LRB 07-0905

4

	specialized medical vehicle under s. 49.46 (2) (b) 3. that is provided in a human service vehicle that is not equipped to transport a person in a wheelchair if the person being transported does not use a wheelchair. The reimbursement rate for transportation by specialized medical vehicle provided in a vehicle that is not equipped to accommodate a wheelchair shall be the same as for transportation by specialized medical vehicle provided in a vehicle that is equipped to accommodate a wheelchair.	
49.45(8m) (intro.)	**(8m) Rates for respiratory care services.** Notwithstanding the limit under sub. (8), the rates under sub. (8) and rates charged by providers under s. 49.46 (2) (a) 4. d. that are not home health agencies, for reimbursement for respiratory care services for ventilator-dependent individuals under ss. 49.46 (2) (b) 6. m. and 49.47 (6) (a) 1., shall be as follows:	No change needed.
49.45(18) (b) 3.	**(18) Recipient cost sharing.** (b) The following services are not subject to recipient cost sharing under this subsection: 3. Any service provided under s. 49.46 (2) to a pregnant woman, if the service relates to the pregnancy or to other conditions that may complicate the pregnancy.	Part of whole rewrite for BC+ mentioned in last cross reference document.
49.45(21) (ar)	(ar) Before a person may take over the operation of a provider that is liable for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497, full repayment shall be made. Upon request, the department shall notify the provider or the person that intends to take over the operation of the provider as to whether the provider is liable.	No change needed.
49.45(24g) (a) repealed	(a) The department shall, in consultation with the Wisconsin Dental Association, develop a pilot project for the provision of dental services under a managed care system. The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to implement the pilot project developed under this subsection. If the waiver is granted and in effect, and if the department of health and family services determines that the costs of providing dental services under s. 49.46 (2) (b) 1. under the pilot project will not exceed the costs of providing those dental services in the absence of the pilot project, the department shall implement the pilot project in Ashland, Douglas, Bayfield and Iron counties. Only those dental services covered under s. 49.46 (2) (b) 1. may be covered under the pilot project.	Delete.
49.45(24m) (a) did not repeal	(24m)Home health care and personal care pilot program. From the appropriation accounts under s. 20.435 (4) (b), (gp), (o), and (w), in order to test the feasibility of	Delete. Ignore for BC+.

	instituting a system of reimbursement for providers of home health care and personal care services for medical assistance recipients that is based on competitive bidding, the department shall: (a) By September 1, 1990, select a county in this state and solicit bids from providers of home health care and personal care services in that county for the provision, on a contractual basis, of home health and personal care services authorized under ss. 49.46 (2) (a) 4. d. and (b) 6. j. and 49.47 (6) (a) 1.	
49.45 (25) (am)(intro.) and (d)	(am) Except as provided under pars. (be), (bg), and (bj) and sub. (24), case management services under s. 49.46 (2) (b) 9. and (bm) are reimbursable under Medical Assistance only if provided to a Medical Assistance beneficiary who receives case management services from or through a certified case management provider in a county, city, village, or town that elects, under par. (b), to make the services available and who meets at least one of the following conditions: (d) This subsection does not apply to case management services provided under sub. (15) or s. 49.46 (2) (a) 2. or through a community support program under s. 49.46 (2) (b) 6. L.	No change needed.
49.45(30) (a) and (b)	(a) A county shall provide the portion of the cost of services under s. 49.46 (2) (b) 6. L. that is not provided by the federal government. (b) The department shall reimburse a provider of services under s. 49.46 (2) (b) 6. L. only for the amount of the allowable charges for those services that is provided by the federal government.	No change needed.
49.45(30e) (a) (intro.), 1., and 2., (b) 2., and (c)	**(30e) Community-based psychosocial service programs.** (a) When services are reimbursable. Services under s. 49.46 (2) (b) 6. Lm. provided to an individual are reimbursable under the medical assistance program only if all of the following conditions are met: 1. Reimbursement for the services under s. 49.46 (2) (b) 6. Lm. in the manner provided under this subsection is permitted pursuant to federal law or pursuant to a waiver from the secretary of the federal department of health and human services. 2. The county in which the individual resides elects to make the services under s. 49.46 (2) (b) 6. Lm. available in the county through the medical assistance program.	No change needed.

	(b) Rules. The department shall promulgate rules regarding all of the following:	
	2. The scope of psychosocial services that may be provided under s. 49.46 (2) (b) 6. Lm.	
	(c) Provider reimbursement. A county that elects to make the services under s. 49.46 (2) (b) 6. Lm. available shall reimburse a provider of the services for the amount of the allowable charges for those services under the medical assistance program that is not provided by the federal government. The department shall reimburse the provider only for the amount of the allowable charges for those services under the medical assistance program that is provided by the federal government.	
49.45(35m)	**(35m) Computer system redesign**. The department shall ensure that any redesign or replacement of the computer network that is used by counties on May 12, 1992, to determine eligibility for medical assistance includes the capability of determining eligibility for medical assistance under s. 49.47 (4) (c) 2.	No change needed.
49.45(37) (intro.)	**(37) Plans of care.** The department may seek a waiver of the requirement under 42 USC 1396n (c) (1) that the department review and approve every written plan of care developed for each individual who receives, under 42 USC 1396n (c) (1), home or community-based services under ss. 49.46 (2) (b) 8. and 49.47 (6) (a) 1. The waiver of the requirement, if granted, shall apply to those county departments or private nonprofit agencies that administer the services and that the department finds and certifies have implemented effective quality assurance systems for service plan development and implementation. If the federal health care financing administration approves the department's request for waiver of the requirement, the department shall, in evaluating a quality assurance system for certification, consider all of the following:	No change needed.
49.45(38)	**(38) Home or community-based services for disabled workers.** The department shall request a waiver from the secretary of the federal department of health and human services to authorize federal financial participation for medical assistance coverage of persons described in ss. 49.46 (1) (a) 14. and 49.47 (4) (as).	No change needed.
49.45(42) (intro.)	**(42) Personal care services**. Personal care services under s. 49.46 (2) (b) 6. j. provided to an individual are reimbursable under medical assistance only if all of the following conditions are met:	No change needed.

No change to personal care law.

