49.45 **(6m)** (br) 1. Notwithstanding s. 20.410 (3) (cd), (ko), or (r), 20.435 (4) (bt) or (7) (b), or 20.445 (3) (dz), the department shall reduce allocations of funds to counties in the amount of the disallowance from the appropriation account under s. 20.435 (4) (bt) or (7) (b), or the department shall direct the department of workforce development to reduce allocations of funds to counties or Wisconsin works agencies in the amount of the disallowance from the appropriation account under s. 20.445 (3) (dz) or direct the department of corrections to reduce allocations of funds to counties in the amount of the disallowance from the appropriation account under s. 20.410 (3) (cd), (ko), or (r) in accordance with s. 16.544 to the extent applicable.

SECTION 1532. 49.45 (6m) (br) 1. of the statutes, as affected by 2007 Wisconsin Act .... (this act), is amended to read:

49.45 **(6m)** (br) 1. Notwithstanding s. 20.410 (3) (cd), (ko), or (r), 20.435 (4) (bt) or (7) (b) or ~~20.445 (3)~~ 20.437 (2) (dz), the department shall reduce allocations of funds to counties in the amount of the disallowance from the appropriation account under s. 20.435 (4) (bt) or (7) (b), or the department shall direct the department of ~~workforce development~~ children and families to reduce allocations of funds to counties or Wisconsin ~~works~~ Works agencies in the amount of the disallowance from the appropriation account under s. ~~20.445 (3)~~ 20.437 (2) (dz) or direct the department of corrections to reduce allocations of funds to counties in the amount of the disallowance from the appropriation account under s. 20.410 (3) (cd), (ko), or (r) in accordance with s. 16.544 to the extent applicable.

SECTION 1533. 49.45 (6m) (m) of the statutes is created to read:

49.45 **(6m)** (m) To hold a bed in a facility, the department may pay the full payment rate under this subsection for up to 30 days for services provided to a person

during the pendency of an undue hardship determination, as provided in s. 49.453 (8) (b) 3.

SECTION 1534. 49.45 (6v) (b) of the statutes is amended to read:

49.45 **(6v)** (b) The department shall, each year, submit to the joint committee on finance a report for the previous fiscal year, except for the 1997–98 fiscal year, that provides information on the utilization of beds by recipients of medical assistance in facilities and a discussion and detailed projection of the likely balances, expenditures, encumbrances and carry over of currently appropriated amounts in the appropriation accounts under s. 20.435 (4) (b), ~~(gp), and~~ (o), and (xd).

SECTION 1535. 49.45 (6x) (a) of the statutes is amended to read:

49.45 **(6x)** (a) Notwithstanding sub. (3) (e), from the appropriation accounts under s. 20.435 (4) (b), ~~(gp),~~ (o), ~~and~~ (w), and (xd), the department shall distribute not more than $4,748,000 in each fiscal year, to provide funds to an essential access city hospital, except that the department may not allocate funds to an essential access city hospital to the extent that the allocation would exceed any limitation under 42 USC 1396b (i) (3).

SECTION 1536. 49.45 (6y) (a) of the statutes is amended to read:

49.45 **(6y)** (a) Notwithstanding sub. (3) (e), from the appropriation accounts under s. 20.435 (4) (b), ~~(gp),~~ (o), ~~and~~ (w), and (xd), the department ~~shall~~ may distribute funding in each fiscal year to provide supplemental payment to hospitals that enter into a contract under s. 49.02 (2) to provide health care services funded by a relief block grant, as determined by the department, for hospital services that are not in excess of the hospitals' customary charges for the services, as limited under 42 USC 1396b (i) (3). If no relief block grant is awarded under this chapter or if the allocation of funds to such hospitals would exceed any limitation under 42 USC

1396b (i) (3), the department may distribute funds to hospitals that have not entered into a contract under s. 49.02 (2).

SECTION 1537. 49.45 (6y) (am) of the statutes is amended to read:

49.45 **(6y)** (am) Notwithstanding sub. (3) (e), from the appropriation accounts under s. 20.435 (4) (b), (h), ~~(gp),~~ (o), ~~and~~ (w), and (xd), the department shall distribute funding in each fiscal year to provide supplemental payments to hospitals that enter into contracts under s. 49.02 (2) with a county having a population of 500,000 or more to provide health care services funded by a relief block grant, as determined by the department, for hospital services that are not in excess of the hospitals' customary charges for the services, as limited under 42 USC 1396b (i) (3).

