HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under current law, DHFS provides financial assistance for the cost of medical care to persons with chronic kidney disease, cystic fibrosis, and hemophilia; this assistance is collectively referred to as the Chronic Disease Program. DHFS also provides payments to pharmacies and pharmacists for providing prescriptions to elderly persons at reduced rates; this program is referred to as Senior Care.

This bill requires health insurers, self-insured plans, service benefits plans, and pharmacy benefits managers (third parties) to provide to DHFS information from their records to enable DHFS to identify persons receiving benefits under the Chronic Disease Program and Senior Care who are eligible, or would be eligible as dependents, for health care coverage from a third party. These third parties may receive compensation for providing the information, must provide the information within certain deadlines, and may be subject to enforcement proceedings for noncompliance. The third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under the Chronic Disease Program or Senior Care has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must

respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

MEDICAL ASSISTANCE

Currently, DHFS may obtain from insurers information DHFS needs to identify a recipient of Medical Assistance (MA) who is eligible for benefits under a disability insurance policy or, if enrolled as the dependent of a beneficiary, would be eligible for benefits; claims submittal information; and types of benefits provided under the policy. DHFS must enter into an agreement with the insurer that identifies the information to be disclosed, safeguards confidentiality, and specifies how the insurer's reasonable costs will be determined and paid from state general purpose revenues and federal moneys. Insurers must provide the information within specified deadlines, and the commissioner of insurance may initiate enforcement proceedings for noncompliance.

This bill expands the sources from which DHFS may receive health care services coverage information about MA recipients to include entities that are responsible for payment of a claim for a health care item or service and makes available compensation for providing the information. The sources, termed "third parties," include, in addition to insurers, self-insured plans, service benefits plans, and pharmacy benefits managers. The bill authorizes DHFS to notify the attorney general of third parties, other than insurers, that fail to provide information requested.

Under the bill, third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under MA, or under a program administered under MA under a federal waiver, has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the

health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

Lastly, the bill applies the information recovery, acceptance of assignment, recovery of third-party payment, and compensation provisions of current law and as affected by this bill so as to enable DHFS also to identify Badger Care health care program recipients who are eligible, or who would be eligible as dependents, for health care coverage from a third party.

HEALTH

Currently, DHFS administers the Well-Woman Program, under which certain medical services related to breast cancer, cervical cancer, and multiple sclerosis and certain general medical services are provided to underinsured and uninsured women of low income.

This bill requires health insurers, self-insured plans, service benefits plans, and pharmacy benefits managers (third parties) to provide to DHFS information from their records to enable DHFS to identify persons receiving benefits under the Well-Woman Program who are eligible, or would be eligible as dependents, for health care coverage from a third party. These third parties may receive compensation for providing the information, must provide the information within certain deadlines,

and may be subject to enforcement proceedings for noncompliance. The third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under the Well-Woman Program has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

OTHER HEALTH AND FAMILY SERVICES

Currently, DHFS administers Family Care, a program that provides a flexible benefit of long-term care and services to certain persons who are at least 18 years of age, meet functional and financial eligibility requirements, and have a physical or developmental disability or degenerative brain disorder.

This bill requires health insurers, self-insured plans, service benefits plans, and pharmacy benefits managers (third parties) to provide to DHFS information

from their records to enable DHFS to identify persons receiving benefits under Family Care who are eligible, or would be eligible as dependents, for health care coverage from a third party. These third parties may receive compensation for providing the information, must provide the information within certain deadlines, and may be subject to enforcement proceedings for noncompliance. The third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under Family Care has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

Under current law, DHFS may request from health insurers information to enable DHFS to identify Medical Assistance recipients who are eligible, or who would be eligible as dependents, for health insurance coverage. An insurer that receives a request must provide the information within a certain period of time. Under the bill, DHFS must provide any information that it receives from a health insurer, self-insured plan, service benefit plan, and pharmacy benefits manager to DWD for purposes of DWD's program related to child and spousal support, paternity

establishment, and medical support liability. DWD may allow county and tribal child support agencies access to the information, subject to use and disclosure restrictions under current law, and must consult with DHFS regarding procedures to safeguard the confidentiality of the information.