49.45 (42m) (a)	**(42m) Physical and occupational therapy.** (a) If, in authorizing the provision of physical or occupational therapy services under s. 49.46 (2) (b) 6. b., the department authorizes a reduced duration of services from the duration that the provider specifies in the authorization request, the department shall substantiate the reduction that the department made in the duration of the services if the provider of the services requests any additional authorizations for the provision of physical or occupational therapy services to the same individual.	Cross-reference to BC+ Benchmark.
49.45 (44) (intro.), (a), and (c)	**(44) Prenatal, postpartum and young child care coordination.** Providers in Milwaukee County that are certified to provide care coordination services under s. 49.46 (2) (b) 12. may be certified to provide to medical assistance recipients prenatal and postpartum care coordination services and care coordination services for children who have not attained the age of 7. A provider of those care coordination services shall provide to a person receiving those services the information relating to shaken baby syndrome and impacted babies required under s. 253.15 (6). The department shall provide reimbursement for those care coordination services only if at least one of the following conditions is met: (a) The recipient is a resident of Milwaukee County and has received services under s. 49.46 (2) (b) 12. and is pregnant or has given birth within 8 weeks after the individual ceased to receive services under s. 49.46 (2) (b) 12. (c) The recipient is a resident of Milwaukee County, has given birth within the 8 weeks immediately preceding the request for services under s. 49.46 (2) (b) 12m. and has received a risk assessment approved by the department.	Cross-reference to BC+ Benchmark and possibly add language under PNCC proposal.
49.45 (45) (a) (intro.), 1., and 2. and (b)	**(45) In-home and community mental health and alcohol and other drug abuse services.** (a) Services under s. 49.46 (2) (b) 6. fm. provided to an individual are reimbursable under the medical assistance program only if all of the following conditions are met: 1. Reimbursement for the services under s. 49.46 (2) (b) 6. fm. in the manner provided under this subsection is permitted pursuant to federal law or pursuant to a waiver from the secretary of the federal department of health and human services. 2. The county, city, town or village in which the individual resides elects to make the services under s. 49.46 (2) (b) 6. fm. available in the county, city, town or village through the medical assistance program.	No change needed. Not covered under BC+.

(b) A county, city, town or village that elects to make the services under s. 49.46 (2) (b) 6. fm. available shall reimburse a provider of the services for the amount of the allowable charges for those services under the medical assistance program that is not provided by the federal government. The department shall reimburse the provider only for the amount of the allowable charges for those services under the medical assistance program that is provided by the federal government.

49.45 (48)

(48) Payment of medicare part B outpatient hospital services coinsurances. The department shall include in the state plan for medical assistance a methodology for payment of the medicare part B outpatient hospital services coinsurance amounts that are authorized under ss. 49.46 (2) (c) 2., 4., and 5m., 49.468 (1) (b), and 49.47 (6) (a) 6. b., d., and f.

Unsure if we are doing this.

do add x ref

49.45(49m) (c) 1.

(49m) Prescription drug cost controls; purchasing agreements.

Cross-reference to BC+ benchmark.

(c) The department may design and implement a program to reduce the cost of prescription drugs and to maintain high quality in prescription drug therapies, which shall include all of the following:

1. A list of the prescription drugs that are included as a benefit under s. 49.46 (2) (b) 6. h. that identifies preferred choices within therapeutic classes and includes prescription drugs that bear only generic names.

49.45 (51) (a)

(51) Medical care transportation services.

No change needed.

(a) By November 1 annually, the department shall provide to the department of revenue information concerning the estimated amounts of supplements payable from the appropriation under s. 20.435 (4) (b) to specific local governmental units for the provision of transportation for medical care, as specified under s. 49.46 (2) (b) 3., during the fiscal year. Beginning November 1, 2004, the information that the department provides under this paragraph shall include any adjustments necessary to reflect actual claims submitted by service providers in the previous fiscal year.

49.45 (52)

(52) Payment adjustments. Beginning on January 1, 2003, the department may, from the appropriation account under s. 20.435 (7) (b), make Medical Assistance payment adjustments to county departments under s. 46.215, 46.22, 46.23, or 51.42, or 51.437 or to local health departments, as defined in s. 250.01 (4), as appropriate, for covered services under s. 49.46 (2) (a) 2. and 4. d. and f. and (b) 6. b., c., f., fm., g., j., k., L., Lm., and m., 9., 12., 12m., 13., 15., and 16. Payment adjustments under this subsection shall include the state share of the payments. The

No change needed.

total of any payment adjustments under this subsection and Medical Assistance payments made from appropriation accounts under s. 20.435 (4) (b), (gp), (o), and (w) may not exceed applicable limitations on payments under 42 USC 1396a (a) (30) (A).

49.45 (53)

(53) Payments for certain services. Beginning on January 1, 2003, the department may, from the appropriation account under s. 20.435 (7) (b), make Medical Assistance payments to providers for covered services under s. 49.46 (2) (a) 4. d. and (b) 6. j. and m.

Cross-reference to BC+ benchmark.

49.49 (3m) (a) 1., 2., and 3.

49.49 Medical assistance offenses.
(3m) Prohibited provider charges.
(a) No provider may knowingly impose upon a recipient charges in addition to payments received for services under ss. 49.45 to 49.47 or knowingly impose direct charges upon a recipient in lieu of obtaining payment under ss. 49.45 to 49.47 except under the following conditions:

1. Benefits or services are not provided under s. 49.46 (2) and the recipient is advised of this fact prior to receiving the service.

2. If an applicant is determined to be eligible retroactively under s. 49.46 (1) (b) and a provider bills the applicant directly for services and benefits rendered during the retroactive period, the provider shall, upon notification of the applicant's retroactive eligibility, submit claims for reimbursement under s. 49.45 for covered services or benefits rendered during the retroactive period. Upon receipt of payment, the provider shall reimburse the applicant or other person who has made prior payment to the provider. No provider may be required to reimburse the applicant or other person in excess of the amount reimbursed under s. 49.45.

3. Benefits or services for which recipient copayment, coinsurance or deductible is required under s. 49.45 (18), not to exceed maximum amounts allowable under 42 CFR 447.53 to 447.58.

Cross-reference to BC+ benchmark.

49.496 (3) (a) 2. d.

(3) Recovery from estates.
(a) Except as provided in par. (b), the department shall file a claim against the estate of a recipient for all of the following unless already recovered by the department under this section:
2. The following medical assistance services paid on behalf of the recipient after the recipient attained 55 years of age:
d. Personal care services under s. 49.46 (2) (b) 6. j.

Cross-reference to BC+ benchmark.