SECTION 1538. 49.45 (6z) (a) (intro.) of the statutes is amended to read:

49.45 **(6z)** (a) (intro.) Notwithstanding sub. (3) (e), from the appropriation accounts under s. 20.435 (4) (b), ~~(gp),~~ (o), ~~and~~ (w), and (xd), the department ~~shall~~ may distribute funding in each fiscal year to supplement payment for services to hospitals that enter into ~~a contract under s. 49.02 (2) to provide health care services funded by a relief block grant under this chapter~~ indigent care agreements, in accordance with the approved state plan for services under 42 USC 1396a, with relief agencies that administer the medical relief block grant under this chapter, if the department determines that the hospitals serve a disproportionate number of low–income patients with special needs. If no medical relief block grant under this chapter is awarded or if the allocation of funds to such hospitals would exceed any limitation under 42 USC 1396b (i) (3), the department may distribute funds to hospitals that have not entered into ~~a contract under s. 49.02 (2)~~ indigent care agreements. The department may not distribute funds under this subsection to the extent that the distribution would do any of the following:

SECTION 1539. 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 1540. 49.45 (8) (b) of the statutes is amended to read:

49.45 **(8)** (b) Reimbursement under s. 20.435 (4) (b), ~~(gp),~~ (o), ~~and~~ (w), and (xd) for home health services provided by a certified home health agency or independent nurse shall be made at the home health agency's or nurse's usual and customary fee per patient care visit, subject to a maximum allowable fee per patient care visit that is established under par. (c).

SECTION 1541. 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 1542. 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 1543. 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 1544. 49.45 (18m) of the statutes is created to read:

49.45 **(18m)** MEDICARE PART B ENROLLMENT AND PREMIUM PAYMENT. (a) The department may require an individual who is eligible for Medicare Part B under 42 USC 1395j to 1395L and who also is eligible for any of the following medical assistance services under any of the following to enroll in Medicare Part B as a condition of receiving those medical assistance services:

1. Medical assistance services under s. 49.46, 49.47, or 49.472.

2. Health care coverage under the Badger Care health care program under s. 49.665.

3. Services under s. 46.27 (11), 46.275, 46.277, 46.278, or 46.2785.

4. Medical assistance services provided as part of a family care benefit, as defined in s. 46.2805 (4).

5. Services provided under a waiver requested under 2001 Wisconsin Act 16, section 9123 (16rs), or 2003 Wisconsin Act 33, section 9124 (8c).

6. Services provided under the program of all–inclusive care for persons aged 55 or older authorized under 42 USC 1396u–4.

7. Services provided under the demonstration program under a federal waiver authorized under 42 USC 1315.

(b) If the department requires an individual specified in par. (a) to enroll in Medicare Part B, the department shall pay the monthly premiums for the coverage under Medicare Part B.

SECTION 1545. 49.45 (18m) (a) 1. of the statutes, as created by 2007 Wisconsin Act .... (this act), is amended to read:

49.45 **(18m)** (a) 1. Medical assistance services under s. 49.46, 49.47, 49.471, or 49.472.

SECTION 1546. 49.45 (23) of the statutes is created to read:

49.45 **(23)** ASSISTANCE FOR CHILDLESS ADULTS DEMONSTRATION PROJECT. (a) 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 health care coverage for basic primary and preventive care to adults who are under the age of 65, who have family incomes not to exceed 200 percent of the poverty line, and who are not otherwise eligible for medical assistance under this subchapter, the Badger Care health care program under s. 49.665, or Medicare under 42 USC 1395 et seq. Any individual who had coverage under the Health Insurance Risk–Sharing Plan under subch. II of ch. 149 within 6 months before applying for the project under this subsection is not eligible to participate in the project under this subsection.

(b) If the waiver is granted and in effect, the department may promulgate rules defining the health care benefit plan, including more specific eligibility requirements and cost–sharing requirements. Notwithstanding s. 227.24 (3), the plan details under this subsection may be promulgated as an emergency rule under

s. 227.24 without a finding of emergency. If the waiver is granted and in effect, the demonstration project under this subsection shall begin on January 1, 2009, or on the effective date of the waiver, whichever is later.

SECTION 1547. 49.45 (24g) of the statutes is repealed.

SECTION 1548. 49.45 (24m) (intro.) of the statutes is amended to read:

49.45 **(24m)** (intro.) From the appropriation accounts under s. 20.435 (4) (b), ~~(gp),~~ (o), ~~and~~ (w), and (xd), in order to test the feasibility of instituting a system of reimbursement for providers of home health care and personal care services for medical assistance recipients that is based on competitive bidding, the department shall:

SECTION 1549. 49.45 (24r) of the statutes is amended to read:

49.45 **(24r)** FAMILY PLANNING DEMONSTRATION PROJECT. The department shall request ~~a~~ an amended 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)~~ (a), under medical assistance to any woman or man 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 or man's family. ~~If~~ The department shall implement any waiver granted and, if the amendment to the waiver is granted and in effect, the department shall implement the amended waiver no later than ~~July 1, 1998~~ January 1, 2008, or on the federally approved effective date of the amended waiver, whichever is later.

