State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0905/P2
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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SECTION 1. 20.435 (4) (bc) of the statutes is repealed.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

SECTION 2. 20.435 (4) (bm) of the statutes is amended to read:

20.435 **(4)** (bm) *Medical Assistance, and food ~~stamps, and Badger Care~~ stamp program administration; contract costs, insurer reports, and resource centers.*

Biennially, the amounts in the schedule to provide the state share of administrative contract costs for the Medical Assistance program under s. 49.45, the food stamp program under s. 49.79, ~~and the Badger Care health care program under s. 49.665,~~ other than payments to counties and tribal governing bodies under s. 49.78 (8), to develop and implement a registry of recipient immunizations, to reimburse insurers for their costs under s. 49.475, for costs associated with outreach activities, and for services of resource centers under s. 46.283. No state positions may be funded in the department of health and family services from this appropriation, except positions for the performance of duties under a contract in effect before January 1, 1987, related to the administration of the Medical Assistance program between the subunit of the department primarily responsible for administering the Medical Assistance program and another subunit of the department. ~~Total administrative funding authorized for the program under s. 49.665 may not exceed 10% of the amounts budgeted under pars. (bc), (p), and (x).~~

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

SECTION 3. 20.435 (4) (bn) of the statutes is amended to read:

20.435 **(4)** (bn) *Income maintenance.* Biennially, the amounts in the schedule for funeral expenses under s. 49.785 and for payments under s. 49.78 (8) relating to the administration of the Medical Assistance program, ~~the Badger Care health care program under s. 49.665,~~ the food stamp program, and the cemetery, funeral, and burial expenses program under s. 49.785.

SECTION 4. 20.435 (4) (jw) of the statutes is created to read:

20.435 **(4)** (jw) *BadgerCare Plus administrative costs.* Biennially, the amounts in the schedule to provide a portion of the state share of administrative costs for the

BadgerCare Plus Medical Assistance program under s. 49.471. Ten percent of all moneys received from penalty assessments under s. 49.471 (9) (c) shall be credited to this appropriation account.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

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

20.435 **(4)** (jz) *~~Badger Care~~ Medical Assistance cost sharing and employer penalty assessments.* All moneys received in cost-sharing from ~~payments under s. 49.665 (5)~~ medical assistance recipients and 90 percent of all moneys received from penalty assessments under s. ~~49.665 (7) (b) 2.~~ 49.471 (9) (c) to be used for the ~~Badger Care health care~~ Medical Assistance program ~~under s. 49.665~~.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

SECTION 6. 20.435 (4) (nn) of the statutes is amended to read:

20.435 **(4)** (nn) *Federal aid; income maintenance.* All moneys received from the federal government for the costs of contracting for the administration of the Medical Assistance program under subch. IV of ch. 49 ~~and the Badger Care health care program under s. 49.665~~ and the food stamp program, other than moneys received under par. (pa), for payments under s. 49.78 (8).

SECTION 7. 20.435 (4) (o) of the statutes is amended to read:

20.435 **(4)** (o) *Federal aid; medical assistance.* All federal moneys received for meeting costs of ~~medical assistance~~ Medical Assistance administered under ss. 46.284 (5)~~,~~ and 49.45 ~~and 49.665~~, to be used for those purposes and for transfer to the ~~medical assistance~~ Medical Assistance trust fund, for those purposes.

SECTION 8. 20.435 (4) (p) of the statutes is repealed.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

SECTION 9. 20.435 (4) (x) of the statutes is repealed.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

SECTION 10. 46.206 (1) (bm) of the statutes is amended to read:

46.206 **(1)** (bm) All records of the department relating to aid provided under s. 49.46, 49.465, 49.468, 49.47, 49.471, or 49.77 are open to inspection at reasonable hours by members of the legislature who require the information contained in the records in pursuit of a specific state legislative purpose. All records of any county relating to aid provided under s. 49.46, 49.465, 49.468, 49.47, 49.471, or 49.77 are open to inspection at reasonable hours by members of the board of supervisors of the county or the governing body of a city, village or town located in the county who require the information contained in the records in pursuit of a specific county or municipal legislative purpose. The right to records access provided by this paragraph does not apply if access is prohibited by federal law or regulation or if this state is required to prohibit such access as a condition precedent to participation in a federal program in which this state participates.

SECTION 11. 46.22 (1) (b) 1. d. of the statutes is amended to read:

46.22 **(1)** (b) 1. d. To submit a final budget in accordance with s. 46.031 (1) for services authorized in this section, except for the administration of and cost of aid granted under ss. 49.02, 49.19 and 49.45 to ~~49.47~~ 49.471.

SECTION 12. 46.27 (6u) (c) 1. a. of the statutes is amended to read:

46.27 **(6u)** (c) 1. a. Eligible for medical assistance under s. 49.46, 49.468 ~~or~~, 49.47, or 49.471 (4) (a).

SECTION 13. 46.27 (6u) (d) (intro.) of the statutes is amended to read:

46.27 **(6u)** (d) (intro.) In determining financial eligibility under par. (c) 1. and in calculating the amount under par. (c) 2., the county department or aging unit shall include as the assets for any person, except those persons who are eligible for medical assistance under s. 49.46, 49.468 ~~or~~, 49.47, or 49.471 (4) (a), any portion of assets that the person or the person's spouse has, after August 12, 1993, transferred to another as specified in par. (b), unless one of the following conditions applies:

SECTION 14. 46.27 (7) (am) of the statutes is amended to read:

46.27 **(7)** (am) From the appropriation under s. 20.435 (7) (bd), the department shall allocate funds to each county or private nonprofit agency with which the department contracts to pay assessment and case plan costs under sub. (6) not otherwise paid by fee or under s. 49.45 or 49.78 (2). The department shall reimburse counties for the cost of assessing persons eligible for medical assistance under s. 49.46, 49.468, ~~or~~ 49.47, or 49.471 (4) (a) as part of the administrative services of medical assistance, payable under s. 49.45 (3) (a). Counties may use unspent funds allocated under this paragraph to pay the cost of long-term community support services and for a risk reserve under par. (fr).

SECTION 15. 46.27 (7) (b) of the statutes is amended to read:

46.27 **(7)** (b) From the appropriations under s. 20.435 (7) (bd) and (im), the department shall allocate funds to each county to pay the cost of providing long-term community support services under sub. (5) (b) not otherwise paid under s. 49.45 to persons eligible for medical assistance under s. 49.46 ~~or~~, 49.47, or 49.471 (4) (a) or to persons whom the county department or aging unit administering the program finds likely to become medically indigent within 6 months by spending excess income or assets for medical or remedial care. The average per person reimbursement under this paragraph may not exceed the state share of the average per person payment

rate the department expects under s. 49.45 (6m). The county department or aging unit administering the program may spend funds received under this paragraph only in accordance with the case plan and service contract created for each person receiving long-term community support services. Counties may use unspent funds allocated under this paragraph from the appropriation under s. 20.435 (7) (bd) for a risk reserve under par. (fr).