***** ANALYSIS FROM -0267/5 *****

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under current law, DWD allocates specific amounts of moneys in each fiscal year, including federal Child Care Development Funds (CCDF) and federal moneys received under the federal Temporary Assistance for Needy Families (TANF) block grant program, for various public assistance programs and for child care-related purposes, including transferring moneys to DHFS for its day care licensing operations. This bill increases and decreases those allocations. The bill also expands the purpose of the allocation for the program that provides services in Milwaukee County to ensure the safety of children remaining at home to cover providing services in Milwaukee County to families with children placed in out-of-home care.

***** ANALYSIS FROM -1313/3 *****

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under current law, DHFS administers the provision of benefits under the federal food stamp program and contracts with DWD for DWD to administer an employment and training program for food stamp program recipients. Under this bill, administration of the employment and training program for food stamp

recipients is transferred to DHFS. DHFS may contract with county departments of social services and human services and with tribal governing bodies to administer the program. Under current law, DWD may subcontract with Wisconsin Works agencies to handle the actual program administration. Under the bill, DHFS may contract, and county departments and tribal governing bodies may subcontract, with Wisconsin Works agencies or other providers to administer the program.

Under current law, an individual is ineligible for food stamps in any month in which the individual is not in compliance with various child support enforcement requirements, such as by refusing to cooperate with efforts to establish paternity with respect to a child or being delinquent in the payment of child support. This bill removes noncompliance with the child support enforcement requirements as a basis for ineligibility for food stamps.

***** ANALYSIS FROM -0486/1 *****

HEALTH AND HUMAN SERVICES

WISCONSIN WORKS

The Wisconsin Works (W-2) program under current law provides work experience and benefits for low-income custodial parents who are at least 18 years old; job search assistance to noncustodial parents who are required to pay child support, to minor custodial parents, and to pregnant women who are not custodial

parents; and child care subsidies for certain parents who need child care services to participate in various educational or work activities. W-2, which is funded with federal Temporary Assistance for Needy Families (TANF) block grant moneys, federal child care block grant moneys, and state general purpose revenue (GPR), is administered by DWD, which in turn contracts with W-2 agencies to administer W-2 on the local level.

The work components under W-2, called employment positions, consist of three categories: 1) trial jobs, under which an individual receives at least minimum wage from an employer and the W-2 agency pays a wage subsidy of up to $300 per month to the employer; 2) community service jobs, under which an individual works in a project that serves a useful public purpose or that will generate revenue to wholly or partially offset the project's cost and receives a monthly grant of up to $673 from the W-2 agency; and 3) transitional placements, under which an individual participates in work activities in a community rehabilitation program, a job similar to a community service job, or volunteer activities and receives a monthly grant of up to $628 from the W-2 agency. A participant in an employment position must search for unsubsidized employment the entire time that he or she is participating

in the W-2 employment position. Also under current law, DWD is directed to continue the creation and implementation of a subsidized work program.

This bill eliminates the directive to DWD to continue the creation and implementation of a subsidized work program and requires DWD to conduct and evaluate, from January 1, 2008, to December 31, 2009, a real work, real pay pilot project. The pilot project is limited to 500 participants, who must satisfy the eligibility requirements for W-2, and must be conducted in at least one of the geographical areas of the state established for administering the W-2 program that is located in Milwaukee County and in at least two of those geographical areas that are not in Milwaukee County. An individual may participate in the pilot project for up to six months, with a possible three-month extension. Under the project, a W-2 agency pays a wage subsidy, which may not exceed the federal minimum wage for no more than 30 hours of work per week, to an employer that employs a project participant. The employer is also reimbursed for up to 100 percent of federal social security taxes, state and federal unemployment contributions, and worker's compensation insurance premiums paid on behalf of a participant. The W-2 agency and the employer of a participant must work together to find a mentor for the participant at the work site. A mentor receives a monthly stipend of $50 from the

W-2 agency. An employer that employs a participant and receives a wage subsidy must agree to make a good faith effort to retain the participant as an unsubsidized employee after the wage subsidy ends if the participant successfully completes participation in the pilot project. If the employer does not retain the participant, the employer must serve as an employment reference for the participant or provide a written performance evaluation of the participant, including recommendations for improvement.

***** ANALYSIS FROM -0484/3 *****

HEALTH AND HUMAN SERVICES

WISCONSIN WORKS

Under current law, a person who meets the eligibility requirements for the Wisconsin Works (W-2) program and who is the custodial parent of a child who is 12 weeks old or less may receive a monthly grant of $673 and may not be required to work in a W-2 employment position. Current law also provides generally that receiving a monthly grant as the custodial parent of an infant counts toward the time limits that apply to how long an individual may receive certain benefits only if the child was born more than ten months after the date on which the individual was first determined to be eligible for W-2.