SECTION 1550. 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 1551c. 49.45 (31) of the statutes is repealed and recreated to read:

49.45 **(31)** LONG–TERM CARE PARTNERSHIP PROGRAM. (a) The department shall submit to the federal department of health and human services, not later than 3 months after the effective date of this paragraph .... [revisor inserts date], an amendment to the state medical assistance plan that establishes in this state a Long–Term Care Partnership Program, as described in this subsection, and shall implement the program if the amendment to the state plan is approved. Under the program, the department shall exclude an amount equal to the amount of benefits that an individual receives under a qualifying long–term care insurance policy, as described in par. (b), when determining any of the following:

1. The individual's resources for purposes of determining the individual's eligibility for medical assistance.

2. The amount to be recovered from the individual's estate if the individual receives medical assistance.

(b) To be eligible for the program, an individual must have been a resident of this state when the long–term care insurance policy was issued, and the policy must satisfy all of the following criteria:

1. The policy was not issued before the date specified in the amendment to the state plan, which may not be before the first day of the calendar quarter in which the amendment is submitted to the federal department of health and human services.

2. The policy meets the definition of a qualified long–term care insurance policy under 26 USC 7702B (b).

3. The policy meets the long–term care insurance model regulations and the requirements of the long–term care insurance model act promulgated by the

National Association of Insurance Commissioners that are specified in 42 USC 1396p (b) (5).

4. The policy includes the applicable inflation protection specified in 42 USC 1396p (b) (1) (C) (iii) (IV).

5. The commissioner of insurance certifies to the department that the policy meets the criteria under subds. 2. to 4.

(c) 1. The department and the office of the commissioner of insurance shall work together to develop a training program for individuals who sell long–term care insurance policies in the state to ensure that those individuals understand the relation of long–term care insurance to the Medical Assistance program and are able to explain to consumers the protections offered by long–term care insurance and how this type of insurance relates to private and public financing of long–term care.

2. The training program developed under this paragraph shall include initial training that is not less than 8 hours long and ongoing training sessions that are not less than 4 hours long per session. Individuals who sell long–term care insurance policies shall be required to attend an ongoing training session every 24 months after the initial training. The commissioner may approve the initial and ongoing training sessions for continuing education requirements under s. 628.04 (3).

3. The training under this paragraph shall cover at a minimum long–term care insurance, long–term care services, qualified partnerships, and the relationship between qualified partnerships and other public and private coverage of long–term care costs.

(d) An insurer that issues a long–term care insurance policy described in par. (b) shall be required to submit reports to the secretary of the federal department of health and human services, in accordance with regulations developed by the

secretary, that include notice of when benefits are paid under the policy, the amount of the benefits, notice of the termination of the policy, and any other information required by the secretary.

SECTION 1552. 49.45 (35) of the statutes is repealed.

SECTION 1553. 49.45 (40) of the statutes is amended to read:

49.45 **(40)** PERIODIC RECORD MATCHES. If the department contracts with the department of ~~workforce development~~ children and families under s. 49.197 (5), the department shall cooperate with the department of ~~workforce development~~ children and families in matching records of medical assistance recipients under s. 49.32 (7).

SECTION 1554. 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.

SECTION 1554m. 49.45 (44m) of the statutes is created to read:

49.45 **(44m)** EXTENSION OF PARENT ELIGIBILITY WHEN CHILD DIES. The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to extend the eligibility of a parent, for up to 90 days, under the Medical Assistance program under this subchapter or the Badger Care health care program under s. 49.665 if the parent's child dies while both the parent and the child are covered under the Medical Assistance program or the

Badger Care health care program and the parent would lose eligibility solely due to the death of the child. The department shall implement any waiver that is granted.

SECTION 1555. 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.

SECTION 1556. 49.45 (49m) (c) 1. of the statutes is amended to read:

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.

SECTION 1557. 49.45 (52) of the statutes is amended to read:

49.45 **(52)** PAYMENT ADJUSTMENTS. Beginning on January 1, 2003, the department may, from the appropriation account under s. 20.435 (7) (b), make Medical Assistance payment adjustments to county departments under s. 46.215, 46.22, 46.23, or 51.42, or 51.437 or to local health departments, as defined in s. 250.01 (4), as appropriate, for covered services under s. 49.46 (2) (a) 2. and 4. d. and f. and (b) 6. b., c., f., fm., g., j., k., L., Lm., and m., 9., 12., 12m., 13., 15., and 16. Payment adjustments under this subsection shall include the state share of the payments. The total of any payment adjustments under this subsection and Medical Assistance payments made from appropriation accounts under s. 20.435 (4) (b), ~~(gp),~~ (o), ~~and~~ (w), and (xd) may not exceed applicable limitations on payments under 42 USC 1396a (a) (30) (A).

SECTION 1558. 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).

SECTION 1559. 49.45 (54) of the statutes is created to read:

49.45 **(54)** MANAGED CARE PILOT PROGRAM FOR LONG–TERM CARE OF CHILDREN WITH DISABILITIES. The department shall seek waivers of federal medical assistance statutes and regulations from the federal department of health and human services necessary to implement, in at least 3 pilot sites, a program of managed care for the long–term care of children with disabilities.

SECTION 1559e. 49.45 (55) of the statutes is created to read:

49.45 **(55)** HEALTH OPPORTUNITY ACCOUNTS DEMONSTRATION PROGRAM. The department shall request from the federal Centers for Medicare and Medicaid Services approval to participate in a demonstration program under 42 USC 1396u–8, under which Badger Care recipients may voluntarily enroll to contribute to health opportunity accounts and receive certain alternative benefits under medical assistance. If the Centers for Medicare and Medicaid Services approve the department's request, the department shall submit a proposed plan for implementation of the demonstration program to the joint committee on finance. The department may not implement the plan until it is approved by the committee, as submitted or as modified.