51.038	**51.038 Outpatient mental health clinic certification.** Except as provided in s. 51.032, if a facility that provides mental health services on an outpatient basis holds current accreditation from the council on accreditation of services for families and children, the department may accept evidence of this accreditation as equivalent to the standards established by the department, for the purpose of certifying the facility for the receipt of funds for services provided as a benefit to a medical assistance recipient under s. 49.46 (2) (b) 6. f., a community aids funding recipient under s. 51.423 (2) or as mandated coverage under s. 632.89.	Cross-reference to BC+ benchmark. (K)
51.04	**51.04 Treatment facility certification.** Except as provided in s. 51.032, any treatment facility may apply to the department for certification of the facility for the receipt of funds for services provided as a benefit to a medical assistance recipient under s. 49.46 (2) (b) 6. f. or to a community aids funding recipient under s. 51.423 (2) or provided as mandated coverage under s. 632.89. The department shall annually charge a fee for each certification.	Cross-reference to BC+ benchmark. (K)
59.58 (5)	59.58 Transportation. (5) Specialized transportation services. The board may coordinate specialized transportation services, as defined in s. 85.21 (2) (g), for county residents who are disabled or are aged 60 or older, including services funded under 42 USC 3001 to 3057n, 42 USC 5001 and 42 USC 5011 (b), under ss. 49.43 to 49.499 and 85.21 and under other public funds administered by the county.	No change needed.
108.02 (15) (k) 20. a. and b.	**Chapter 108 UNEMPLOYMENT INSURANCE AND RESERVES** **108.02 Definitions.** As used in this chapter: (15) Employment. (k) "Employment" as applied to work for a given employer other than a government unit or nonprofit organization, except as the employer elects otherwise with the department's approval, does not include service: 20. Provided to a recipient of medical assistance under ch. 49 by an individual who is not an employee of a home health agency, if the service is: a. Private duty nursing service or part-time intermittent care authorized under s. 49.46 (2) (b) 6. g., for which medical assistance reimbursement is available as a covered service, provided by an individual who is certified by the department of health and family services under s. 49.45 (2) (a) 11. as a nurse in independent practice or as an independent nurse practitioner; or	Intro. No change needed. a. & b.

b. Respiratory care service for ventilator-dependent individuals authorized under s. 49.46 (2) (b) 6. m., for which medical assistance reimbursement is available as a covered service, provided by an individual who is certified by the department of health and family services under s. 49.45 (2) (a) 11. as a provider of respiratory care services in independent practice.

227.01 (13) (um)

CHAPTER 227 ADMINISTRATIVE PROCEDURE AND REVIEW

227.01 Definitions. In this chapter:

(13) "Rule" means a regulation, standard, statement of policy or general order of general application which has the effect of law and which is issued by an agency to implement, interpret or make specific legislation enforced or administered by the agency or to govern the organization or procedure of the agency. "Rule" does not include, and s. 227.10 does not apply to, any action or inaction of an agency, whether it would otherwise meet the definition under this subsection, which:

(um) Lists over-the-counter drugs covered by medical assistance under s. 49.46 (2) (b) 6. i.

Cross-reference to BC+ benchmark.

253.10 (3) (d) 1.

CHAPTER 253 MATERNAL AND CHILD HEALTH

253.10 Voluntary and informed consent for abortions.

(3) Voluntary and informed consent.

(d) Printed information. By the date that is 60 days after May 16, 1996, the department shall cause to be published in English, Spanish, and other languages spoken by a significant number of state residents, as determined by the department, materials that are in an easily comprehensible format and are printed in type of not less than 12-point size. The department shall distribute a reasonably adequate number of the materials to county departments as specified under s. 46.245 and upon request, shall annually review the materials for accuracy and shall exercise reasonable diligence in providing materials that are accurate and current. The materials shall be all of the following:

1. Geographically indexed materials that are designed to inform a woman about public and private agencies, including adoption agencies, and services that are available to provide information on family planning, as defined in s. 253.07 (1) (a), including natural family planning information, to provide ultrasound imaging

Add cross reference to BC+ Benchmark plan

services, to assist her if she has received a diagnosis that her unborn child has a disability or if her pregnancy is the result of sexual assault or incest and to assist her through pregnancy, upon childbirth and while the child is dependent. The materials shall include a comprehensive list of the agencies available, a description of the services that they offer and a description of the manner in which they may be contacted, including telephone numbers and addresses, or, at the option of the department, the materials shall include a toll-free, 24-hour telephone number that may be called to obtain an oral listing of available agencies and services in the locality of the caller and a description of the services that the agencies offer and the manner in which they may be contacted. The materials shall provide information on the availability of governmentally funded programs that serve pregnant women and children. Services identified for the woman shall include medical assistance for pregnant women and children under s. 49.47 (4) (am), the availability of family or medical leave under s. 103.10, the Wisconsin works program under ss. 49.141 to 49.161, child care services, child support laws and programs and the credit for expenses for household and dependent care and services necessary for gainful employment under section 21 of the internal revenue code. The materials shall state that it is unlawful to perform an abortion for which consent has been coerced, that any physician who performs or induces an abortion without obtaining the woman's voluntary and informed consent is liable to her for damages in a civil action and is subject to a civil penalty, that the father of a child is liable for assistance in the support of the child, even in instances in which the father has offered to pay for an abortion, and that adoptive parents may pay the costs of prenatal care, childbirth and neonatal care. The materials shall include information, for a woman whose pregnancy is the result of sexual assault or incest, on legal protections available to the woman and her child if she wishes to oppose establishment of paternity or to terminate the father's parental rights. The materials shall state that fetal ultrasound imaging and auscultation of fetal heart tone services are obtainable by pregnant women who wish to use them and shall describe the services.

255.056 (7) (e)

255.056 Cancer and chronic diseases drug repository.

No change needed.

(7) The department shall promulgate all of the following as rules:

(e) The maximum handling fee that a medical facility or pharmacy may charge for accepting, distributing, or dispensing donated cancer or chronic disease drugs or supplies The fee under this paragraph may not be less than 300 percent of the dispensing fee permitted to be charged for prescription drugs for which coverage is provided under s. 49.46 (2) (b) 6. h.

449.17 (8)

449.17 Use of diagnostic pharmaceuticals.

Cross-reference to BC+ benchmark.

(8)Reimbursement prohibited. No optometrist may be reimbursed under s. 49.46

rural health
clinic services ? ?

(2) (a) 3. for any increase in charges or separate charge which is attributable to the use of topical ocular diagnostic pharmaceutical agents.