This bill changes the eligibility requirement by increasing the maximum age of the child so that the custodial parent of a child who is 26 weeks old or less may receive the monthly grant and may not be required to work in a W-2 employment position. The bill also provides that receiving a monthly grant as the custodial parent of an infant counts toward the time limits that apply to how long an individual may receive certain benefits regardless of when the child was born in relation to when the individual was first determined to be eligible for W-2. In addition, the bill provides that an unmarried woman who would be eligible for W-2 except that she is not a custodial parent may also receive a monthly grant of $673 and may not be required to work in a W-2 employment position if she is in the third trimester of a medically verified pregnancy that is at risk and that renders the woman unable to participate in the workforce. Her receipt of a grant does not count toward the time limits for how long an individual may receive certain benefits.

***** ANALYSIS FROM -1538/2 *****

HEALTH AND HUMAN SERVICES

WISCONSIN WORKS

The Wisconsin Works (W-2) program under current law provides work experience and benefits for low-income custodial parents who are at least 18 years old. Also, an individual who is the parent of a child under the age of 13 or, if the child

is disabled, under the age of 19, is eligible for a child care subsidy under the W-2 program if the individual needs child care services to participate in various educational or work activities and satisfies other eligibility criteria. One of those criteria is that the individual's family income may not exceed 185 percent of the poverty line. If an individual is already receiving a child care subsidy, however, their family income may be as high as 200 percent of the poverty line before they lose eligibility. This bill changes those maximum family income levels to 175 percent of poverty for an individual who is first applying for a child care subsidy and to 190 percent of poverty for an individual who is already receiving a subsidy. These new maximum family income levels only apply to individuals who first apply for a child care subsidy, or who, after losing eligibility, reapply for a child care subsidy, on or after the effective date of the act.

***** ANALYSIS FROM -0905/3 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program and the Badger Care health care program (BadgerCare), 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 on which 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; physicians' 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 on which 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, limited to prenatal care, 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, limited to prenatal care, 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 he or she applied for coverage if he or she was otherwise eligible and his or her 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 the individual has 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. Regardless of family income, however, an unborn child is not eligible for BC+ if the unborn child or its mother has any type of health insurance coverage. Unless there is a good cause reason for not enrolling in the coverage, if an individual whose family income exceeds 150 percent of poverty or an unborn child or its mother had access in the 12 months before applying for BC+ to 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, the individual or unborn child is not eligible for BC+. 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, if an unborn child or its mother had health insurance 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, unborn child, 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, with certain exceptions, 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 six-month period for an employer with fewer than 250 employees, and to no more than $15,000 in any six-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 the recipient's

family income is at least 150 percent of poverty. The premium may not exceed 5 percent of the recipient's family income. A BC+ recipient who is a child must pay a premium for BC+ coverage if the recipient's 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 the recipient's 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 the recipient may not be eligible for BC+ again for six months.

***** ANALYSIS FROM -0892/11 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current federal and state law, Medical Assistance (MA) is a jointly funded, federal-state program that DHFS administers to provide health care services to eligible individuals with very low incomes and few assets; the state share of MA is paid from a combination of general purpose revenues, program revenues from hospital assessments, and segregated funds under the MA trust fund. Under

a waiver of federal Medicaid laws from the federal Department of Health and Human Services, DHFS also administers under MA the Badger Care Health Care Program (BadgerCare). BadgerCare provides health care coverage to certain low-income families and to certain low-income children who do not reside with a parent. This bill establishes a trust fund designated as the health care quality fund, from moneys obtained from an increase in cigarette and other tobacco products taxes and from certain other sources. Under the bill, moneys from the health care quality fund are used as another source of funding for MA and for BadgerCare.

Under current law, DHFS annually assesses hospitals a total of $1,500,000, in proportion to each hospital's respective gross private-pay patient revenues during the hospital's most recent fiscal year. Moneys from the assessments are credited to a program revenue appropriation account, from which is paid a portion of MA program benefits, certain long-term care pilot projects under the Long-term Support Community Options Program (COP), and services under the Family Care Program. The bill eliminates the current hospital assessment and, instead, authorizes DHFS to levy, enforce, and collect an annual assessment on hospitals, based on claims information collected by an entity from hospitals under the laws relating to health care information. Under the bill, the assessments are due before

December 1 and are based on a rate not to exceed 1 percent of a hospital's gross revenues, as adjusted by DHFS, although DHFS may consider the hospital's MA reimbursement. The assessments must be deposited into the health care quality fund, as created in the bill, and are first due before December 1, 2007.