SECTION 16. 46.275 (1m) (a) of the statutes is amended to read:

46.275 **(1m)** (a) "Medical assistance" means aid provided under subch. IV of ch. 49, except ~~s.~~ ss. 49.468 and 49.471.

SECTION 17. 46.277 (1m) (a) of the statutes is amended to read:

46.277 **(1m)** (a) "Medical assistance" means aid provided under subch. IV of ch. 49, except ~~s.~~ ss. 49.468 and 49.471.

SECTION 18. 46.278 (1m) (b) of the statutes is amended to read:

46.278 **(1m)** (b) "Medical assistance" means aid provided under subch. IV of ch. 49, except ~~s.~~ ss. 49.468 and 49.471.

SECTION 19. 46.283 (3) (k) of the statutes is amended to read:

46.283 **(3)** (k) A determination of eligibility for state supplemental payments under s. 49.77, medical assistance under s. 49.46, 49.468 ~~or~~, 49.47, or 49.471, or the federal food stamp program under 7 USC 2011 to 2029.

SECTION 20. 46.485 (3g) of the statutes is amended to read:

46.485 **(3g)** The amount that the department may transfer under sub. (2g) for counties may not exceed the estimated state share of payments under s. 49.45, 49.46 ~~or~~, 49.47, or 49.471 for mental health care and treatment that is provided in inpatient facilities for children with severe emotional disturbances.

SECTION 21. 48.57 (3m) (e) of the statutes is amended to read:

48.57 **(3m)** (e) The department shall determine whether the child is eligible for medical assistance under ss. 49.43 to ~~49.47~~ 49.471.

SECTION 22. 48.57 (3n) (e) of the statutes is amended to read:

48.57 **(3n)** (e) The department shall determine whether the child is eligible for medical assistance under ss. 49.43 to ~~49.47~~ 49.471.

SECTION 23. 49.22 (2m) (a) of the statutes is amended to read:

49.22 **(2m)** (a) The department may request from any person in this state information it determines appropriate and necessary for the administration of this section, ss. 49.141 to 49.161, 49.19, 49.46, 49.468 ~~and~~, 49.47, and 49.471 and programs carrying out the purposes of 7 USC 2011 to 2029. Unless access to the information is prohibited or restricted by law, or unless the person has good cause, as determined by the department in accordance with federal law and regulations, for refusing to cooperate, the person shall make a good faith effort to provide this information within 7 days after receiving a request under this paragraph. Except as provided in subs. (2p) and (2r) and subject to sub. (12), the department or the county child support agency under s. 59.53 (5) may disclose information obtained under this paragraph only in the administration of this section, ss. 49.141 to 49.161, 49.19, 49.46 ~~and~~, 49.47, and 49.471 and programs carrying out the purposes of 7 USC 2011 to 2029. Employees of the department or a county child support agency under s. 59.53 (5) are subject to s. 49.83.

SECTION 24. 49.22 (2m) (b) of the statutes is amended to read:

49.22 **(2m)** (b) The department or county child support agency under s. 59.53 (5) may issue a subpoena, in substantially the form authorized under s. 885.02, to compel the production of financial information and other documentary evidence in

the administration of this section, ss. 49.145, 49.19, 49.46 ~~and~~, 49.47, and 49.471 and programs carrying out the purposes of 7 USC 2011 to 2029.

SECTION 25. 49.22 (2m) (c) 3. of the statutes is amended to read:

49.22 **(2m)** (c) 3. Any other action taken in good faith to comply with this section or a subpoena described in par. (bc) or to comply with a request for information or access to records from the department or a county child support agency under s. 59.53 (5) in the administration of this section, ss. 49.145, 49.19, 49.46 ~~and~~, 49.47, and 49.471 and programs carrying out the purposes of 7 USC 2011 to 2029.

SECTION 26. 49.45 (2) (a) 1. of the statutes is amended to read:

49.45 **(2)** (a) 1. Exercise responsibility relating to fiscal matters, the eligibility for benefits under standards set forth in ss. 49.46 to ~~49.47~~ 49.471, and general supervision of the medical assistance program.

SECTION 27. 49.45 (2) (a) 3. of the statutes is amended to read:

49.45 **(2)** (a) 3. Determine the eligibility of persons for medical assistance, rehabilitative, and social services under ss. 49.46, 49.468, ~~and~~ 49.47, and 49.471 and rules and policies adopted by the department and may, under a contract under s. 49.78 (2), delegate all, or any portion, of this function to the county department under s. 46.215, 46.22, or 46.23 or a tribal governing body.

SECTION 28. 49.45 (2) (b) 3. of the statutes is amended to read:

49.45 **(2)** (b) 3. Audit all claims filed by any contractor making the payment of benefits paid under ss. 49.46 to ~~49.47~~ 49.471 and make proper fiscal adjustments.

SECTION 29. 49.45 (3) (b) 1. of the statutes is amended to read:

49.45 **(3)** (b) 1. The contractor, if any, administering benefits or providing prepaid health care under s. 49.46, 49.465, 49.468 ~~or~~, 49.47, or 49.471 shall be entitled to payment from the department for benefits so paid or prepaid health care

so provided or made available when a certification of eligibility is properly on file with the contractor in addition to the payment of administrative expense incurred pursuant to the contract and as provided in sub. (2) (a) 4., but the contractor shall not be reimbursed for benefits erroneously paid where no certification is on file.

SECTION 30. 49.45 (3) (b) 2. of the statutes is amended to read:

49.45 **(3)** (b) 2. The contractor, if any, insuring benefits under s. 49.46, 49.465, 49.468 ~~or,~~ 49.47, or 49.471 shall be entitled to receive a premium, in an amount and on terms agreed, for such benefits for the persons eligible to receive them and for its services as insurer.

SECTION 31. 49.45 (3) (dm) of the statutes is amended to read:

49.45 **(3)** (dm) After distribution of computer software has been made under 1993 Wisconsin Act 16, section 9126 (13h), no payment may be made for home health care services provided to persons who are enrolled in the federal medicare program and are recipients of medical assistance under s. 49.46 ~~or,~~ 49.47, or 49.471 unless the provider of the services has in use the computer software to maximize payments under the federal medicare program under 42 USC 1395.

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SECTION 32. 49.45 (3) (L) 2. of the statutes is amended to read:

49.45 **(3)** (L) 2. The department may not pay a provider for a designated health service that is authorized under this section or s. 49.46 ~~or,~~ 49.47, or 49.471, that is provided as the result of a referral made to the provider by a physician and that, under 42 USC 1396b (s), if made on behalf of a beneficiary of medicare under the requirements of 42 USC 1395nn, as amended to August 10, 1993, would result in the denial of payment for the service under 42 USC 1395nn.