SECTION 1559g. 49.45 (56) of the statutes is created to read:

49.45 **(56)** DISEASE MANAGEMENT PROGRAM. Based on the health conditions identified by the physical health risk assessments, if performed under sub. (57), the

department shall develop and implement, for Medical Assistance recipients, disease management programs that are similar to that developed and followed by the Marshfield Clinic in this state under the Physician Group Practice Demonstration Program authorized under 42 USC 1315 (e) and (f). These programs shall have at least the following characteristics:

(a) The use of information science to improve health care delivery by summarizing a patient's health status and providing reminders for preventive measures.

(b) Educating health care providers on health care process improvement by developing best practice models.

(c) The improvement and expansion of care management programs to assist in standardization of best practices, patient education, support systems, and information gathering.

(d) Establishment of a system of provider compensation that is aligned with clinical quality, practice management, and cost of care.

(e) Focus on patient care interventions for certain chronic conditions, to reduce hospital admissions.

SECTION 1559h. 49.45 (57) of the statutes is created to read:

49.45 **(57)** PHYSICAL HEALTH RISK ASSESSMENT. The department shall encourage each individual who is determined on or after the effective date of this subsection .... [revisor inserts date], to be eligible for Medical Assistance to receive a physical health risk assessment as part of the first physical examination the individual receives under Medical Assistance.

SECTION 1560. 49.453 (1) (a) of the statutes is amended to read:

49.453 **(1)** (a) "Assets" has the meaning given in 42 USC 1396p ~~(e)~~ (h) (1).

SECTION 1561. 49.453 (1) (ar) of the statutes is created to read:

49.453 **(1)** (ar) "Community spouse" means the spouse of either the institutionalized person or the noninstitutionalized person.

SECTION 1562. 49.453 (1) (d) of the statutes is amended to read:

49.453 **(1)** (d) "Income" has the meaning given in 42 USC 1396p ~~(e)~~ (h) (2).

SECTION 1563. 49.453 (1) (e) of the statutes is amended to read:

49.453 **(1)** (e) "Institutionalized individual" has the meaning given in 42 USC 1396p ~~(e)~~ (h) (3).

SECTION 1564. 49.453 (1) (f) (intro.) of the statutes is amended to read:

49.453 **(1)** (f) (intro.) "Look–back date" means ~~for a covered individual,~~ either of the following:

1m. For transfers made before February 8, 2006, the date that is 36 months before, or with respect to payments from a trust or portions of a trust that are treated as assets transferred by the covered individual under s. 49.454 (2) (c) or (3) (b) the date that is 60 months before:

SECTION 1565. 49.453 (1) (f) 1. of the statutes is renumbered 49.453 (1) (f) 1m. a.

SECTION 1566. 49.453 (1) (f) 2. of the statutes is renumbered 49.453 (1) (f) 1m. b.

SECTION 1567. 49.453 (1) (f) 2m. of the statutes is created to read:

49.453 **(1)** (f) 2m. For all transfers made on or after February 8, 2006, the date that is 60 months before the dates specified in subd. 1m. a. and b.

SECTION 1568. 49.453 (1) (fm) of the statutes is amended to read:

49.453 **(1)** (fm) "Noninstitutionalized individual" has the meaning given in 42 USC 1396p ~~(e)~~ (h) (4).

SECTION 1569. 49.453 (1) (i) of the statutes is amended to read:

49.453 **(1)** (i) "Resources" has the meaning given in 42 USC 1396p ~~(e)~~ (h) (5).

SECTION 1570. 49.453 (3) (a) of the statutes is renumbered 49.453 (3) (a) (intro.) and amended to read:

49.453 **(3)** (a) (intro.) The period of ineligibility under this subsection begins on either of the following:

1. In the case of a transfer of assets made before February 8, 2006, the first day of the first month beginning on or after the look–back date during or after which assets have been transferred for less than fair market value and that does not occur in any other periods of ineligibility under this subsection.

SECTION 1571. 49.453 (3) (a) 2. of the statutes is created to read:

49.453 **(3)** (a) 2. In the case of a transfer of assets made on or after February 8, 2006, the first day of a month beginning on or after the look–back date during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance and would otherwise be receiving institutional level care described in sub. (2) (a) 1. to 3. based on an approved application for the care but for the application of the penalty period, whichever is later, and that does not occur during any other period of ineligibility under this subsection.

SECTION 1572. 49.453 (3) (b) (intro.) of the statutes is amended to read:

49.453 **(3)** (b) (intro.) ~~The~~ Subject to par. (bc), the department shall determine the number of months of ineligibility as follows:

SECTION 1573. 49.453 (3) (bc) of the statutes is created to read:

49.453 **(3)** (bc) In determining the number of months of ineligibility under par. (b), with respect to asset transfers that occur after February 8, 2006, the department

may not round down the quotient, or otherwise disregard any fraction of a month, obtained in the division under par. (b) 3.