***** ANALYSIS FROM -0266/3 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, which provides federal and state moneys to pay for health care and long-term care services, including care in a nursing home, provided to MA recipients, who are, generally, low-income, elderly, or disabled persons who meet other specific eligibility requirements. To be eligible for MA for long-term care services, an individual must meet certain very low income and resource requirements, and may have to "spend down" his or her income and resources by paying for his or her own long-term care until the eligibility requirements are met.

Current law provides rules, based on federal law, concerning divestment, which refers to the transferring of one's assets for less than fair market value for the purpose of reducing one's income and resources to become eligible for MA for long-term care services. If a person divests assets on or after the person's look-back

date (generally, the date that is three years before the person applies for MA for long-term care services), the person may be ineligible for MA for a specific time period (penalty period). The federal Deficit Reduction Act, which became effective on February 8, 2006, made a number of changes in the divestment rules. To conform Wisconsin law to the federal law, this bill makes a number of changes with respect to divestment, including, among other things:

1. Changes the look-back date to five years for transfers that occur on or after February 8, 2006.

2. Changes the beginning date for the penalty period from the date on which assets were transferred to the later of the date on which assets were transferred or the date on which the person applies and is eligible for MA for long-term care services.

3. Provides that the purchase of a loan, promissory note, mortgage, or life estate after February 8, 2006, is a divestment and specifies the requirements for when such a purchase is not to be considered a divestment.

4. Provides that as a condition of receiving MA for long-term care services an applicant (when applying) or recipient (when being recertified) must disclose any interest he or she or his or her spouse has in an annuity that was purchased on or

after February 8, 2006, or with respect to which a transaction occurred on or after February 8, 2006. A transaction is defined as any action that changes the course of payments to be made or the treatment of income or principal.

5. Specifies the conditions under which the purchase of an annuity on or after February 8, 2006, is not to be considered a divestment, including designating DHFS as a remainder beneficiary under the annuity in the first position.

6. Requires DHFS to establish a hardship waiver process, with certain criteria, under which the divestment rules would not apply to a person because it would result in undue hardship for the person and allows DHFS to pay the full nursing facility payment rate for up to 30 days to hold a bed in the facility for a person involved in a pending undue hardship determination.

7. Provides, generally, that a person is ineligible for MA for long-term care services if the equity in their home exceeds $750,000 unless their spouse or minor or disabled child is living in the home. Under current law, a person's home, regardless of the value, is not counted when the person's income and resources for MA eligibility are determined.

***** ANALYSIS FROM -1521/6 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program and the Badger Care (BadgerCare) health care program, under which eligible individuals or families receive health care benefits. Under MA, eligible individuals generally include low-income elderly or disabled individuals, low-income children, and low-income pregnant women. Under BadgerCare, low-income families, low-income children who do not live with a parent, and unborn children of certain low-income women are eligible. This bill requires DHFS to request a waiver from the secretary of the federal department of health and human services to conduct a demonstration project under which DHFS would provide health care coverage of primary and preventive care for adults under the age of 65 who have family incomes not to exceed 200 percent of the poverty level, who are not otherwise eligible for MA, BadgerCare, or Medicare, and who did not have coverage under the Health Insurance Risk-Sharing Plan within six months before applying.

Also under current law, DHFS provides relief block grant moneys to Milwaukee County for providing assistance in the form of health care services to persons who meet certain criteria for dependency. Under this bill, the amount that DHFS would otherwise provide in relief block grant moneys would be offset by amounts paid for

individuals in Milwaukee County under the demonstration project to provide health care coverage for eligible adults.

***** ANALYSIS FROM -0248/3 *****

MEDICAL ASSISTANCE

Currently, DHFS may obtain from insurers information DHFS needs to identify a recipient of Medical Assistance (MA) who is eligible for benefits under a disability insurance policy or, if enrolled as the dependent of a beneficiary, would be eligible for benefits; claims submittal information; and types of benefits provided under the policy. DHFS must enter into an agreement with the insurer that identifies the information to be disclosed, safeguards confidentiality, and specifies how the insurer's reasonable costs will be determined and paid from state general purpose revenues and federal moneys. Insurers must provide the information within specified deadlines, and the commissioner of insurance may initiate enforcement proceedings for noncompliance.