Kahler, Pam

From: Jones, James D - DHFS
Sent: Friday, January 19, 2007 3:13 PM
To: Johnston, James; Pink, Michelle; Kahler, Pam; DiMiceli, Gregory M - DHFS; Matano, Alfred - DHFS; Nelson, Kirstin B - DHFS; Wong, Donna J - DHFS
Cc: LaPhilliph, John O - DHFS
Subject: BC+ Statutory Language

Attachments: BCCross-RefSheet.doc

BCCross-RefSheet.doc (131 KB)

I've attached a chart with the additional statutory cross-references that we've checked out for BadgerCare Plus, which Pam asked us to look into.

It's also been pointed out that we need to make changes to some of the stat language concerning cost sharing for the BadgerCare Plus benchmark plan. In the private insurance product that is used as the basis for the benchmark plan, co-payments for the following services were not flat amounts ($5, $100, etc.) but percentage of eligible expenses. The following services had co-payments that are 20% of eligible expenses:

-Inpatient Hospital
-Outpatient Hospital (including surgical) -Durable Medical Equipment -Rehabilitation Services (outpatient & inpatient) -Skilled Nursing -Transportation

This is the benchmark plan as it should be included in the statutory language. It was include in the various policy development papers that were written. If we include "no more than 10%", it is unlikely that a flat fee would be more expensive than 10%, should someone decide to go that direction.

Kahler, Pam

From: LaPhilliph, John O - DHFS
Sent: Friday, January 19, 2007 3:16 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: RE: BC+

I've confirmed with Jim, that the cross reference in 66.0137 should not include presumptively eligible children.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/19/2007 9:43:39 AM
>>>
Thanks. I know, it seems almost silly to include presumptively eligible since it's so short lived.

-----Original Message-----
From: LaPhilliph, John O - DHFS
Sent: Thursday, January 18, 2007 5:43 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: RE: BC+

Sorry I didn't understand your question. I am not sure about an answer.
On the one hand, these presumptively eligible (PE) children are only eligible for two months. On the other hand, while PE, these children have access to the full benefits. We need to check with Jim on this one.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/18/2007 5:13:42
PM
>>>
Sorry, but I was asking if children (not pregnant women) with presumptive eligiblity should be specifically included in the cross-reference in s. 66.0137 (3).

-----Original Message-----
From: LaPhilliph, John O - DHFS
Sent: Thursday, January 18, 2007 5:01 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: RE: BC+

Pregnant women with presumptive eligibility are only eligible for a very limited set of benefits. In addition, the current language in s.
66.0137 (3) does not specify pregnant women who are determined presumptively eligible under s. 49.465. For these reasons, I do not think you want to add a cross reference in chapter 66 to BC+ presumptively eligible pregnant women.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/18/2007 2:23:35
PM
>>>
Thanks. I just had another question that I was going to send, so I'm glad I got your e-mail. It looks to me as though in the draft youths exiting out of foster care are not specifically exempted from paying premiums. They should be, shouldn't they? One more fine point on the first question. It looks as though after our meeting last Friday I had intended to add children (but not pregnant women) with presumtive eligibility to the cross-reference in s. 66.0137 (3), but I'm not sure why. Should I?

-----Original Message-----
From: LaPhilliph, John O - DHFS
Sent: Thursday, January 18, 2007 1:40 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: Re: BC+

Pam,

Jim asked me to respond on his behalf. (FYI - he will be out the rest of the afternoon, so if you have additional questions that need a quick reply, please copy me and I'll try to answer if I can.)

The reference Jim made to include persons with incomes at or below 200% of poverty does not include children or pregnant women with presumptive eligibility.

John

John LaPhilliph
Lead Health Care Eligibility Innovations Planner Bureau of Eligibility Management Division of Health Care Financing Wisconsin Department of Health and Family Services
608-266-6772
laphijo@dhfs.state.wi.us

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/18/2007 12:10:38 PM >>>
Jim:

I have a question as I'm reviewing the cross-references - some of which we went over last Friday. For those in s. 46.27 (and there may be others-I just haven't come to them yet) you say to include those with incomes at or below 200 % of poverty. The reference generally would be to a person eligible under sub. (4) (a), but do you want the reference to specifically include a child with presumptive eligibility, too (under sub. (5) (b) 2.)?

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

Kahler, Pam

From: LaPhilliph, John O - DHFS
Sent: Tuesday, January 23, 2007 10:24 AM
To: Kahler, Pam
Cc: Johnston, James; Pink, Michelle; DiMiceli, Gregory M - DHFS; Jones, James D - DHFS; Matano, Alfred - DHFS; Nelson, Kirstin B - DHFS; Wong, Donna J - DHFS
Subject: Re: BC+ Statutory Language

Pam,

I'm responding to your questions you asked over the phone yesterday. The statutory language that we are would like for all the items listed in Jim's email below is to require a cost share not to exceed 10% of the Medicaid allowable payment amount for these services.

The outpatient Rehabilitation Services referred to below are physical, occupational, speech and pulmonary therapies, limited to 20 outpatient visits per year for each type of therapy. It also refers to outpatient cardiac rehabilitation therapy, limited to 36 visits per year.

Emergency Room services would remain as a $75 copay and would not be subject to the 10% outpatient hospital cost share.

Hope this answers your questions. If I missed something, please let me know.

John

John LaPhilliph
Lead Health Care Eligibility Innovations Planner Bureau of Eligibility Management Division of Health Care Financing Wisconsin Department of Health and Family Services
608-266-6772
laphijo@dhfs.state.wi.us

>>> James Jones 1/19/2007 3:13:51 PM >>>
I've attached a chart with the additional statutory cross-references that we've checked out for BadgerCare Plus, which Pam asked us to look into.

It's also been pointed out that we need to make changes to some of the stat language concerning cost sharing for the BadgerCare Plus benchmark plan. In the private insurance product that is used as the basis for the benchmark plan, co-payments for the following services were not flat amounts ($5, $100,
etc.) but percentage of eligible expenses. The following services had co-payments that are 20% of eligible expenses:

-Inpatient Hospital
-Outpatient Hospital (including surgical) -Durable Medical Equipment -Rehabilitation Services (outpatient & inpatient) -Skilled Nursing -Transportation

This is the benchmark plan as it should be included in the statutory language.
It was include in the various policy development papers that were written.
If we include "no more than 10%", it is unlikely that a flat fee would be more expensive than 10%, should someone decide to go that direction.

Kahler, Pam

From: LaPhilliph, John O - DHFS
Sent: Thursday, January 18, 2007 5:43 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: RE: BC+

Sorry I didn't understand your question. I am not sure about an answer.
On the one hand, these presumptively eligible (PE) children are only eligible for two months. On the other hand, while PE, these children have access to the full benefits. We need to check with Jim on this one.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/18/2007 5:13:42 PM
>>>
Sorry, but I was asking if children (not pregnant women) with presumptive eligiblity should be specifically included in the cross-reference in s. 66.0137 (3).