SECTION 1574. 49.453 (4) (a) of the statutes is renumbered 49.453 (4) (ag).

SECTION 1575. 49.453 (4) (ac) of the statutes is created to read:

49.453 **(4)** (ac) In this subsection, "transaction" means any action taken by an individual that changes the course of payments to be made under an annuity or the treatment of the income or principal of an annuity, including all of the following:

1. An addition of principal.

2. An elective withdrawal.

3. A request to change the distribution of the annuity.

4. An election to annuitize the contract.

5. A change in ownership.

SECTION 1576. 49.453 (4) (am) of the statutes is amended to read:

49.453 **(4)** (am) Paragraph ~~(a)~~ (ag) 1. does not apply to a variable annuity that is tied to a mutual fund that is registered with the federal securities and exchange commission.

SECTION 1577. 49.453 (4) (b) of the statutes is amended to read:

49.453 **(4)** (b) The amount of assets that is transferred for less than fair market value under par. ~~(a)~~ (ag) is the amount by which the transferred amount exceeds the expected value of the benefit.

SECTION 1578. 49.453 (4) (c) of the statutes is amended to read:

49.453 **(4)** (c) The department shall promulgate rules specifying the method to be used in calculating the expected value of the benefit, based on 26 CFR 1.72–1 to 1.72–18, and specifying the criteria for adjusting the expected value of the benefit based on a medical condition diagnosed by a physician before the assets were

transferred to the annuity, or transferred by promissory note or similar instrument. In calculating the amount of the divestment when a transfer to an annuity, or a transfer by promissory note or similar instrument, is made, payments made to the transferor in any year subsequent to the year in which the transfer was made shall be discounted to the year in which the transfer was made by the applicable federal rate specified under par. ~~(a)~~ (ag) on the date of the transfer.

SECTION 1579. 49.453 (4) (cm) of the statutes is created to read:

49.453 **(4)** (cm) Paragraphs (ag) to (c) apply to annuities purchased before February 8, 2006, for which no transaction has occurred on or after February 8, 2006.

SECTION 1580. 49.453 (4) (d) of the statutes is created to read:

49.453 **(4)** (d) For purposes of sub. (2), the purchase of an annuity by an institutionalized individual or his or her community spouse, or anyone acting on their behalf, shall be treated as a transfer of assets for less than fair market value unless any of the following applies:

1. The state is designated as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual.

2. The state is named as a beneficiary in the 2nd position after the community spouse or a minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value.

3. The annuity satisfies the requirements under par. (e) 1. or 2.

SECTION 1581. 49.453 (4) (e) of the statutes is created to read:

49.453 **(4)** (e) For purposes of sub. (2), the purchase of an annuity by or on behalf of an annuitant who has applied for medical assistance for nursing facility services

or other long–term care services described in sub. (2) is a transfer of assets for less than fair market value unless either of the following applies:

1. The annuity is either an annuity described in section 408 (b) or (q) of the Internal Revenue Code of 1986 or purchased with proceeds from any of the following:

a. An account or trust described in section 408 (a), (c), or (p) of the Internal Revenue Code of 1986.

b. A simplified employee pension, within the meaning of section 408 (k) of the Internal Revenue Code of 1986.

c. A Roth IRA described in section 408A of the Internal Revenue Code of 1986.

2. All of the following apply with respect to the annuity:

a. The annuity is irrevocable and nonassignable.

b. The annuity is actuarily sound, as determined in accordance with actuarial publications of the office of the chief actuary of the social security administration.

c. The annuity provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

SECTION 1582. 49.453 (4) (em) of the statutes is created to read:

49.453 **(4)** (em) Paragraphs (d) and (e) apply to all of the following:

1. Annuities purchased on or after February 8, 2006.

2. Annuities purchased before February 8, 2006, for which a transaction has occurred on or after February 8, 2006.

SECTION 1583. 49.453 (4c) of the statutes is created to read:

49.453 **(4c)** PURCHASE OF NOTE, LOAN, OR MORTGAGE. (a) For purposes of sub. (2), the purchase by an individual or his or her spouse of a promissory note, loan, or mortgage after February 8, 2006, is a transfer of assets for less than fair market value unless all of the following apply with respect to the note, loan, or mortgage:

1. The repayment term is actuarially sound.

2. The payments are to be made in equal amounts during the term of the loan, with no deferral and no balloon payment.

3. Cancellation of the balance upon the death of the lender is prohibited.

(b) The value of a promissory note, loan, or mortgage that does not satisfy the requirements under par. (a) 1. to 3. is the outstanding balance due on the date that the individual applies for medical assistance for nursing facility services or other long–term care services described in sub. (2).

SECTION 1584. 49.453 (4m) of the statutes is created to read:

49.453 **(4m)** PURCHASE OF LIFE ESTATE. For purposes of sub. (2), the purchase by an individual or his or her spouse of a life estate in another individual's home after February 8, 2006, is a transfer of assets for less than fair market value unless the purchaser resides in the home for at least one year after the date of the purchase.