This bill expands the sources from which DHFS may receive health care services coverage information about MA recipients to include entities that are responsible for payment of a claim for a health care item or service and makes available compensation for providing the information. The sources, termed "third parties," include, in addition to insurers, self-insured plans, service benefits plans,

and pharmacy benefits managers. The bill authorizes DHFS to notify the attorney general of third parties, other than insurers, that fail to provide information requested.

Under the bill, third parties must accept assignment to DHFS of a right of an individual to receive payment from the third party for a health care item or service for which payment under MA, or under a program administered under MA under a federal waiver, has been made. Third parties must also accept the right of DHFS to recover any third-party payment made for which assignment had not been accepted. A third party must respond to an inquiry by DHFS concerning a claim for payment of a health care item or service if the inquiry is made within 36 months after the item or service is provided. Further, third parties must agree not to deny a DHFS claim on the basis of certain circumstances, if submitted less than 36 months after the health care item or service is provided and if action by DHFS to enforce its rights is commenced less than 72 months after DHFS submits the claim.

Lastly, the bill applies the information recovery, acceptance of assignment, recovery of third-party payment, and compensation provisions of current law and as affected by this bill so as to enable DHFS also to identify Badger Care health care

program recipients who are eligible, or who would be eligible as dependents, for health care coverage from a third party.

***** ANALYSIS FROM -0647/3 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, reimbursements to nursing homes for care provided to Medical Assistance (MA) recipients are determined under a system that considers, among other things, direct care costs, as adjusted by DHFS for regional labor cost variations. For this purpose, DHFS treats the counties of Dane, Iowa, Columbia, and Sauk as a single labor region. This bill adds Rock County to this labor region.

Currently, under the MA waiver community integration program for persons relocated from, or meeting requirements of, nursing homes (commonly known as CIP II), DHFS provides enhanced MA reimbursement to up to 150 persons who are diverted from imminent entry into nursing homes. Approval of enhanced reimbursement for more than 150 persons must, however, be made by JCF under a passive review process. This bill eliminates approval by JCF of enhanced CIP II reimbursement for persons in excess of 150 persons and, instead, requires approval for this enhanced reimbursement from the secretary of administration.

OTHER HEALTH AND HUMAN SERVICES

Under current law, the maximum number of licensed nursing home beds statewide is 51,795. A nursing home may transfer a licensed bed to another nursing home only under certain conditions, including if the transferring and receiving nursing homes are within the same bed allocation area, as determined by DHFS, or if the receiving nursing home is located in a county that adjoins the bed allocation area of the transferring nursing home.

This bill reduces the statewide licensed nursing home bed cap to 42,000 beds and changes the limitation on transferring a licensed bed from one nursing home to another to require that the receiving nursing home be in the same bed allocation area or in an adjoining area.

*** ANALYSIS FROM -0263/4 ***
HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, under which eligible individuals, generally low-income, elderly, or disabled, receive health care benefits. Some individuals who are eligible for MA are also eligible for Medicare Part D, which is the portion of the federal health insurance program for individuals who are, generally, 65 years of age or older or disabled that provides prescription drug coverage. Enrollment in Medicare Part D is voluntary. Not all Part

D plans in which individuals may enroll cover all of the prescription drugs that may be covered under Medicare Part D.

This bill provides that, for an individual who is eligible for both MA and Medicare Part D, benefits under MA do not include payment for any prescription drug for which there may be coverage under Medicare Part D, regardless of whether the individual is enrolled in Medicare Part D and, if he or she is enrolled, regardless of whether the individual's Part D plan covers the drug. Thus, to have coverage for a prescription drug for which Medicare Part D may provide coverage, an individual who is eligible for both MA and Medicare Part D must enroll in Medicare Part D in a Part D plan that covers the drug; MA will not cover it.

***** ANALYSIS FROM -0268/2 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, under which eligible individuals, generally low-income or disabled, receive health care benefits. Some individuals who are eligible for MA are also eligible for Medicare, which is a federal health insurance program for individuals who are, generally, 65 years of age or older or disabled. Medicare Part A covers hospital and related services, and coverage is automatic. Medicare Part B covers outpatient, nursing, and

physician services and various other health care services, such as diagnostic tests. Enrollment in Medicare Part B is voluntary, and an enrollee must pay a premium. Current law does not require an individual who is eligible for both MA and Medicare to enroll in Medicare Part B, and DHFS reimburses providers under MA for services that would be covered under Medicare Part B if the individual were enrolled in Medicare Part B.