SECTION 33. 49.45 (6c) (d) 1. of the statutes is amended to read:

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49.45 **(6c)** (d) 1. No payment may be made under sub. (6m) to a facility or to an institution for mental diseases for the care of an individual who is otherwise eligible for medical assistance under s. 49.46 ~~or~~, 49.47, or 49.471, who has developmental disability or mental illness and for whom under par. (b) or (c) it is determined that he or she does not need facility care, unless it is determined that the individual requires active treatment for developmental disability or active treatment for mental illness and has continuously resided in a facility or institution for mental diseases for at least 30 months prior to the date of the determination. If that individual requires active treatment and has so continuously resided, he or she shall be offered the choice of receiving active treatment for developmental disability or active treatment for mental illness in the facility or institution for mental diseases or in an alternative setting. A facility resident who has developmental disability or mental illness, for whom under par. (c) it is determined that he or she does not need facility care and who has not continuously resided in a facility for at least 30 months prior to the date of the determination, may not continue to reside in the facility after December 31, 1993, and shall, if the department so determines, be relocated from the facility after March 31, 1990, and before December 31, 1993. The county department shall be responsible for securing alternative residence on behalf of an individual who is required to be relocated from a facility under this subdivision, and the facility shall cooperate with the county department in the relocation.

SECTION 34. 49.45 (6c) (d) 2. of the statutes is amended to read:

49.45 **(6c)** (d) 2. Payment may be made under sub. (6m) to a facility or institution for mental diseases for the care of an individual who is otherwise eligible for medical assistance under s. 49.46 ~~or~~, 49.47, or 49.471 and who has developmental disability or mental illness and is determined under par. (b) or (c) to need facility care,

regardless of whether it is determined under par. (b) or (c) that the individual does or does not require active treatment for developmental disability or active treatment for mental illness.

SECTION 35. 49.45 (8) (a) 4. of the statutes is amended to read:

49.45 **(8)** (a) 4. "Patient care visit" means a personal contact with a patient in a patient's home that is made by a registered nurse, licensed practical nurse, home health aide, physical therapist, occupational therapist, or speech-language pathologist who is on the staff of or under contract or arrangement with a home health agency, or by a registered nurse or licensed practical nurse practicing independently, to provide a service that is covered under s. 49.46 ~~or~~, 49.47, or 49.471. "Patient care visit" does not include time spent by a nurse, therapist, or home health aide on case management, care coordination, travel, record keeping, or supervision that is related to the patient care visit.

SECTION 36. 49.45 (9) of the statutes is amended to read:

49.45 **(9)** FREE CHOICE. Any person eligible for medical assistance under ~~ss.~~ s. 49.46, 49.468 ~~and~~, 49.47, or 49.471 may use the physician, chiropractor, dentist, pharmacist, hospital, skilled nursing home, health maintenance organization, limited service health organization, preferred provider plan or other licensed, registered or certified provider of health care of his or her choice, except that free choice of a provider may be limited by the department if the department's alternate arrangements are economical and the recipient has reasonable access to health care of adequate quality. The department may also require a recipient to designate, in any or all categories of health care providers, a primary health care provider of his or her choice. After such a designation is made, the recipient may not receive services from other health care providers in the same category as the primary health care provider

unless such service is rendered in an emergency or through written referral by the primary health care provider. Alternate designations by the recipient may be made in accordance with guidelines established by the department. Nothing in this subsection shall vitiate the legal responsibility of the physician, chiropractor, dentist, pharmacist, skilled nursing home, hospital, health maintenance organization, limited service health organization, preferred provider plan or other licensed, registered or certified provider of health care to patients. All contract and tort relationships with patients shall remain, notwithstanding a written referral under this section, as though dealings are direct between the physician, chiropractor, dentist, pharmacist, skilled nursing home, hospital, health maintenance organization, limited service health organization, preferred provider plan or other licensed, registered or certified provider of health care and the patient. No physician, chiropractor, pharmacist or dentist may be required to practice exclusively in the medical assistance program.

SECTION 37. 49.45 (18) (ac) of the statutes is amended to read:

49.45 **(18)** (ac) Except as provided in pars. (am) to (d), and subject to par. (ag), any person eligible for medical assistance under s. 49.46, 49.468, or 49.47, or for the benefits under s. 49.46 (2) (a) and (b) under s. 49.471 shall pay up to the maximum amounts allowable under 42 CFR 447.53 to 447.58 for purchases of services provided under s. 49.46 (2). The service provider shall collect the specified or allowable copayment, coinsurance, or deductible, unless the service provider determines that the cost of collecting the copayment, coinsurance, or deductible exceeds the amount to be collected. The department shall reduce payments to each provider by the amount of the specified or allowable copayment, coinsurance, or deductible. No provider may deny care or services because the recipient is unable to share costs, but

an inability to share costs specified in this subsection does not relieve the recipient of liability for these costs.

SECTION 38. 49.45 (18) (am) of the statutes is amended to read:

49.45 **(18)** (am) No person is liable under this subsection for services provided through prepayment contracts. This paragraph does not apply to a person who is eligible for the benefits under s. 49.46 (2) (a) and (b) under s. 49.471.

SECTION 39. 49.45 (24r) of the statutes is amended to read:

49.45 **(24r)** FAMILY PLANNING DEMONSTRATION PROJECT. The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide family planning services, as defined in s. 253.07 (1) (b), under ~~medical assistance~~ Medical Assistance to any woman between the ages of 15 and 44 whose family income does not exceed ~~185%~~ 200 percent of the poverty line for a family the size of the woman's family. If the waiver is granted and in effect, the department shall implement the waiver no later than July 1, 1998, or on the effective date of the waiver, whichever is later.

SECTION 40. 49.45 (29) of the statutes is amended to read:

49.45 **(29)** HOSPICE REIMBURSEMENT. The department shall promulgate rules limiting aggregate payments made to a hospice under ss. 49.46 ~~and~~, 49.47, and 49.471.

SECTION 41. 49.45 (35) of the statutes is repealed.

SECTION 42. 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 43. 49.468 (1) (b) of the statutes is amended to read:

49.468 **(1)** (b) For an elderly or disabled individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and who does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 ~~or~~, 49.47 (4), or 49.471 but meets the limitations on income and resources under par. (d), medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums payable under 42 USC 1395v; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w, other than payment of coinsurance for outpatient hospital services, may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

SECTION 44. 49.468 (1) (c) of the statutes is amended to read:

49.468 **(1)** (c) For an elderly or disabled individual who is only entitled to coverage under part A of medicare and who does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 ~~or~~, 49.47 (4), or 49.471 but meets the limitations on income and resources under par. (d), medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i which are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty for premiums under part A of medicare, if applicable.

SECTION 45. 49.468 (1m) (a) of the statutes is amended to read:

49.468 **(1m)** (a) Beginning on January 1, 1993, for an elderly or disabled individual who is entitled to coverage under part A of medicare and is entitled to coverage under part B of medicare, does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 ~~or,~~ 49.47 (4), or 49.471 but meets the limitations on income and resources under par. (b), medical assistance shall pay the monthly premiums under 42 USC 1395r.

SECTION 46. 49.468 (2) (a) of the statutes is amended to read:

49.468 **(2)** (a) Beginning on January 1, 1991, for a disabled working individual who is entitled under P.L. 101-239, section 6012 (a), to coverage under part A of medicare and who does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 ~~or,~~ 49.47 (4), or 49.471 but meets the limitations on income and resources under par. (b), medical assistance shall pay the monthly premiums for the coverage under part A of medicare, including late enrollment fees, if applicable.

