spouse resides with the custodial parent's child who is under the age of 19.

2. The person does not have health insurance coverage and has not been covered at any time in the previous 3 calendar months. The 3 calendar month period does not apply if the coverage ended for a good cause reason. A good cause reason is any of the following:

a. The person was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber's employment ended for a reason other than voluntary termination, except for cases in which the voluntary termination was a result of the incapacitation of the subscriber.

b. The person was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber changed to a new employer who does not offer family coverage.

c. The person was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber's employer discontinued health plan coverage for all employees.

d. COBRA continuation coverage was exhausted in accordance with 29 CFR 2590.701–2(4).

e. The person was covered by insurance that has ended due to the death or change in marital status of the subscriber.

f. Any other reason determined by the department to be a good cause reason.

3. The person does not have access to family coverage under a group health insurance plan offered by an employer for which the employer pays 80% of the cost, excluding any deductibles or co–payments that may be required under the plan, or to a state employee health plan through any of the following:

a. The person's employer.

b. The employer of the person's spouse when the spouse is residing with the person.

c. The employer of the person's parent, step–parent or other caretaker relative residing with the person, when the person is under 19 years of age.

4. Except as provided in subd. 5., the applicant for BadgerCare did not at any time in the 18 months immediately preceding application for BadgerCare have access to employer–subsidized health care coverage, or a state employee's health plan. The applicant is ineligible for BadgerCare the first day of the month that the employer's plan would have provided coverage for the recipient if the family had been enrolled in the plan. The applicant remains ineligible for each month that coverage would have been available up to 18 months from the month the failure to enroll in the plan occurred. The insurance the applicant had access to shall have been available only through one of the following:

a. The person's employer.

b. The employer of the person's spouse when the spouse is residing with the person.

c. The employer of the person's parent, step–parent or other caretaker relative residing with the person, when the person is under 19 years of age.

5. The 18 month period in subd. 4. does not apply if one of the following statements is true about access to employer–subsidized health care coverage:

a. The employment ended.

b. The person's employer discontinued health care coverage for all employees.

c. A member or members of the family were eligible for other health insurance coverage or MA at the time the employee failed to enroll in the employer–subsidized health care coverage and no member of the group was eligible for BadgerCare at that time.

d. The person was covered by insurance that has ended due to the death or change in marital status of the subscriber.

e. Any other reason determined by the department to be a good cause reason.

6. The person is not eligible for MA under AFDC–related or SSI–related criteria in this chapter.

7. A person required to pay a premium under s. HFS 103.085(1) has made the first payment.

8. A person has not chosen to receive AFDC–related or SSI–related MA through a spend–down, as described in s. HFS 103.08 (2) (a), or has chosen to end a spend–down period at any time prior to the date at which the expenditure or obligation of excess income has been achieved.

(g) *Medicaid purchase plan non–financial eligibility.* To be non–financially eligible for the medicaid purchase plan a person shall meet the conditions described in par. (c) for SSI–related persons and shall be age 18 or older and the person shall meet any of the following conditions:

1. a. The person shall be employed.

b. The person shall be enrolled in a department–certified health and employment counseling program.

c. The health of the person participating in the medicaid purchase plan for at least 6 months shall have deteriorated to the point that he or she is unable to participate under subd. 1. a. or b. and the county agency has waived the requirement for a period up to 6 calendar months. The county agency may waive the requirement if the person is hospitalized, injured or suffers any other health setback. The county agency may waive the requirement as long as it had not granted a waiver of the requirement twice within the 36 months immediately preceding the current waiver request. The waiver periods shall be non–consecutive. The person shall supply proof of health difficulties. In addition to the discretion the county agency has to grant a waiver, the department may grant a temporary waiver of the work requirement upon a showing of good cause.

2. The person meets SSI–related non–financial eligibility requirements under par. (c) as verified under par. (d) and s. 49.472 (3) (c), Stats.

3. The applicant meets the eligibility requirements described in s. HFS 103.087.

(h) *Medicaid purchase plan health and employment counseling eligibility.* 1. Initial eligibility. To be eligible for the health and employment counseling program within the medicaid purchase plan, a person shall complete an employment plan.

a. The employment plan shall be reviewed by a screening agency and approved by the department before the person receives approval from the department as a participant.

b. The screening agency shall refer the person to community resources as appropriate to meet all employment plan requirements. The screening agency may assist the person in completing the written employment plan or providing any other services required under the plan.

c. A notice of participation status shall be sent by the department to the person, the screener and the appropriate county or tribal economic support office.

2. Period of eligibility. a. A person may participate in a health and employment counseling program for a period of up to nine consecutive calendar months and for any allowable periods of extension described under subd. 3.

b. Upon completion of a period of eligibility, a person shall be ineligible for a health and employment counseling program for a period of 6 consecutive calendar months. Following the 6–month period, a person may begin a new period of eligibility, but a given person may only use 2 periods of eligibility within a period of 5 consecutive calendar years.

c. Participation in a health and employment counseling program approved by the department meets the eligibility requirement in par. (g) 1. b.