This bill provides that DHFS may require an individual who is eligible for Medicare and for MA services under a number of eligibility categories to enroll in Medicare Part B as a condition of receiving those MA services. The bill also provides that, if DHFS requires an individual to enroll in Medicare Part B, DHFS must pay the monthly premiums for the coverage under Medicare Part B. Because MA does not pay for benefits to which an individual is entitled under another benefit program, MA would no longer pay for any benefits that are covered under Medicare Part B after the individual enrolls in Medicare Part B.

***** ANALYSIS FROM -0250/2 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current law, DHFS administers the Medical Assistance (MA) program, which provides federal and state moneys to pay providers for health care provided

to MA recipients. MA recipients are persons with very low income and resources who apply for MA benefits and meet certain eligibility requirements. One category of MA recipients is termed "categorically needy"; these persons have incomes and resources at the eligible levels and can be determined to be retroactively eligible for MA for a certain period of months. Currently, if an MA applicant is found to be retroactively eligible as a "categorically needy" recipient and a provider has billed the recipient directly for services provided during the retroactive period, the provider, upon notice that the applicant is retroactively eligible, must submit claims for MA payment to DHFS. When paid by DHFS, the provider must reimburse the MA recipient for payment the MA recipient or another person made to the provider for services provided to the recipient during the retroactively eligible period. Regardless of the amount the provider has charged the MA recipient, no provider may be required to reimburse the recipient more than the amount that the provider is paid for the services by MA.

This bill eliminates the provision that prohibits requiring a health care provider to reimburse for services paid for by an MA "categorically needy" recipient in an amount that is greater than the provider is paid for the services under the MA program. Instead, the bill requires that the health care provider reimburse the MA

recipient or another person in the amount that the recipient or other person has paid the provider for the recipient's care. The bill also extends this repayment requirement to persons who are determined to be retroactively eligible for MA as "medically needy" recipients (persons with higher incomes than are usually allowed who incur medical expenses that, if paid, bring their incomes within applicable limits).

***** ANALYSIS FROM -1333/1 *****

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Currently, family planning is provided as a benefit to recipients of Medical Assistance (MA). In addition, DHFS is required to request, and has received, a waiver of federal Medicaid laws to conduct a demonstration project to provide family planning services under MA to women between the ages of 15 and 44 with family incomes of not more than 185 percent of the federal poverty level.

This bill requires DHFS to request an amended waiver from the federal Department of Health and Human Services to provide, under the current demonstration project, family planning under MA to men, as well as women, between the ages of 15 and 44 and to increase the financial eligibility limitation under the demonstration project to 200 percent of the federal poverty level.

*** ANALYSIS FROM -1261/4 ***

HEALTH AND HUMAN SERVICES

CHILDREN

Under current law, DHFS provides or oversees county provision of various services to children and families. Those services include services for children in need of protection or services and their families; adoption services for children whose parents' parental rights have been terminated; licensing of child welfare agencies, foster homes, group homes, day care centers, and shelter care facilities; conducting background investigations of caregivers of children; investigating cases of suspected child abuse or neglect; providing a state supplemental food program for women, infants, and children; and distributing funding for children's community programs, child abuse and neglect prevention programs, services for children and families, food distribution programs, domestic abuse services, tribal adolescent services, community action programs to assist poor persons, and a brighter futures initiative to prevent delinquent behavior, alcohol and other other abuse, child abuse and neglect, and nonmarital pregnancy. This bill creates the Department of Children and Families (DCF) and transfers from DHFS to DCF the duty to provide or oversee the provision of those services. The bill also renames DHFS as the Department of Health Services.

Under current law, DWD administers the Wisconsin Works program, which provides work experience and benefits for low-income custodial parents; job search assistance to noncustodial parents who are required to pay child support, to minor custodial parents, and to pregnant women who are not custodial parents; and child care subsidies for eligible parents who need child care services to participate in various educational or work activities. DWD also administers the program for child and spousal support establishment and enforcement and paternity and medical support liability establishment. This bill transfers from DWD to DCF, created in the bill, the responsibility for administering those programs.