-----Original Message-----
From: LaPhilliph, John O - DHFS
Sent: Thursday, January 18, 2007 5:01 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: RE: BC+

Pregnant women with presumptive eligibility are only eligible for a very limited set of benefits. In addition, the current language in s.
66.0137 (3) does not specify pregnant women who are determined presumptively eligible under s. 49.465. For these reasons, I do not think you want to add a cross reference in chapter 66 to BC+ presumptively eligible pregnant women.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/18/2007 2:23:35
PM
>>>
Thanks. I just had another question that I was going to send, so I'm glad I got your e-mail. It looks to me as though in the draft youths exiting out of foster care are not specifically exempted from paying premiums. They should be, shouldn't they? One more fine point on the first question. It looks as though after our meeting last Friday I had intended to add children (but not pregnant women) with presumtive eligibility to the cross-reference in s. 66.0137 (3), but I'm not sure why. Should I?

-----Original Message-----
From: LaPhilliph, John O - DHFS
Sent: Thursday, January 18, 2007 1:40 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: Re: BC+

Pam,

Jim asked me to respond on his behalf. (FYI - he will be out the rest of the afternoon, so if you have additional questions that need a quick reply, please copy me and I'll try to answer if I can.)

The reference Jim made to include persons with incomes at or below 200% of poverty does not include children or pregnant women with presumptive eligibility.

John

laws, regulations and agreements. If you received this email in error, please notify the sender; delete the email; and do not use, disclose or store the information it contains.
* * * * * * * * *

John LaPhilliph
Lead Health Care Eligibility Innovations Planner Bureau of Eligibility Management Division of Health Care Financing Wisconsin Department of Health and Family Services
608-266-6772
laphijo@dhfs.state.wi.us

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/18/2007 12:10:38 PM >>>
Jim:

I have a question as I'm reviewing the cross-references - some of which we went over last Friday. For those in s. 46.27 (and there may be others-I just haven't come to them yet) you say to include those with incomes at or below 200 % of poverty. The reference generally would be to a person eligible under sub. (4) (a), but do you want the reference to specifically include a child with presumptive eligibility, too (under sub. (5) (b) 2.)?

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

Kahler, Pam

From: Kahler, Pam
Sent: Wednesday, January 24, 2007 5:00 PM
To: Jones, James D - DHFS
Subject: RE: Cross-references

Jim:

I made the changes with two differences from your instructions:
Section 49.45 (42) (intro.) relates to personal care services, which are not included under Benchmark, so I did not add a cross-reference.
Section 49.45 (53) has both home health and personal care. Benchmark does have home health under s. 49.471 (11) (f), so I left the cross-reference at that (i.e., no personal care)

From: Jones, James D - DHFS
Sent: Wednesday, January 24, 2007 3:57 PM
To: Kahler, Pam
Cc: DiMiceli, Gregory M - DHFS; James Johnston; LaPhilliph, John O - DHFS; Matano, Alfred - DHFS; Nelson, Kirstin B - DHFS; Michelle Pink; Wong, Donna J - DHFS
Subject: Re: Cross-references

I've attached a document that includes the answers to your questions/comments.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/22/2007 12:18 PM >>>
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

Kahler, Pam

From: Jones, James D - DHFS
Sent: Thursday, January 25, 2007 11:26 AM
To: Kahler, Pam
Subject: Fwd: RE: Cross-references

Attachments: TEXT.htm

TEXT.htm (341 B)

I've attached Greg's answer on the personal care issue.

-----Original Message-----
Date: 01/25/2007 11:25 am -0600 (Thursday)
From: Gregory DiMiceli
To: Jones, James
CC: LaPhilliph, John
Subject: Fwd: RE: Cross-references

Jim,

Pam is correct in her delineation of personal care.

>>> James Jones 1/25/2007 8:36 AM >>>
Check out Pam's e-mail on cross references. Since these are benchmark plan cross references, I thought I'd check to see if these were okay with you?

Kahler, Pam

From: Jones, James D - DHFS
Sent: Thursday, January 25, 2007 11:27 AM
To: Kahler, Pam
Subject: Fwd: RE: Cross-references

Attachments: TEXT.htm

TEXT.htm (377 B)

I've attached Greg's answer to your concern regarding the MKE program.

-----Original Message-----
Date: 01/25/2007 11:26 am -0600 (Thursday)
From: Gregory DiMiceli
To: Jones, James
CC: LaPhilliph, John
Subject: Fwd: RE: Cross-references

Pam is also correct with respect to the MKE program.

-Greg

>>> James Jones 1/25/2007 8:37 AM >>>
Another comment for you to look at and get back to me on. Thanks.

Kahler, Pam

From: Kahler, Pam
Sent: Wednesday, January 24, 2007 5:05 PM
To: Jones, James D - DHFS
Subject: RE: Cross-references

One other thing, I removed all of s. 49.45 (44) from the draft because I assumed you meant the section relates to a Milwaukee-based program, not just the part under s. 49.45 (44) (c). Let me know if I'm wrong on that.

From: Jones, James D - DHFS
Sent: Wednesday, January 24, 2007 3:57 PM
To: Kahler, Pam
Cc: DiMiceli, Gregory M - DHFS; James Johnston; LaPhilliph, John O - DHFS; Matano, Alfred - DHFS; Nelson, Kirstin B - DHFS; Michelle Pink; Wong, Donna J - DHFS
Subject: Re: Cross-references

I've attached a document that includes the answers to your questions/comments.

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 1/22/2007 12:18 PM >>>
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

Kahler, Pam

From: LaPhilliph, John O - DHFS
Sent: Friday, January 26, 2007 2:52 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: BEM Response to 2nd LRB Draft of Statutes for BadgerCare PlusDRAFT.doc

Attachments: BEM Response to 2nd LRB Draft of Statutes for BadgerCare Plus DRAFT.doc

BEM Response to 2nd LRB Draft ...

Jim has said I may go ahead and send you this draft version of our comments to the statutes. He plans to send you an official version of our comments later this afternoon. I'll be around for questions. Given your time frames, feel free to call me on my cell phone at 577-1771 if you have any questions and you can't reach me at my desk. Thank you.

John LaPhilliph
Lead Health Care Eligibility Innovations Planner Bureau of Eligibility Management Division of Health Care Financing Wisconsin Department of Health and Family Services
608-266-6772
laphijo@dhfs.state.wi.us

BEM Response to 2nd LRB Draft of Statutes for BadgerCare Plus Provisions

January 26, 2007

The following remarks are comments and/or edits to the LRB draft dated 1/19/07. The headers refer to the page and line number of the draft document.