SECTION 47. 49.471 of the statutes is created to read:

49.471 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) "Caretaker relative" means an individual who is maintaining a residence as a child's home, who exercises primary responsibility for the child's care and control, including making plans for the child, and who is any of the following with respect to the child:

1. A blood relative, including those of half-blood, and including first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.

2. A stepfather, stepmother, stepbrother, or stepsister.

3. An individual who is the adoptive parent of the child's parent, a natural or legally adopted child of such individual, or a relative of an adoptive parent.

4. A spouse of any individual named in this paragraph even if the marriage is terminated by death or divorce.

(c) "Child" means an individual who is under the age of 19 years. "Child" includes an unborn child.

(d) "Essential person" means an individual who satisfies all of the following:

1. Is related to a BadgerCare Plus group member.

****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.

2. Is otherwise nonfinancially eligible, except that the individual need not have a minor child under his or her care.

3. Provides at least one of the following to another member of the BadgerCare Plus group:

****NOTE: We do not have a definition for or use the concept of a "BadgerCare Plus group." See question on language above.

a. Child care that enables a caretaker to work outside the home for at least 30 hours per week for pay, to receive training for at least 30 hours per week, or to attend, on a full-time basis as defined by the school, high school or a course of study meeting the standards established by the state superintendent of public instruction for the granting of a declaration of equivalency of high school graduation under s. 115.29 (4).

b. Care for anyone who is incapacitated.

(e) "Family" means all children for whom assistance is requested, their minor siblings, including half brothers, half sisters, stepbrothers, and stepsisters, and any parents of these minors and their spouses. For an unborn child, a sibling is a child of the unborn child's mother.

****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?

(f) "Family income" means the total gross earned and unearned income received by all members of a family.

(g) "Group health plan" has the meaning given in 42 USC 300gg–91 (a) (1).

(h) "Health insurance coverage" has the meaning given in 42 USC 300gg–91 (b) (1), and also includes any arrangement under which a 3rd party agrees to pay for the health care costs of the individual.

(i) "Parent" has the meaning given in s. 49.141 (1) (j).

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

(k) "Unborn child" means an individual from conception until he or she is born alive for whom all of the following requirements are met:

1. The unborn child's mother is not eligible for medical assistance under this subchapter, except that she may be eligible for benefits under s. 49.45 (27).

2. The income of the unborn child's mother, mother and her spouse, or mother and her family, whichever is applicable, does not exceed 300 percent of the poverty line.

3. Each of the following applicable persons who is employed provides verification from his or her employer, in the manner specified by the department, of his or her earnings:

a. The unborn child's mother.

b. The spouse of the unborn child's mother.

c. Members of the unborn child's mother's family.

4. The unborn child's mother provides medical verification of her pregnancy, in the manner specified by the department.

5. The unborn child and the mother of the unborn child meet all other applicable eligibility requirements under this chapter or established by the department by rule except for any of the following:

a. The mother is not a U.S. citizen or an alien qualifying for Medicaid under 8 USC 1612.

b. The mother is an inmate of a public institution.

c. The mother does not provide a social security number, but only if subd. 5. a. applies.

(2) WAIVER. The department shall request a waiver from, and submit 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 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, 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 under sub. (2) that is consistent with all of the provisions of this section 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 BadgerCare health program benefits. The eligibility of an individual described in sub. (4) (a) or (b) or (5) for Medical Assistance benefits shall be determined under this section.

2. Subdivision 1. does not apply to an individual described in sub. (4) (a) or (b) or (5) who is eligible for medical assistance under s. 49.46 (1) (a) 3. or 4.

3. Notwithstanding subd. 1., the department shall determine whether 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) is eligible for medical assistance under this section or under s. 49.46 or 49.47.

(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) GENERAL 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, on the day the child was born, eligible for and receiving medical assistance under subd. 1. or 5. or s. 49.46 or 49.47, and who lives with his or her mother in this state.

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

4. An individual who satisfies all of the following criteria:

a. The individual is a parent or caretaker relative of a child who is living in the home with the parent or caretaker relative or who is temporarily absent from the home for not more than 6 months or, if the child has been removed from the home for

more than 6 months, the parent or caretaker relative is working toward unifying the family by complying with a permanency plan under s. 48.38.

b. Except as provided in subd. 4. c., the individual's family income does not exceed 200 percent of the poverty line and does not include self-employment income.

c. If the individual's family income includes self-employment income, the individual's family income does not exceed 200 percent of the poverty line as calculated under sub. (7) (a) 2.

5. An individual who, regardless of family income, was born on or after January 1, 1990, and who, on his or her 18th birthday, was in a foster care or treatment foster care placement under the responsibility of a state, as determined by the department. The coverage for an individual under this subdivision ends on the last day of the month in which the individual becomes 21 years of age, unless he or she otherwise loses eligibility sooner.

****NOTE: Is it possible for an individual under this subdivision to lose eligibility sooner?

6. Migrant workers and their dependents who are determined eligible under sub. (6) (f).

(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 whose family income exceeds 200 percent but does not exceed 300 percent of the poverty line.

4. An individual who satisfies all of the following criteria:

a. The individual is a parent or caretaker relative of a child who is living in the home with the parent or caretaker relative or who is temporarily absent from the home for not more than 6 months or, if the child has been removed from the home for more than 6 months, the parent or caretaker relative is working toward unifying the family by complying with a permanency plan under s. 48.38.

b. The individual's family income includes self-employment income and does not exceed 200 percent of the poverty line as calculated under sub. (7) (a) 3.

(c) Except as otherwise provided in this section, a child 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 coverage.

(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 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) at the time of the determination.

(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, including a pregnant woman under sub (5) (b) 1., child, including a child under sub. (5) (b) 2., parent, or caretaker relative 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 and had a family income of less than 150 percent of the poverty line in that month.

(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).

(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) 1. Except as provided in subd. 2., as a condition of eligibility for coverage under this section, an individual with earned income that does not appear in a computer data match used by the department shall provide verification, as determined by the department, of that earned income.

2. Subdivision 1. does not apply to an individual under sub. (4) (a) 5. or a child under the age of 18.

(h) Within 10 days after the change occurs, a recipient shall report to the department any change that might affect his or her eligibility or any change that might require premium payment by a recipient who was not required to pay premiums before the change.

(i) 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.

(j) 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) 1. In the calculation of family income, if an adult member of the family has self-employment income, the department shall count the net self-employment earnings. Net self-employment earnings shall be determined by subtracting from gross self-employment income all self-employment expenses that are allowed under federal and state tax law, except for depreciation.

2. If a parent's or caretaker relative's family income includes self-employment income and, without deducting depreciation, does not exceed 200 percent of the poverty line, the parent or caretaker relative is eligible under sub. (4) (a) 4.

3. If a parent's or caretaker relative's family income includes self-employment income and, without deducting depreciation, exceeds 200 percent of the poverty line, the parent or caretaker relative is eligible under sub. (4) (b) 4. if his or her family income does not exceed 200 percent of the poverty line after depreciation is deducted.