3. Extending eligibility. a. If a person is not employed at the end of the period of eligibility, the person may request an extended period of eligibility from the department. The extended period of eligibility shall be valid for a period of three consecutive calendar months.

b. The extended period of eligibility shall be approved by the department.

c. The person may not request more than one extension of eligibility per period of eligibility.

d. After participation in a health and employment counseling [program] ends, a person may continue to receive services from an agency that also provides screening services, in accordance with the agency's rules.

4. Retroactive eligibility. a. A person may request retroactive participation in a health and employment counseling program for a period of up to three months if the person demonstrates he or she met all eligibility requirements of the employment plan during those months.

b. Any retroactive months of eligibility requested by the person shall count toward the period of eligibility as described in this paragraph.

c. The department shall approve requested months of retroactive eligibility.

would lose coverage under MA or BC
+ are not eligible for BC+
~~for~~ for financial reasons —

continue (like COBRA) current
coverage for 18 months
↓
(MA or BC)

No pen ⇒ preg w. $300%

STATE OF WISCONSIN – **LEGISLATIVE REFERENCE BUREAU**

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call Jim → for trans. grandfathering –
are those the people who are under
49.46(1)(c), (cg), + (co)?

due to inc ↑, they wouldn't be
eligible under any
program?

preg. women	200 - 300%	prem	BM
adults	150 - 200	prem	MA or BM
children	> 200%	prem	BM

49.474

John LaPhillips
send inserts
66772

Kahler, Pam

From: Kahler, Pam
Sent: Monday, January 22, 2007 12:18 PM
To: Pink, Michelle C - DOA; Jones, James D - DHFS
Subject: Cross-references

I've gone over the responses to the latest list of possible cross-references that I sent and have a few follow-up questions/comments:

I repealed s. 49.45 (24g) (a), but did not do anything with s. 49.45 (24m) (a). OK?

Section 49.45 (42) (intro.) was not addressed. Should it have a cross-reference to BC+ or Benchmark?

For s. 49.45 (44) (intro.) and (a), I added a cross-reference to s. 49.471 (11) (r), which is prenatal care coordination, but there doesn't seem to be anything entirely comparable to "prenatal, postpartum, and young child care coordination" under the Benchmark plan to cross-reference in 49.45 (44) (c). Should I just use s. 49.471 (11) (r) (prenatal care coordination) again?

I did not do anything with s. 49.45 (48). OK? (The response was "unsure if we are doing this.")

For s. 49.45 (53), I added home health services under Benchmark, but was unsure which services under Benchmark, if any, correspond with personal care and respiratory care.

Same thing for s. 49.496 (3) (a) 2. d. What corresponds under Benchmark to personal care services?

Am I correct that nothing needs to be added to s. 108.02 (15) (k) 20. a. and b.?

For s. 449.17 (8), I added a cross-reference to s. 49.471 (11) (n), but the cross-reference in current law refers to "rural health clinic services". I don't know if the cross-reference in current law is wrong, and if not, what is comparable under Benchmark?

Pamela J. Kahler
Legislative Attorney
Legislative Reference Bureau
608-266-2682

from Jim Jones at DHFS 1-24

I've gone over the responses to the latest list of possible cross-references that I sent and have a few follow-up questions/comments:

I repealed s. 49.45 (24g) (a), but did not do anything with s. 49.45 (24m) (a). OK? Your action is correct, the section should be repealed. Nothing further needs to be done with this.

Section 49.45 (42) (intro.) was not addressed. Should it have a cross-reference to BC+ or Benchmark? Yes, cross-reference it to the BC+ benchmark plan. personal care services
no - not covered!

For s. 49.45 (44) (intro.) and (a), I added a cross-reference to s. 49.471 (11) (r), which is prenatal care coordination, but there doesn't seem to be anything entirely comparable to "prenatal, postpartum, and young child care coordination" under the Benchmark plan to cross-reference in 49.45 (44) (c). Should I just use s. 49.471 (11) (r) (prenatal care coordination) again? Correction: This is a Milwaukee-based program and should not be cross-referenced to the BC+ benchmark plan. removed 49.45(44) from draft

I did not do anything with s. 49.45 (48). OK? (The response was "unsure if we are doing this.") Cross-reference to the BC+ benchmark plan. 49.471 (6) (j) 1.

For s. 49.45 (53), I added home health services under Benchmark, but was unsure which services under Benchmark, if any, correspond with personal care and respiratory care. Correction: No home health care services under the BC+ benchmark. Do not cross-reference. (11)(f) no personal care serv.