Chapter 20

All GPR and federal funding for BadgerCare Plus will be consolidated into Medical Assistance.

Page 1

Please revise 20.435(4)(b) to provide authority for payments for the BC+ program under 49.471.

Page 1, Line 3: Sections 2, 3, and 6 all contain changes to eliminate references to the BadgerCare program in the DHFS budget. Therefore, we do not have budget authority in place to operate the BadgerCare Plus program. Please amend sections 2, 3, and 6 to add "BadgerCare Plus" where "BadgerCare" has been deleted to provide authority to fund BC+ benefits as defined in 49.471.

Page 1, Line 2: Sections 1, 2, 3, 5, 6, 7, 8 & 9 all contain changes to eliminate references to the BadgerCare program in the DHFS budget. The concern is that should BadgerCare Plus (BC+) not be approved by the federal government, or should that approval later be revoked, we would not have budget authority in place to continue operating the regular BadgerCare program. Please amend these sections in a different manner to address this concern. (DHFS is now waiting for DOA agreement on this change).

Page 2, Line 21: Eliminate section 4. Move the language regarding the 10% to (4)(bm) on page 1, line 4.

Page 3, Line 4: Add BC+ to section 5 so the language should read "BadgerCare Plus and Medical Assistance."

Page 3, Line 16: Add BC+ to section 7 under 49.471.

Page 12, Line 15: Section 37 amends 49.45(18) to link co-payments for the BC+ standard plan to be the same as regular Medicaid, with the exception that BC+ recipients in a managed care plan will have to make co-payments for services. However, there are no provisions drafted in this section to allow for the treatment of co-payments by providers in the case of BC+ recipients covered by the benchmark plan. Likewise, exceptions for co-payments in this section appear to contradict the co-payment policies for the BC+ benchmark plan. While it is clear that co-payments under the BadgerCare Plus Benchmark Plan are not 'voluntary' in the sense that they are in the standard MA plan, we are not sure how to handle this in the statute. In essence providers may choose to refuse to provide a covered good or service if the copayment is not made. Regardless, under the fee-for-service plan and in calculating rates for the BadgerCare Plus Benchmark Plan, BEM will assume that the co-payment has been collected by the provider.

Page 16, Line 9: The definition of a "child" includes an unborn child. While there are instances in the BC+ section of the statute, where this definition may apply, we are concerned that there are many places in the statute where such a definition creates ambiguity as to whether it applies to both born and unborn children. The following citations within the draft statute are of particular

BEM Response to 2nd LRB Draft of Statutes for BadgerCare Plus Provisions
DRAFT
January 26, 2007

The following remarks are comments and/or edits to the LRB draft dated 1/19/07. The headers refer to the page and line number of the draft document.

Page 1, Line 2: Sections 1, 2, 3, 5, 6, 7, 8 & 9 all contain changes to eliminate references to the BadgerCare program in the DHFS budget. The concern is that should BadgerCare Plus (BC+) not be approved by the federal government, or should that approval later be revoked, we would not have budget authority in place to continue operating the regular BadgerCare program. Please amend these sections in a different manner to address this concern. WAITING FOR DOA AGREEMENT ON THIS REQUEST

Page 12, Line 15: Section 37 amends 49.45(18) to link co-payments for the BC+ standard plan to be the same as regular Medicaid, with the exception that BC+ recipients in a managed care plan will have to make co-payments for services. However, there are no provisions drafted in this section to allow for the treatment of co-payments by providers in the case of BC+ recipients covered by the benchmark plan. Likewise, exceptions for co-payments in this section appear to contradict the co-payment policies for the BC+ benchmark plan. While it is clear that co-payments under the BadgerCare Plus Benchmark Plan are not 'voluntary' in the sense that they are in the standard MA plan, we are not sure how to handle this in the statute. In essence providers may choose to refuse to provide a covered good or service if the copayment is not made. Regardless, under the fee-for-service plan and in calculating rates for the BadgerCare Plus Benchmark Plan, BEM will assume that the co-payment has been collected by the provider.

Page 16, Line 9: The definition of a "child" includes an unborn child. While there are instances in the BC+ section of the statute, where this definition may apply, we are concerned that there are many places in the statute where such a definition creates ambiguity as to whether it applies to both born and unborn children. The following citations within the draft statute are of particular concern. 49.471 (4) (a) 3., (b) 3., (c), (5) (b), (d), (e), (f), (6) (a), (c), (7) (b) 2.; (8) (d) 1.; (10) (d) 2. Either these sections need to be modified to clarify that they do not apply to unborn children or the definition should be changed.

Page 16, Line 12: LRB NOTE - We do not have a definition for or use the concept of a "BadgerCare Plus group." Should this be something like "is related to a member of a family (or individual?) receiving benefits under this section"? Alternatively, do you want to define "group"? The definition would apply only to this definition. Response: We do not need to define "group". Please use your suggested wording, "Is related to an individual receiving benefits under this section."

Page 16, Line 16: LRB NOTE - We do not have a definition for or use the concept of a "BadgerCare Plus group." See question on language above. Response: Same as above.

Page 17, Line 2: Please delete the second sentence in paragraph (e).

Page 17, Line 6: LRB NOTE - This definition does not include stepbrothers and sisters of an unborn child, and may not include half brothers and sisters, of an unborn child. Is that okay? Response: No. See comment above.

Page 18, Line 4: Please add to subd. 4. the following. "An unborn child's eligibility for coverage under (4) ?? shall not begin before the first day of the month in which the unborn child's mother provides the medical verification."

Page 19 Lines 1 – 14: We are concerned that paragraph (3) (a) is not clear about our intent. Some suggested changes follow. For (3) (a) 2., "Notwithstanding subd. 1., a person eligible for medical assistance under s. 49.46 (1) (a) 3. or 4. may not receive benefits under this section." For (3) (a) 3., "Notwithstanding subd. 1., an individual described in sub. (4) (a) or (b) or (5) who is eligible for medical assistance under s. 49.46 (1) (a) 5., 6m., 14., 14m., or 15. or (d) or 49.47 (4) (a) or (as) may receive medical assistance benefits under this section or under s. 49.46 or 49.47."

Page 20, Line 16: Please add to subd 1. the following: "Eligibility obtained under this subdivision continues 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 family income." already in — ok not to add here, too

Page 21, Line 13: LRB NOTE: Is it possible for an individual under this subdivision to lose eligibility sooner? Response: Yes. If they leave Wisconsin, fail to cooperate with child support, etc..