(b) 1. A pregnant woman, or an unborn child, whose family income exceeds 300 percent of the poverty line may become eligible for coverage under this section if the difference between the pregnant woman's or unborn child's family income and the applicable income limit under sub. (4) (b) is obligated or expended for any member of the pregnant woman's or unborn child's family for medical care or any other type of remedial care recognized under state law or for personal health insurance premiums or for both. 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.

2. A child who has the health insurance coverage specified in sub. (8) (b) 1. and whose family income exceeds 150 percent of the poverty line may obtain eligibility

under this section if the difference between the child's family income and 150 percent of the poverty line is obligated or expended on behalf of the child or any member of child's family for medical care or any other type of remedial care recognized under state law or for personal health insurance premiums or for both. Eligibility obtained under this subdivision during any 6-month period, as determined by the department, continues for the remainder of the 6-month period.

****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.

(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 or maintenance.

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 BadgerCare Plus 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 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. The individual could be covered under the health insurance coverage specified in subd. 1. if the coverage is applied for, and the coverage could become available to the individual in the month in which the individual applies for benefits under this section or in any of the next 3 calendar months.

(c) An unborn child, regardless of family income, is not eligible for BadgerCare Plus if the unborn child or the unborn child's mother has individual or family health insurance coverage.

(d) 1. None of the following is ineligible for BadgerCare Plus by reason of having health insurance coverage or access to health insurance coverage:

a. A pregnant woman.

b. A child described in sub. (4) (a) 2. or (b) 2.

c. A child who has health insurance coverage, or access to health insurance coverage, as a dependent of an absent parent but who resides outside of the service area of the absent parent's plan.

d. An individual described in sub. (4) (a) 5.

2. An individual under par. (b) 2. is not ineligible if any of the following good cause reasons applies to the individual's access to the health insurance coverage under par. (b) 1.:

a. The individual's employment ended.

b. The individual's employer discontinued health insurance coverage for all employees.

c. One or more members of the individual's family were eligible for other health insurance coverage or Medical Assistance at the time the employee failed to enroll in the health insurance coverage under par. (b) 1. and no member of the family was eligible for coverage under this section at that time.

****NOTE: I changed "coverage under BadgerCare" to "coverage under this section." Is that correct?

d. The individual's health insurance coverage has ended due to the death or change in marital status of the subscriber.

e. Any other reason that the department determines is a good cause reason.

(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. but no longer has the coverage, or if a pregnant woman specified in par. (e) 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 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 on an immediate family member's health condition.

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

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

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

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 in the format specified 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, and for each of the individual's family members with coverage under BadgerCare Plus, for each month in which the individual and the individual's family members are 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 accounts under s. 20.435 (4) (jw) and (jz).

(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.

(10) COST SHARING. (a) Except as provided in s. 49.45 (18) (am), 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) Except as provided in par. (d) 2., 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., the premium may not exceed 5 percent of family income calculated before depreciation was deducted.

(c) Except as provided in par. (e), a recipient who is an unborn child, or a pregnant woman eligible under sub. (4) (b) 1., 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 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.

2. None of the following shall pay a premium:

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.

b. A child who is eligible under sub. (4) (a) 2. or (b) 2.

Except as provided in par. (e), pars. (d) and (e) move this par. after next par.

3. An individual who is eligible under sub. (4) (a) 5.

4. 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, and subject to the Badger Rx Gold program discounts.

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

(c) Inpatient hospital services as medically necessary, ~~with a copayment of $100~~ per inpatient stay 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 use of emergency room services for treatment of a condition that is not an emergency medical condition, as defined in s. 632.85 (1) (a), shall require a copayment of no more than $75.

(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.

remove comma here

(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.~~ insert 33-23

(j) Cardiac rehabilitation, limited to 36 visits per year, ~~with a copayment of no more than $15 per visit.~~ insert 33-23

(k) Inpatient, 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).

keep

(L) Durable medical equipment, limited to $2,500 per year, ~~with a copayment of no more than $5 per unit of equipment.~~ insert 34-10

(m) Transportation to obtain emergency medical care only, as medically necessary, ~~with a copayment of no more than $50.~~ insert 33-23

(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) RULES; NOTICE OF EFFECTIVE DATE. (a) 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 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.

(b) If the amendments to the state plan submitted under sub. (2) are 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.

SECTION 48. 49.473 (2) (a) of the statutes is amended to read:

49.473 **(2)** (a) The woman is not eligible for medical assistance under ss. 49.46 (1) and (1m), 49.465, 49.468, 49.47, 49.471, and 49.472, and is not eligible for health care coverage under s. 49.665.

SECTION 49. 49.49 (3m) (a) (intro.) of the statutes is amended to read:

49.49 **(3m)** (a) (intro.) No provider may knowingly impose upon a recipient charges in addition to payments received for services under ss. 49.45 to ~~49.47~~ 49.471 or knowingly impose direct charges upon a recipient in lieu of obtaining payment under ss. 49.45 to ~~49.47~~ 49.471 except under the following conditions:

insert 35-21

SECTION 50. 49.665 (4) (a) 1. of the statutes is amended to read:

49.665 **(4)** (a) 1. The family's income does not exceed 185% of the poverty line, except ~~as provided in par. (at) and except~~ that a family that is already receiving health care coverage under this section may have an income that does not exceed

200% of the poverty line. The department shall establish by rule the criteria to be used to determine income.

SECTION 51. 49.665 (4) (am) 1. of the statutes is amended to read:

49.665 **(4)** (am) 1. The child's income does not exceed 185% of the poverty line, except ~~as provided in par. (at) and except~~ that a child that is already receiving health care coverage under this section may have an income that does not exceed 200% of the poverty line. The department shall use the criteria established under par. (a) 1. to determine income under this subdivision.

SECTION 52. 49.665 (4) (ap) 1. of the statutes is amended to read:

49.665 **(4)** (ap) 1. The income of the unborn child's mother, mother and her spouse, or mother and her family, whichever is applicable, does not exceed 185 percent of the poverty line, except ~~as provided in par. (at) and except~~ that, if an unborn child is already receiving health care coverage under this section, the applicable specified person or persons may have an income that does not exceed 200 percent of the poverty line. The department shall establish by rule the criteria to be used to determine income.

SECTION 53. 49.665 (4) (ap) 2. of the statutes is repealed.

SECTION 54. 49.665 (4) (at) of the statutes is repealed.

SECTION 55. 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 56. 49.688 (5) (a) (intro.) of the statutes is amended to read:

49.688 **(5)** (a) (intro.) Beginning on September 1, 2002, except as provided in sub. (7) (b), as a condition of participation by a pharmacy or pharmacist in the program under s. 49.45, 49.46, ~~or~~ 49.47, or 49.471, the pharmacy or pharmacist may not charge a person who presents a valid prescription order and a card indicating that he or she meets eligibility requirements under sub. (2) an amount for a prescription drug under the order that exceeds the following:

SECTION 57. 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 58. 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. 49.471 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.