SECTION 1585. 49.453 (8) of the statutes is renumbered 49.453 (8) (a) (intro.) and amended to read:

49.453 **(8)** (a) (intro.) Subsections (2) and (3) do not apply to transfers of assets if ~~the~~ any of the following applies:

1. The assets are exempt under 42 USC 1396p (c) (2) ~~or if the~~ (A), (B), or (C).

2. The department determines under the process under par. (b) that application of this section would work an undue hardship. ~~The department shall promulgate rules concerning the transfer of assets exempt under 42 USC 1396p (c) (2).~~

SECTION 1586. 49.453 (8) (b) of the statutes is created to read:

49.453 **(8)** (b) The department shall establish a hardship waiver process that includes all of the following:

1. The department determines that undue hardship exists if the application of subs. (2) and (3) would deprive the individual of medical care to the extent that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life.

2. A facility in which an institutionalized individual who has transferred assets resides is permitted to file an application for undue hardship on behalf of the individual with the consent of the individual or the individual's authorized representative.

3. The department may, during the pendency of an undue hardship determination, pay the full payment rate under s. 49.45 (6m) for nursing facility services for up to 30 days for the individual who transferred assets, to hold a bed in the facility in which the individual resides.

SECTION 1587. 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 1588. 49.46 (1) (a) 14m. of the statutes is amended to read:

49.46 **(1)** (a) 14m. Any person who would meet the financial and other eligibility requirements for home or community–based services under the family care benefit but for the fact that the person engages in substantial gainful activity under 42 USC 1382c (a) (3), if a waiver under s. 46.281 ~~(1) (c)~~ (1d) is in effect or federal law permits federal financial participation for medical assistance coverage of the person and if funding is available for the person under the family care benefit.

SECTION 1589. 49.46 (2) (b) (intro.) of the statutes is amended to read:

49.46 **(2)** (b) (intro.) Except as provided in ~~par.~~ pars. (be) and (dc), the department shall audit and pay allowable charges to certified providers for medical assistance on behalf of recipients for the following services:

SECTION 1590. 49.46 (2) (b) 8. of the statutes is amended to read:

49.46 **(2)** (b) 8. Home or community–based services, if provided under s. 46.27 (11), 46.275, 46.277, 46.278, or 46.2785, under the family care benefit if a waiver is in effect under s. 46.281 ~~(1) (c)~~ (1d), or under ~~a waiver requested under 2001 Wisconsin Act 16, section 9123 (16rs), or 2003 Wisconsin Act 33, section 9124 (8c)~~ the disabled children's long–term support program, as defined in s. 46.011 (1g).

SECTION 1591. 49.46 (2) (dc) of the statutes is created to read:

49.46 **(2)** (dc) For an individual who is eligible for medical assistance and who is eligible for coverage under Part D of Medicare under 42 USC 1395w–101 et seq., benefits under par. (b) 6. h. do not include payment for any Part D drug, as defined in 42 CFR 423.100, regardless of whether the individual is enrolled in Part D of Medicare or whether, if the individual is enrolled, his or her Part D plan, as defined in 42 CFR 423.4, covers the Part D drug.

SECTION 1592. 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 1593. 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 1594. 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 1595. 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 1596. 49.47 (4) (a) (intro.) of the statutes is amended to read:

49.47 **(4)** (a) (intro.) Any individual who meets the limitations on income and resources under pars. (b) ~~and~~ to (c) and who complies with ~~par.~~ pars. (cm) and (cr) shall be eligible for medical assistance under this section if such individual is:

SECTION 1597. 49.47 (4) (as) 1. of the statutes is amended to read:

49.47 **(4)** (as) 1. The person would meet the financial and other eligibility requirements for home or community–based services under s. 46.27 (11), 46.277, or 46.2785 or under the family care benefit if a waiver is in effect under s. 46.281 ~~(1) (c)~~ (1d) but for the fact that the person engages in substantial gainful activity under 42 USC 1382c (a) (3).

SECTION 1598. 49.47 (4) (as) 3. of the statutes is amended to read:

49.47 **(4)** (as) 3. Funding is available for the person under s. 46.27 (11), 46.277, or 46.2785 or under the family care benefit if a waiver is in effect under s. 46.281 ~~(1)~~ ~~(c)~~ (1d).

SECTION 1598r. 49.47 (4) (b) (intro.) of the statutes is amended to read:

49.47 **(4)** (b) (intro.) Eligibility exists if the applicant's property, subject to the exclusion of any amounts under the Long–Term Care Partnership Program established under s. 49.45 (31), does not exceed the following:

SECTION 1599. 49.47 (4) (b) 1. of the statutes is amended to read:

49.47 **(4)** (b) 1. ~~A~~ Subject to par. (bc), a home and the land used and operated in connection therewith or in lieu thereof a mobile home if the home or mobile home is used as the person's or his or her family's place of abode.