Page 21, Line 15: Please add another group under (a). These are children referred to in (7) (b) 2., who have met the spenddown which brings the family income down to 150% of the FPL in a 6-month period.

Page 21, Line 18: Please add to subd 1. the following: "Eligibility obtained under this subdivision continues 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 family income." already in — ok not to add here, too

Page 21, Line 20: Please change (b) 2. to read: "2. A child who is under one year of age, whose mother was, on the day the child was born, eligible for and receiving medical assistance under subd. 1. and who lives with his or her mother in this state."

Page 22, Line 8: Please add another group under (b). These are the pregnant women referred to in (7) (b) 1. who have met the spenddown which brings the family income down to 300% of the FPL in a 6-month period.

Page 22, Line 11: Please add another set of benefits under (4). Unborn children are only eligible for prenatal care benefits. We did not define "prenatal care" in BC and do not see a need to define it for BC+. We also need to distinguish that unborn children with family incomes not exceeding 200% of the FPL receive prenatal care benefits under the standard plan, while unborn children with incomes over 200% up to 300% receive prenatal care benefits under the benchmark plan. Finally, unborn children whose family meets the spenddown to 300% of the FPL under (7) (b) 1., qualify for prenatal care benefits under the benchmark plan.

Page 25 Line 3: Please change (g) 1. to read, "1. Except as provided in subd. 2., as a condition of eligibility for coverage under this section, an individual with income shall provide verification, as determined by the department, of that income."

Page 26, Line 23: Please add that unborn children who become eligible under (b) 1. do not get the 60-day postpartum extension that pregnant women get. (This is a special provision we have to follow because of federal regulations. The mothers of the unborn children are not eligible themselves for BC+ and therefore do not qualify for the 60-day extension.)

Page 26, Line 23: Please delete from (b)2. the following, "has the health insurance coverage specified in sub. (8) (b) 1. and". Eligibility for spenddowns applies to both insured and uninsured children.

Page 27, Line 2: Please add the word, "the" at the end of this line.

Page 27, Line 6: : LRB NOTE: I'm sure these provisions are still not correct. I'm not quite sure of what is meant by all pregnant women and all children in the household becoming eligible. Response: This section (b) does need more policy added. The spenddowns are determined as the difference between the family's monthly income and the income limits (300% and 150% of poverty) for each month during a six consecutive month period which are then added up to a 6-month spenddown amount. If a family's income in April is $2,000 and the limit is $1,800, then the family is $200 over the monthly limit. Assuming no changes in the income or the limits occurs during the next six months, the spenddown is $200/month times 6 months, or $1,200. The other policy we would like to have in the statute is that if the family incurs enough medical bills (that are not covered by insurance or other liable parties) within the 6-month spenddown period, from the date they meet the spenddown to the end of that period, all the qualifying children in the family become eligible for BC+ benefits under the standard plan, with no premiums. So if one child has a big hospital bill, it could result in all his siblings becoming BC+ eligible for up to six months. Similarly, if a family has more than one pregnant member, should they meet the 300% spenddown, then all the pregnant women get covered.

by rule or policy?

Page 28, Line 18: Please add to (c) that for an unborn child the provisions in (b) also apply, irregardless of income, to both the unborn child and the unborn child's mother. In other words, an unborn child or his or her mother, regardless of the family's income, may not have any health insurance coverage, including employer sponsored coverage where 80% of the premiums are paid by the employer. Nor may they have been covered in the last three calendar months unless they have good cause for losing the coverage. In addition, they may not have access to the employer sponsored insurance or have had access in the last 12 months without good cause, or have access to such insurance in the next three months. (These stringent conditions have to be applied because unborn children are covered under the separate State Children's Health Insurance Program.)

unborn child — access

Page 29, Line 4: Please add another group under (d) 1. These are the children in a family that meets a spenddown in (7) (b) 2. but this is only for the remainder of the spenddown period.

Page 29, Line 5: Please clarify 2. by making the following changes: "2. An individual under par. (b) 2. is not ineligible if any of the following good cause reasons applies to the individual's not accessing health insurance coverage under par. (b) 1."

Page 29, Line 14: LRB NOTE: I changed "coverage under BadgerCare" to "coverage under this section." Is that correct? Response: Yes.

Page 29, Line 15: Please change the word "coverage" to "access" on this line.

Page 30, Line 23: Please add after, "pregnant woman," "a child described in sub. (4) (a) 2. or (b) 2. or an individual described in sub. (4) (a) 5. These are individuals for whom insurance coverage is not a bar to eligibility, so there is no reason to require verification of insurance from the employers.

Page 31, Line 6: In par. (b), we are dropping the 10 days for recipients and applying the "30 calendar days" requirement for both recipients and applicants. Please modify this paragraph to accommodate this change.

Page 31, Line 16: Please add after the word "paragraph", "attributable to", and delete the word "in", and do the same on line 18. We want it to be clear that the $1,000 and the $15,000 amounts refer to the penalties incurred for a six month period from non- or late responses that occur in that 6-month period. DHFS also wants to add to (c) that employers must pay the penalties to DHFS 45 calendar days after failing to comply with the requirements in par. (b). In addition, we would like to have the same authority to issue Orders to Compel Payment, request lien judgments and request tax intercepts for delinquent employers as we have for Medicaid recoveries under 49.497 and 49.85.

Page 31, Line 18: Please add a provision that requires employers to pay the penalties to DHFS 45 calendar days after they

delete

Page 31, Line 20: Please add another subdivision to (c). We want to make it clear that employers who provide DHFS insurance coverage information, for their company as a whole, won't have to worry about being penalized for failing to respond to an inquiry for one employee's case. DHFS plans to set up a process for employers to provide us with the basic information about health insurance coverage that they offer to all their employees. We'll save that information in a data base and use that information to determine BC+ eligibility for an employee, instead of sending forms to the employer. So subd.4. should day something like: "The fines do not apply to employers who provide timely information once a year to the department in the format specified by the department, which is needed to determine whether the employer provides access to health insurance coverage as provided for under state law and Department policy."

Page 33, Line 1: Please add three more groups to (d) 2. who do not have to pay a premium. These are:

- The children in families that meet the spenddown under (7) (b) 2.
- Children (including unborn children) with incomes not exceeding 200% of poverty
- Pregnant women with incomes not exceeding 200% of poverty

Page 34, Line 1: Please add "pulmonary therapy" to the other therapies in (i).