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

SECTION 59. 49.81 (4) of the statutes is amended to read:

49.81 **(4)** The right to a speedy determination of the recipient's status or eligibility for public assistance, to notice of any proposed change in such status or eligibility, and, in the case of assistance granted under s. 49.19, 49.46, 49.468 ~~or~~, 49.47, or 49.471, to a speedy appeals process for resolving contested determinations.

SECTION 60. 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.

SECTION 61. 49.89 (7) (b) of the statutes is amended to read:

49.89 **(7)** (b) The incentive payment shall be an amount equal to 15% of the amount recovered because of benefits paid under s. 49.46, 49.465, 49.468 ~~or~~, 49.47, or 49.471. The incentive payment shall be taken from the federal share of the sum recovered as provided under 42 CFR 433.153 and 433.154.

SECTION 62. 59.53 (5) (a) of the statutes is amended to read:

59.53 **(5)** (a) The board shall contract with the department of workforce development to implement and administer the child and spousal support and establishment of paternity and the medical support liability programs provided for by Title IV of the federal social security act. The board may designate by board resolution any office, officer, board, department or agency, except the clerk of circuit

Insert 38-19 ✓

court, as the county child support agency. The board or county child support agency shall implement and administer the programs in accordance with the contract with the department of workforce development. The attorneys responsible for support enforcement under sub. (6) (a), circuit court commissioners and all other county officials shall cooperate with the county and the department of workforce development as necessary to provide the services required under the programs. The county shall charge the fee established by the department of workforce development under s. 49.22 for services provided under this paragraph to persons not receiving benefits under s. 49.148 or 49.155 or assistance under s. 46.261, 49.19 ~~or,~~ 49.46, 49.465, 49.47, 49.471, or 49.472.

SECTION 63. 66.0137 (3) of the statutes is amended to read:

66.0137 **(3)** HEALTH INSURANCE FOR UNEMPLOYED PERSONS. Any city, village, town, or county may purchase health or dental insurance for unemployed persons residing in the city, village, town, or county who are not eligible for medical assistance under s. 49.46, 49.468 ~~or,~~ 49.47, or 49.471 (4) (a) or (b).

SECTION 64. 302.38 (3) of the statutes is amended to read:

302.38 **(3)** The maximum amount that a governmental unit may pay for the costs of medical or hospital care under this section is limited for that care to the amount payable by medical assistance under subch. IV of ch. 49, ~~except s.~~ excluding ss. 49.468 and 49.471 (11), for care for which a medical assistance rate exists. No provider of medical or hospital care may bill a prisoner under sub. (1) for the cost of care exceeding the amount paid under this subsection by the governmental unit. If no medical assistance rate exists for the care provided, there is no limitation under this subsection.

SECTION 65. 632.746 (7m) (b) 1. of the statutes is amended to read:

insert 39-15 ✓

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632.746 **(7m)** (b) 1. The employee or dependent is eligible for benefits under the Medical Assistance program under s. 49.471 or 49.472 or for coverage under the Badger Care health care program under s. 49.665.

SECTION 66. 814.61 (13) of the statutes is amended to read:

814.61 **(13)** SUPPORT OR MAINTENANCE PETITION. For the cost of court services, whenever a person not receiving benefits under s. 49.148 or 49.155 or aid under s. 49.19, 49.46, 49.465, 49.468 ~~or~~, 49.47, or 49.471 files a petition requesting child support, maintenance or family support payments, $10 in addition to any other fee required under this section. This subsection does not apply to a petition filed by the state or its delegate.

SECTION 67. 885.01 (5) of the statutes is amended to read:

885.01 **(5)** By the department of workforce development or a county child support agency under s. 59.53 (5) in the administration of ss. 49.145, 49.19, 49.22, 49.46 ~~and~~, 49.47, and 49.471 and programs carrying out the purposes of 7 USC 2011 to 2029.

SECTION 9421. Effective dates; Health and Family Services.

(1) BADGERCARE PLUS. The treatment of sections 20.435 (4) (bc), (bm), (bn), (jw), (jz), (nn), (o), (p), and (x), 46.206 (1) (bm), 46.22 (1) (b) 1. d., 46.27 (6u) (c) 1. a. and (d) (intro.) and (7) (am) and (b), 46.275 (1m) (a), 46.277 (1m) (a), 46.278 (1m) (b), 46.283 (3) (k), 46.485 (3g), 48.57 (3m) (e) and (3n) (e), 49.22 (2m) (a), (b), and (c) 3., 49.45 (2) (a) 1. and 3. and (b) 3., (3) (b) 1. and 2., (dm), and (L) 2., (6c) (d) 1. and 2., (8) (a) 4., (9), (18) (ac) and (am), (29), and (35), 49.468 (1) (b) and (c), (1m) (a), and (2) (a), 49.473 (2) (a), 49.49 (3m) (a) (intro.), 49.665 (4) (a) 1., (am) 1., (ap) 1. and 2., and (at) and (7) (a) 1., 49.688 (5) (a) (intro.), 49.785 (1) (intro.) and (1c), 49.81 (4), 49.82 (2), 49.89 (7) (b), 59.53 (5) (a), 66.0137 (3), 302.38 (3), 632.746 (7m) (b) 1., 814.61 (13),

and 885.01 (5) of the statutes takes effect on the date stated in the Wisconsin Administrative Register by the department of health and family services under section 49.471 (12) (b) of the statutes, as created by this act, as the implementation date for BadgerCare Plus.

(END)

INSERT ANAL

Under current law, DHFS administers the Medical Assistance (MA) program and the Badger Care health care program, both of which provide health care benefits for eligible individuals. Individuals who may be eligible for MA, generally, are pregnant women, certain children, and elderly or disabled individuals, all of whom must meet specific low-income requirements. Families, children who do not reside with their parents, and unborn children whose mothers are not eligible for MA or BadgerCare may be eligible for BadgerCare if their incomes do not exceed 185 percent of the federal poverty line and they meet certain nonfinancial criteria, such as not having access to employer-subsidized health care coverage.

Waiver to implement BadgerCare Plus

Under this bill, DHFS must request a waiver from, and submit amendments to the state MA plan to, the secretary of the federal department of health and human services to allow DHFS to implement an MA health care program called BadgerCare Plus (BC+). BC+ would be financed as are other MA programs, partly with federal funds and partly with state funds. BC+ would replace all of BadgerCare and part of MA. Thus, individuals who satisfy eligibility criteria under both BC+ and BadgerCare would receive benefits under BC+. Individuals who satisfy eligibility criteria under both BC+ and MA would receive benefits under either BC+ or MA, depending on the basis for their eligibility for MA. For example, an individual who is eligible for MA because he or she receives supplemental security income would continue to receive benefits as usual under MA rather than under BC+.