SECTION 1600. 49.47 (4) (bc) of the statutes is created to read:

49.47 **(4)** (bc) 1. Subject to subd. 2., a person shall be ineligible under this section for medical assistance for nursing facility services or other long–term care services described in s. 49. 453 (2) if the equity in his or her home and the land used and operated in connection with the home exceeds $750,000. This subdivision does not apply if any of the following persons lawfully resides in the home:

a. The person's spouse.

b. The person's child who is under age 21 or who is disabled, as defined in s. 49.468 (1) (a) 1.

2. Subdivision 1. applies to all of the following:

a. At the time of application, to a person who applies for medical assistance for nursing facility services or other long–term care services described in s. 49.453 (2) after the effective date of this subd. 2. a. .... [revisor inserts date].

b. At the time of the person's first recertification after the effective date of this subd. 2. b. .... [revisor inserts date], to a person not specified in subd. 2. a. who applied for medical assistance for nursing facility services or other long–term care services described in s. 49.453 (2) on or after January 1, 2006, and who was eligible for medical assistance for those services on the effective date of this subd. 2. b. .... [revisor inserts date].

SECTION 1601. 49.47 (4) (bm) of the statutes is created to read:

49.47 **(4)** (bm) For purposes of determining eligibility or benefits amount for a person described in par. (a) 3. or 4. who resides in a continuing care retirement

community or a life care community, any entrance fee paid on admission to the community shall be considered a resource available to the person to the extent that all of the following apply:

1. The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care if the person's other resources or income are insufficient to pay for the care.

2. The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the continuing care retirement community or life care community contract and leaves the community.

3. The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

SECTION 1602. 49.47 (4) (cr) of the statutes is created to read:

49.47 **(4)** (cr) 1. As a condition of receiving medical assistance for long–term care services described in s. 49.453 (2) (a), an applicant for or recipient of the long–term care services shall disclose on the application or recertification form a description of any interest the individual or his or her community spouse, as defined in s. 49.453 (1) (ar), has in an annuity, regardless of whether the annuity is irrevocable or is treated as an asset. The application or recertification form shall include a statement that the state becomes a remainder beneficiary under any annuity in which the individual or his or her spouse has an interest by virtue of the provision of the medical assistance. The applicant or recipient shall, no later than 30 days after the department receives the application or recertification form, take any action required by the annuity issuer to make the state a remainder beneficiary.

2. The department shall notify the issuer of an annuity disclosed under subd. 1. of the state's right as a remainder beneficiary and shall request that the issuer

notify the department of any changes to or payments made under the annuity contract.

3. This paragraph applies to all of the following:

a. Annuities purchased on or after February 8, 2006.

b. Annuities purchased before February 8, 2006, for which a transaction, as defined in s. 49.453 (4) (ac), has occurred on or after February 8, 2006.

SECTION 1603. 49.47 (6) (a) 1. of the statutes is amended to read:

49.47 **(6)** (a) 1. Except as provided in subds. 6. to 7., all beneficiaries, for all services under s. 49.46 (2) (a) and (b), subject to s. 49.46 (2) (dc).

SECTION 1604. 49.47 (9m) of the statutes is repealed.

SECTION 1605. 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 an individual receiving benefits under this section.

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 an individual receiving benefits under this section:

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.

(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. An unborn child's eligibility for coverage under this section does not begin before the first day of the month in which the unborn child's mother provides the medical verification.

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, excluding sub. (2m), 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, excluding sub. (2m), 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, excluding sub. (2m), is granted but not continued in effect, BadgerCare Plus shall be discontinued.

(2m) APPROVAL TO QUALIFY AS A HEALTH COVERAGE TAX CREDIT PLAN. The department shall seek any necessary federal approvals to ensure that BadgerCare Plus is qualified health insurance under 26 USC 35 (e). Notwithstanding subs. (4) and (5), if BadgerCare Plus is determined to be qualified health insurance under 26 USC 35 (e), the department shall expand eligibility under BadgerCare Plus to include individuals who are eligible individuals under 26 USC 35 (c). Notwithstanding sub. (10) (a) and (b) 1. to 4., individuals who are eligible for coverage under BadgerCare Plus under this subsection shall pay premiums that are equal to the capitation payments that the department would make on behalf of similar

individuals with coverage under BadgerCare Plus, or the full per member per month cost of coverage, whichever is appropriate.

(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, excluding sub. (2m), 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. Notwithstanding subd. 1., an individual who is eligible for medical assistance under s. 49.46 (1) (a) 3. or 4. may not receive benefits under this section.

3. Notwithstanding subd. 1., an individual described in sub. (4) (a) or (b) or (5) who is eligible for medical assistance under s. 49.46 (1) (a) 5., 6m., 14., 14m., or 15. or (d) or 49.47 (4) (a) or (as) may receive medical assistance benefits under this section or under s. 49.46 or 49.47.

(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), subject to sub. (6) (k):

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. For a child under this subdivision who is an unborn child, benefits are limited to prenatal care.

3m. A child who obtains eligibility under sub. (7) (b) 2.

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.