***** ANALYSIS FROM -1270/3 *****

HEALTH AND HUMAN SERVICES

CHILDREN

Under current law, DHFS administers a child abuse and neglect prevention program under which DHFS awards grants to counties and Indian tribes that offer voluntary home visitation services to first-time parents who are eligible for Medical Assistance. Current law requires DHFS to determine the amount of a grant awarded to a county or an Indian tribe in excess of the statutory minimum grant amount of $10,000 based on the number of births that are funded by Medical Assistance in that county or the reservation of that Indian tribe in proportion to the number of those

births in all of the counties and the reservations of all of the Indian tribes to which grants are awarded. Currently, no more than six rural counties, three urban counties, and two Indian tribes may be selected to participate in the program.

This bill requires the Department of Children and Families (DCF) to determine the amount of a grant in excess of the statutory minimum based simply on the number of births that are funded by Medical Assistance in a county or a reservation of an Indian tribe without regard to the number of those births in other counties and reservations. The bill also eliminates the caps on the number of counties and Indian tribes that may be selected to participate in the program.

In addition, the bill directs DCF to award grants to applying county departments of human services or social services (county departments), local health departments, Indian tribes, private nonprofit agencies, and local partnerships consisting of two or more county departments, local health departments, Indian tribes, and private nonprofit agencies (organizations) for the provision to all first-time parents in the community served by the organization of one-time, voluntary home visits. The purposes of the home visits are to provide those parents with basic information about infant health and nutrition, the care, safety, and development of infants, and emergency services for infants and with information

about shaken baby syndrome and impacted babies; to identify the needs of those parents; and to provide those parents with referrals to programs, services, and other resources that may meet those needs. Under this bill, any information concerning an individual who is offered a home visit or provided with a referral is confidential, unless disclosure of the information is required or permitted under the child abuse and neglect reporting law, the use or disclosure of the information is connected to the administration of the program, or the individual consents to the use or disclosure of the information.

***** ANALYSIS FROM -0841/5 *****

HEALTH AND HUMAN SERVICES

CHILDREN

Recently, the U.S. Congress enacted the Adam Walsh Child Protection and Safety Act of 2006 (P.L. 109-248) (Adam Walsh Act), which amends Title IV-E of the federal Social Security Act to require the states to provide procedures for criminal records checks, including fingerprint-based checks of national crime information databases, of prospective foster or adoptive parents before those parents may be finally approved for placement of a child, regardless of whether foster care maintenance or adoption assistance payments are to be made. Prior federal law required criminal records checks, but not fingerprint-based checks, of those

prospective parents and required criminal records checks of those prospective parents only if the placement involved a child on whose behalf those payments were to be made.

The Adam Walsh Act also requires a state to check any child abuse or neglect registry maintained by the state for information on any prospective foster or adoptive parent and on any other adult living in the home of that prospective parent (adult resident), and to check any child abuse or neglect registry maintained by any other state in which any prospective foster or adoptive parent or adult resident has resided in the preceding five years, before the prospective foster or adoptive parent may be finally approved for placement of a child, regardless of whether foster care maintenance or adoption assistance payments are to be provided on behalf of the child.

This bill conforms state law relating to criminal history and child abuse or neglect record searches (background checks) of prospective foster, treatment foster, and adoptive homes to federal law, as affected by the Adam Walsh Act. Specifically, the bill requires DHFS, a county department of human services or social services (county department), or a child welfare agency to conduct a background check of a person who is seeking a license to operate a foster or treatment foster home, of a

person licensed to operate a foster or treatment foster home who is seeking to adopt a child, and of any adult resident of the home, regardless of whether foster care maintenance or adoption assistance payments will be provided after the placement is made or the adoption is finalized.

The bill also requires DHFS, a county department, or a child welfare agency to request a fingerprint-based check of the national crime information databases for a person who is seeking an initial license to operate a foster or treatment foster home or relicensure after a break in licensure and of a person who was required to obtain an initial license to operate a foster or treatment foster home or relicensure after a break in licensure before placement of a child for adoption. In addition, if at any time within the five years preceding the date of the background check that person or an adult resident has not been a resident of this state, the bill requires DHFS, a county department, or a child welfare agency to check any child abuse or neglect registry maintained by any state or other United States jurisdiction in which the person or adult resident was a resident within those preceding five years.

***** ANALYSIS FROM -0261/6 *****