Benefits and general eligibility

BC+ would provide health care benefits to recipients under two different plans, depending on the basis for the recipient's eligibility. The first plan provides the same benefits that are provided under regular MA. Individuals eligible for BC+ benefits under that plan (regular MA plan) include: a pregnant woman whose family income does not exceed 200 percent of the poverty level (poverty); a child under one year of age whose mother, on the day the child was born, was eligible for and receiving benefits under MA or BC+ under the regular MA plan; any child whose family income does not exceed 200 percent of poverty; an individual whose family income does not exceed 200 percent of poverty and who is the parent or caretaker relative of a child who is, generally, living in the home of the parent or caretaker relative; certain migrant workers and their dependents; and an individual between 19 and 21 years of age who was in foster care on his or her 18th birthday.

The second plan, called the Benchmark Plan, provides specified benefits, including, but not limited to, coverage for prescription drugs; physician's services; inpatient and outpatient hospital services; home health services; physical, occupational, and speech therapy; treatment for nervous and mental disorders and alcoholism and other drug abuse problems; durable medical equipment; and transportation to obtain emergency medical care. Individuals eligible for BC+ benefits under the Benchmark Plan include: a pregnant woman whose family income exceeds 200 percent, but does not exceed 300 percent, of poverty; a child under one year of age whose mother, on the day the child was born, was eligible for

and receiving BC+ benefits under the Benchmark Plan; any child whose family income exceeds 200 percent, but does not exceed 300 percent, of poverty; and an individual whose family income exceeds 200 percent, but does not exceed 300 percent, of poverty and who is the parent or caretaker relative of a child who is, generally, living in the home of the parent or caretaker relative. In addition, any child whose family income exceeds 300 percent of poverty may purchase coverage under the Benchmark Plan at the full per member per month cost of the coverage.

For coverage under both the regular MA plan and the Benchmark Plan, a child is defined to include an unborn child whose mother is not eligible for MA or BC+ but satisfies all other eligibility criteria except that she is not a U.S. citizen or qualifying alien or is an inmate of a public institution. If the mother's family income does not exceed 200 percent of poverty, the unborn child is eligible for BC+ benefits under the regular MA plan; if the mother's family income exceeds 200 percent, but does not exceed 300 percent, of poverty, the unborn child is eligible for BC+ benefits under the Benchmark Plan.

Various other eligibility provisions apply under BC+. For example, regardless of any increase in income, a pregnant woman who is eligible for regular MA benefits remains eligible for those benefits until the last day of the month in which the 60th day after the last day of the pregnancy falls. A child who is receiving inpatient services under the regular MA plan on the day before his or her 19th birthday remains eligible for those services until the end of the stay for which the services are being provided. A pregnant woman, a child, or a parent or caretaker relative whose family income is less than 150 percent of poverty is eligible for benefits for any of the three months before they applied for coverage if they were otherwise eligible and their family income was less than 150 percent of poverty.

Health insurance-related provisions

Various health insurance qualifications and limitations apply under BC+. As a condition of eligibility for BC+, an individual who is eligible for enrollment in a group health plan must apply for enrollment in that plan if DHFS determines that it is cost-effective. With exceptions for pregnant women, individuals in foster care on their 18th birthday, and certain children, no individual whose family income exceeds 150 percent of poverty is eligible for BC+ if they have health care coverage under the state employee health plan or coverage that is provided by an employer and for which the employer pays at least 80 percent of the premium or, unless there is a good cause reason for not enrolling in the coverage, if they had access to one of those types of coverages in the 12 months before applying for BC+. Regardless of family income, however, an unborn child is not eligible for BC+ if the unborn child or its mother has health insurance coverage. A pregnant woman whose family income exceeds 200 percent of poverty and who has health insurance coverage must maintain that coverage as a condition of eligibility for BC+. If an individual whose family income exceeds 150 percent of poverty had coverage under the state employee health plan or employer-provided coverage but no longer has the coverage, or if a pregnant woman whose family income exceeds 200 percent of poverty did not maintain coverage that she had, the individual or pregnant woman is not eligible for

BC+ for three calendar months following the month in which the coverage ended, unless there was a good cause reason for the termination of the coverage.

Under the bill, for an individual whose family income exceeds 150 percent of poverty, DHFS must verify directly with the employer, if any, whether the individual has or had insurance coverage or access. An employer that receives a request from DHFS for that information must supply the information within a certain time or pay a penalty equal to the full per member per month cost of coverage under BC+ for each month the individual is covered under BC+ until the employer provides the information. Penalties are limited to no more than $1,000 in any 6-month period for an employer with fewer than 250 employees, and to no more than $15,000 in any 6-month period for other employers.

Cost sharing

Generally, the same copayment requirements that apply under MA apply to BC+ recipients with benefits under the regular MA plan. BC+ recipients with benefits under the Benchmark Plan are subject to the copayment and coinsurance requirements specified in the bill for that plan. A BC+ recipient who is an adult and who is not a pregnant woman must pay a premium for BC+ coverage if their family income is at least 150 percent of poverty. The premium may not exceed five percent of their family income. A BC+ recipient who is a child must pay a premium for BC+ coverage if their family income is at least 200 percent of poverty. The premium may not exceed the full per member per month cost of coverage for a child with a family income equal to 300 percent of poverty. A BC+ recipient who is an unborn child or a pregnant woman must pay a premium if their family income exceeds 200 percent of poverty. The premium may not exceed the full per member per month cost of coverage for an adult with a family income equal to 300 percent of poverty. If a recipient who is required to pay a premium does not pay it when it is due, the recipient's coverage terminates and they may not be eligible for BC+ again for six months.

(END OF INSERT ANAL)

INSERT 4-1

SECTION 1. 45.51 (13) (intro.) of the statutes is amended to read:

45.51 **(13)** ADDITIONAL ELIGIBILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES. (intro.) 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, if applicable, s. 49.471 and rules promulgated under those sections during residence at the skilled nursing facility except if any of the following apply:

History: 2005 a. 22, 25.

SECTION 2. 45.51 (13) (a) of the statutes is amended to read:

45.51 **(13)** (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, if applicable, s. 49.471 and rules promulgated under those sections.

History: 2005 a. 22, 25.

SECTION 3. 45.51 (13) (b) of the statutes is amended to read:

45.51 **(13)** (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, if applicable, 49.471 and rules promulgated under those sections.

History: 2005 a. 22, 25.

(END OF INSERT 4-1)

INSERT 8-8

SECTION 4. 49.22 (6) of the statutes is amended to read:

Ins. 8-8 cont'd

49.22 **(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, or 49.471; 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.

History: 1975 c. 82; 1977 c. 26, 29, 203, 418; 1979 c. 196, 221; 1981 c. 20, 93; 1983 a. 27; 1985 a. 29 ss. 861m to 866, 2390 to 2399; 1987 a. 27; 1987 a. 332 s. 64; 1987 a. 399, 403, 413; 1989 a. 31; 1991 a. 39; 1993 a. 16, 481; 1995 a. 27 ss. 2128m to 2134, 9126 (19), 9130 (4); 1995 a. 77, 187, 201, 225, 289; 1995 a. 404 ss. 39 to 43, 45, 46, 48, 173, 174; Stats. 1995 s. 49.22; 1997 a. 27, 105, 191, 237; 1999 a. 32; 2001 a. 16; 2003 a. 33; 2005 a. 25.