Same thing for s. 49.496 (3) (a) 2. d. What corresponds under Benchmark to personal care services? Correction: No personal care services are allowed under the BC+ benchmark. Do not cross-reference.

s/not be in draft

		Should it be changed under BC+?
45.51 (13) (intro.), (a), and (b)	**(13) Additional eligibility requirements for skilled nursing facilities.** Any person admitted to a skilled nursing facility at a veterans home shall meet the eligibility requirements under ss. 49.45 and 49.46 and rules promulgated under those sections during residence at the skilled nursing facility except if any of the following apply: (a) Persons with sufficient income and resources to meet the expenses of care for one or more months may be admitted to the skilled nursing facility but shall apply income and resources to costs to the extent required under ss. 49.45 and 49.46 and rules promulgated under those sections. (b) Persons who meet all the requirements of this section but whose degree of physical disability does not meet the minimum requirements under ss. 49.45 and 49.46 and rules promulgated under those sections may be admitted to the skilled nursing facility but shall apply income and resources to costs to the extent required by ss. 49.45 and 49.46 and rules promulgated under those sections.	Since the focus seems to be on LTC services, I don't think we need to include a BC+ reference. Include BC+ reference since some nursing home care is covered.
46.515 (6g) (a)	**(6g) Confidentiality.** (a) Except as permitted or required under s. 48.981 (2), no person may use or disclose any information concerning any individual who is selected for an assessment under sub. (4) (b), including an individual who declines to undergo the assessment, or concerning any individual who is offered services under a home visitation program funded under this section, including an individual who declines to receive those services, unless the use or disclosure is connected with the administration of the home visitation program or the administration of the medical assistance program under ss. 49.43 to 49.497 or unless the individual has given his or her written informed consent to the use or disclosure. 46.515(6g)	No change needed.
49.22 (6)	(6) The department shall establish, pursuant to federal and state laws, rules and regulations, a uniform system of fees for services provided under this section to individuals not receiving aid under s. 46.261, 49.19 or 49.47; benefits under s. 49.148, 49.155, or 49.79; foster care maintenance payments under 42 USC 670 to 679a; or kinship care payments under s. 48.57 (3m) or long-term kinship care payments under s. 48.57 (3n). The system of fees may take into account an individual's ability to pay. Any fee paid and collected under this subsection may be retained by the county providing the service except for the fee specified in 42 USC 653 (e) (2) for federal parent locator services.	Need cross reference to BC+.

49.43 (intro.) 49.45 (2) (a) 22. and (b) 7. (intro.)	Definitions. As used in ss. 49.43 to 49.497 unless the context indicates otherwise: 22. After consulting with counties, independent living centers, consumer organizations and home health agencies, periodically identify those barriers to the provision of personal care services under s. 49.46 (2) (b) 6. j. which lead to a failure to respond to the needs and preferences of individuals who are eligible for these services and act to remove the barriers to the extent possible.	No change needed. (a) 22. No change needed.
	7. Require, as a condition of certification under par. (a) 11., all providers of a specific service that is among those enumerated under s. 49.46 (2) or 49.47 (6) (a), as specified in this subdivision, to file with the department a surety bond issued by a surety company licensed to do business in this state. Providers subject to this subdivision provide those services specified under s. 49.46 (2) or 49.47 (6) (a) for which providers have demonstrated significant potential to violate s. 49.49 (1) (a), (2) (a) or (b), (3), (3m) (a), (3p), (4) (a), or (4m) (a), to require recovery under par. (a) 10., or to need additional sanctions under par. (a) 13. The surety bond shall be payable to the department in an amount that the department determines is reasonable in view of amounts of former recoveries against providers of the specific service and the department's costs to pursue those recoveries. The department shall promulgate rules to implement this subdivision that specify all of the following:	(b) 7. Add cross reference to BC+ Benchmark plan
49.45 (3) (f) 2. and (m)	2. The department may deny any provider claim for reimbursement which cannot be verified under subd. 1. or may recover the value of any payment made to a provider which cannot be so verified. The measure of recovery will be the full value of any claim if it is determined upon audit that actual provision of the service cannot be verified from the provider's records or that the service provided was not included in s. 49.46 (2). In cases of mathematical inaccuracies in computations or statements of claims, the measure of recovery will be limited to the amount of the error.	Add cross reference to BC+ Benchmark plan to both.
	(m) To be certified under sub. (2) (a) 11. to provide transportation by specialized medical vehicle, a person must have at least one human service vehicle, as defined in s. 340.01 (23g), that satisfies the requirements imposed under s. 110.05 for a vehicle that is used to transport a person in a wheelchair. If a certified provider uses 2 or more vehicles to provide transportation by specialized medical vehicle, at least 2 of the vehicles must be human service vehicles that satisfy the requirements imposed under s. 110.05 for a vehicle that is used to transport a person in a wheelchair, and any 3rd or additional vehicle must be a human service vehicle to which the equipment required under s. 110.05 for transporting a person in a wheelchair may be added. The department shall pay for transportation by	