Page 35, Line 21: Please add a change to s. 49.45 (3m) (a) 3. We want to make it clear that providers will be allowed to charge higher co-payments for BC+ recipients in the benchmark plan than are allowed under the federal regulations cited in 3.

Page 35 line 24: Sections 50, 51, 52 and 54 remove all reference in BadgerCare to the provision that allowed us to restrict new enrollments in the program if we were to face insufficient federal funding. The concern is that should BadgerCare Plus (BC+) not be approved by the federal government, or should that approval later be revoked, we would not have budget authority in place to restrict future BadgerCare enrollments. Please amend these sections in a

BC

different manner to address this concern. WAITING FOR DOA AGREEMENT ON THIS REQUEST

Page 39, Line 24: Please add a reference to BC+ to s. 302.386(1) of the statutes.

in the exclusion or in the main part ?

Kahler, Pam

From: Nelson, Kirstin B - DHFS
Sent: Friday, January 26, 2007 10:51 AM
To: James Johnston
Cc: Bove, Fredi-Ellen E - DHFS; Jones, James D - DHFS; LaPhilliph, John O - DHFS; Megna, Richard - DHFS; Michelle Pink; Kahler, Pam
Subject: BC+ stat language question

Importance: High

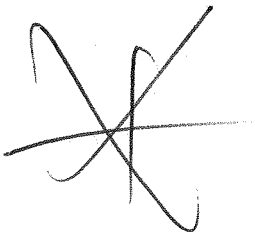
** High Priority **

Jim,

In the budget sections of the draft BC+ stat language, references to BadgerCare have been deleted. Our concern is that if the bill passes and then we don't get the federal waivers, we would not be able to revert back to current BC statutes. Would it be possible to retain the existing BC statutes in case we don't get the federal waivers?

Thanks.
Kirstin

Kirstin Nelson
Budget and Policy Analyst
Office of Strategic Finance
Department of Health and Family Services
(608) 266-5362
nelsokb@dhfs.state.wi.us



Kahler, Pam

From: LaPhilliph, John O - DHFS
Sent: Saturday, January 27, 2007 3:57 PM
To: Kahler, Pam
Subject: RE: BEM Response to 2nd LRB Draft of Statutes for BadgerCarePlusDRAFT.doc

Oops. That's a typo that I forgot to delete. The comment for line 16 covers everything we want. Sorry about that.

John LaPhilliph
Lead Health Care Eligibility Innovations Planner Bureau of Eligibility Management Division of Health Care Financing Wisconsin Department of Health and Family Services
608-266-6772
laphijo@dhfs.state.wi.us

>>> "Kahler, Pam" <Pam.Kahler@legis.wisconsin.gov> 01/26/07 4:50 PM >>>
John:

See comment on page 4 for page 31, line 18 of draft. The end of the sentence is cut off.

-----Original Message-----
From: LaPhilliph, John O - DHFS
Sent: Friday, January 26, 2007 2:52 PM
To: Kahler, Pam
Cc: Jones, James D - DHFS
Subject: BEM Response to 2nd LRB Draft of Statutes for BadgerCare PlusDRAFT.doc

Jim has said I may go ahead and send you this draft version of our comments to the statutes. He plans to send you an official version of our comments later this afternoon. I'll be around for questions. Given your time frames, feel free to call me on my cell phone at 577-1771 if you have any questions and you can't reach me at my desk. Thank you.

* * * * * * * * *
NOTICE: This email and any attachments may contain confidential information. Use and further disclosure of the information by the recipient must be consistent with applicable laws, regulations and agreements. If you received this email in error, please notify the sender; delete the email; and do not use, disclose or store the information it contains.
* * * * * * * * *

John LaPhilliph
Lead Health Care Eligibility Innovations Planner Bureau of Eligibility Management Division of Health Care Financing Wisconsin Department of Health and Family Services
608-266-6772
laphijo@dhfs.state.wi.us

Kahler, Pam

From: Jones, James D - DHFS

Sent: Saturday, January 27, 2007 10:16 AM

To: DiMiceli, Gregory M - DHFS; James Johnston; LaPhilliph, John O - DHFS; Matano, Alfred - DHFS; Nelson, Kirstin B - DHFS; Michelle Pink; Wong, Donna J - DHFS

Cc: Bove, Fredi-Ellen E - DHFS; Dombrowicki, Angela - DHFS; McIlquham, Cheryl J - DHFS; Megna, Richard - DHFS; Pam Kahler

Subject: Latest Comments on DRAFT BC+ Statutory Language for LRB

Attachments: BEM Response to 2nd LRB Draft of Statutes for BadgerCare Plus DRAFT.doc; James Jones.vcf

I have attached our latest comments on the draft BadgerCare Plus statutory language drafted by LRB. There are two outstanding issues that need to be addressed in our comments:

1. We have determined that the manner that the draft reads would eliminate DHFS' ability to run the current BadgerCare program, should the federal government either deny our waiver or state plan amendment requests or if, at some later time, the waiver was terminated by the state or the federal agency. Staff in OSF and BEM have worked to identify the changes necessary to alleviate this concern. We are now waiting for DOA's concurrence on this change. The comments on page one of the attached document from 'Chapter 20' to 'Page 3, Line 16' and on page five the comment that begins "Page 35, Line 24' are related to this issue.

2. The language we currently have for certain copayments and coinsurance for the Benchmark Plan does include any language, as the nominal copayments under the Standard Plan do, governing the effect of the recipient not paying these cost share amounts. A decision on what and how the new requirement needs to be made by COB on Monday, January 29, 2007. The comment on page one of the attached document that starts 'Page 12, Line 15' is related to this issue.

I am copying Pam Kahler at LRB with these comments, so that she can begin working on the changes to the draft since we are so short on time. If I recall this correctly, Pam told John L. that the concatenation of the budget statutory changes begins on Monday at noon.

James Jones, Director
Bureau of Eligibility Management
Division of Health Care Financing
Wisconsin Department of Health & Family Services
jonesjd@dhfs.state.wi.us

Kahler, Pam

From: Kahler, Pam
Sent: Thursday, January 25, 2007 4:57 PM
To: Jones, James D - DHFS
Subject: BC+ premiums

Jim:

I'm going over the draft and thought that it might be a good idea to include the other individuals who do not pay a premium in what is s. 49.471 (10) (d) 2. in the latest version. It appears that both a child whose income is at or below 200% of poverty and a pregnant woman whose income is at or below 200% of poverty do not pay premiums. Should I add these to the exceptions to paying premiums? I don't know about migrant workers. Thanks.

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