(END OF INSERT 8-8)

INSERT 8-21

SECTION 5. 49.45 (2) (b) 7. (intro.) of the statutes is amended to read:

49.45 **(2)** (b) 7. (intro.) 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), or 49.471 (11), 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), or 49.471 (11) 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

Ins 8-21

pursue those recoveries. The department shall promulgate rules to implement this subdivision that specify all of the following:

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

(END OF INSERT 8-21)

INSERT 9-16

SECTION 6. 49.45 (3) (f) 2. of the statutes is amended to read:

49.45 **(3)** (f) 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) or 49.471 (11). In cases of mathematical inaccuracies in computations or statements of claims, the measure of recovery will be limited to the amount of the error.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

(END OF INSERT 9-16)

INSERT 9-23

SECTION 7. 49.45 (3) (m) of the statutes is amended to read:

49.45 **(3)** (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

ins 9-23

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 specialized medical vehicle under s. 49.46 (2) (b) 3. or 49.471 (11) (m) 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.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

(END OF INSERT 9-23)

INSERT 13-6

SECTION 8. 49.45 (24g) of the statutes is repealed.

(END OF INSERT 13-6)

INSERT 13-21 10 of 3

SECTION 9. 49.45 (42) (intro.) of the statutes is amended to read:

lns 13-21 2of3

49.45 **(42)** PERSONAL CARE SERVICES. (intro.) 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:

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

SECTION 10. 49.45 (42m) (a) of the statutes is amended to read:

49.45 **(42m)** (a) If, in authorizing the provision of physical or occupational therapy services under s. 49.46 (2) (b) 6. b. or 49.471 (11) (i), 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.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

SECTION 11. 49.45 (48) of the statutes is amended to read:

49.45 **(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., and 49.471 (6) (j) 1.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

SECTION 12. 49.45 (49m) (c) 1. of the statutes is amended to read:

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49.45 **(49m)** (c) 1. A list of the prescription drugs that are included as a benefit under ~~s.~~ ss. 49.46 (2) (b) 6. h. and 49.471 (11) (a) that identifies preferred choices within therapeutic classes and includes prescription drugs that bear only generic names.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

SECTION 13. 49.45 (53) of the statutes is amended to read:

49.45 **(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.~~ ss. 49.46 (2) (a) 4. d. and (b) 6. j. and m. and 49.471 (11) (f).

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293; 1999 a. 9, 63, 103, 180, 185; 2001 a. 13, 16, 35, 38, 57, 67, 104, 109; 2003 a. 33, 318, 321; 2005 a. 22; 2005 a. 25 ss. 1120 to 1149f, 2503 to 2510; 2005 a. 107, 165, 253, 254, 264, 301, 340, 386, 441.

(END OF INSERT 13-21)

INSERT 33-15

NO of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided NO

(END OF INSERT 33-15)

INSERT 33-17

NO subject to coinsurance payment of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided NO

(END OF INSERT 33-17)

INSERT 33-23

, and subject to coinsurance payment of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided

(END OF INSERT 33-23)

INSERT 34-10

and subject to coinsurance payment of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the articles provided

(END OF INSERT 34-10)

INSERT 35-21

SECTION 14. 49.49 (3m) (a) 1. of the statutes is amended to read:

49.49 **(3m)** (a) 1. Benefits or services are not provided under s. 49.46 (2) or 49.471 (11) and the recipient is advised of this fact prior to receiving the service.

History: 1977 c. 418; 1979 c. 89; 1981 c. 317; 1985 a. 29 s. 3202 (23); 1985 a. 269; 1989 a. 23, 31; 1995 a. 27; 1997 a. 283; 2001 a. 109; 2003 a. 309.

SECTION 15. 49.49 (3m) (a) 2. of the statutes is amended to read:

49.49 **(3m)** (a) 2. If an applicant is determined to be eligible retroactively under s. 49.46 (1) (b) or 49.471 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 or 49.471.

History: 1977 c. 418; 1979 c. 89; 1981 c. 317; 1985 a. 29 s. 3202 (23); 1985 a. 269; 1989 a. 23, 31; 1995 a. 27; 1997 a. 283; 2001 a. 109; 2003 a. 309.

SECTION 16. 49.49 (3m) (a) 3. of the statutes is amended to read:

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49.49 **(3m)** (a) 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, or required under s. 49.471 (11).

History: 1977 c. 418; 1979 c. 89; 1981 c. 317; 1985 a. 29 s. 3202 (23); 1985 a. 269; 1989 a. 23, 31; 1995 a. 27; 1997 a. 283; 2001 a. 109; 2003 a. 309.

(END OF INSERT 35-21)

INSERT 38-19

SECTION 17. 51.038 of the statutes is amended to read:

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. or 49.471 (11) (k), a community aids funding recipient under s. 51.423 (2) or as mandated coverage under s. 632.89.

History: 1987 a. 27; 1997 a. 237.

SECTION 18. 51.04 of the statutes is amended to read:

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 49.471 (11) (k) 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.

History: 1975 c. 224; Stats. 1975 s. 51.44; 1975 c. 430 s. 53m; Stats. 1975 s. 51.04; 1983 a. 27; 1985 a. 29, 176; 1995 a. 27; 1997 a. 237.

(END OF INSERT 38-19)

INSERT 39-15

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SECTION 19. 227.01 (13) (um) of the statutes is amended to read:

227.01 **(13)** (um) Lists over-the-counter drugs covered by ~~medical assistance~~ Medical Assistance under s. 49.46 (2) (b) 6. i. or 49.471 (11) (a).

History: 1985 a. 182; 1987 a. 27, 119, 395, 399, 403; 1989 a. 31, 56, 335, 341; 1991 a. 39, 254, 269, 309, 315; 1993 a. 16, 123, 237, 349, 364, 419, 442, 481, 491; 1995 a. 27, 215, 227, 289, 363; 1997 a. 27, 35, 231, 237; 1999 a. 9, 70; 1999 a. 150 s. 672; 1999 a. 167; 2001 a. 38, 109; 2003 a. 33 ss. 2364, 2813; 2005 a. 217, 418.

SECTION 20. 253.10 (3) (d) 1. of the statutes is amended to read:

253.10 **(3)** (d) 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 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) and 49.471, 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

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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.

History: 1985 a. 56, 176; 1991 a. 263; 1993 a. 27 s. 378; Stats. 1993 s. 253.10; 1995 a. 309; 1997 a. 27; 1999 a. 9; 2005 a. 155, 277, 387.

(END OF INSERT 39-15)

INSERT 39-24

SECTION 21. 449.17 (8) of the statutes is amended to read:

449.17 **(8)** REIMBURSEMENT PROHIBITED. No optometrist may be reimbursed under s. 49.46 (2) (a) 3. or 49.471 (11) for any increase in charges or separate charge which is attributable to the use of topical ocular diagnostic pharmaceutical agents.

History: 1977 c. 280; 1979 c. 162; 1981 c. 15; 1983 a. 273, 524; 1989 a. 31; 1991 a. 39; 2005 a. 297.

(END OF INSERT 39-24)