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.

1m. A pregnant woman or unborn child who obtains eligibility under sub. (7) (b) 1.

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. For a child under this subdivision who is an unborn child, benefits are limited to prenatal care.

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 who is not an unborn child and whose family income exceeds 300 percent of the poverty line is eligible to purchase coverage of the benefits described in sub. (11), at the full per member per month cost of the 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 who is not an unborn 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 who is not an unborn 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 income shall provide verification, as determined by the department, of that 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.

(k) For an individual who is eligible for medical assistance under this section and who is eligible for coverage under Part D of Medicare under 42 USC 1395w–101 et seq., benefits under sub. (11) (a) or s. 49.46 (2) (b) 6. h. do not include payment for any Part D drug, as defined in 42 CFR 423.100, regardless of whether the individual is enrolled in Part D of Medicare or whether, if the individual is enrolled, his or her Part D plan, as defined in 42 CFR 423.4, covers the Part D drug.

(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 without regard to any change in family income for the balance of the pregnancy and, for a pregnant woman but not for an unborn child, to the last day of the month in which the 60th day after the last day of the woman's pregnancy falls. Eligibility obtained by a pregnant woman under this subdivision extends to all pregnant women in the pregnant woman's family.

2. A child who is not an unborn child 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 the 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 and extends to all children in the family.

3. For a pregnant woman or an unborn child to obtain eligibility under subd. 1., the amount that must be obligated or expended in any 6–month period is equal to the sum of the differences in each of those 6 months between the pregnant woman's

or unborn child's monthly family income and the monthly family income that is 300 percent of the poverty line. For a child to obtain eligibility under subd. 2., the amount that must be obligated or expended in any 6–month period is equal to the sum of the differences in each of those 6 months between the child's monthly family income and the monthly family income that is 150 percent of the poverty line.

(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 any of the following applies:

1. The unborn child or the unborn child's mother has individual or family health insurance coverage.

2. The unborn child or the unborn child's mother, in the 12 months before applying, had access to the health insurance coverage specified in par. (b) 1.

3. The unborn child or the unborn child's mother could be covered under individual or family health insurance coverage if the coverage is applied for, and the coverage could become available to the unborn child or the unborn child's mother in the month in which the unborn child applies for benefits under this section or in any of the next 3 calendar months.

(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. Except as provided in par. (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.

e. A child who obtains eligibility under sub. (7) (b) 2., but only for the remainder of the child's eligibility period under sub. (7) (b) 2.

2. An individual under par. (b) 2., or an individual who is an unborn child or an unborn child's mother under par. (c) 2., is not ineligible if any of the following good cause reasons is the reason that the individual did not obtain the health insurance coverage under par. (b) 1. to which they had access:

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.

d. The individual's access to 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, if an individual who is an unborn child or an unborn child's mother, regardless of family income, had health insurance coverage 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) 1. Except as provided in subd. 2., for an applicant or recipient with a family income that exceeds 150 percent of the poverty line, 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.

2. Subdivision 1. does not apply to any of the following:

a. A pregnant woman.

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

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

(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 the request.

(c) 1. Subject to subds. 2. and 3., an employer that does not comply with the requirements under par. (b) shall be required to pay, within 45 days after the requested information was due, 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 that are attributable to 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 that are attributable to any 6–month period.

3. Notwithstanding subd. 1., an employer shall not be subject to any penalties if the employer, at least once per year, timely provides to the department, in the manner and format specified by the department, information from which the department may determine whether the employer provides its employees with access to health insurance coverage.

4. All penalty assessments collected under this paragraph 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) *Copayments.* 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) *Premiums.* 1. Except as provided in subd. 4., 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.

2. Except as provided in subds. 3. and 4., 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.

3. Except as provided in subd. 4., 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.

4. 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.

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

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

e. A child who obtains eligibility under sub. (7) (b) 2.

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

5. If a recipient who is required to pay a premium under this paragraph or under sub. (2m) or (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) Subject to sub. (6) (k), 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, subject to coinsurance payment per inpatient stay of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided and a copayment of no more than $50 per admission for psychiatric services.

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

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

(i) Physical, occupational, speech, and pulmonary therapy, limited to 20 visits per year for each type of therapy, 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.

(j) Cardiac rehabilitation, limited to 36 visits per year 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.

(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).

(L) Durable medical equipment, limited to $2,500 per year, 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.

(m) Transportation to obtain emergency medical care only, as medically necessary, 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.

(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.

(11m) PROVIDER PAYMENTS AND REQUIREMENTS. The provider of a service or equipment under sub. (11) shall collect the specified or allowable copayment or coinsurance, unless the provider determines that the cost of collecting the copayment or coinsurance exceeds the amount to be collected. The department shall reduce payments for services or equipment under sub. (11) by the amount of the specified or allowable copayment or coinsurance. A provider may deny care or services or equipment under sub. (11) if the recipient does not pay the specified or allowable copayment or coinsurance. If a provider provides care or services or equipment under sub. (11) to a recipient who is unable to share costs as specified in sub. (11), the recipient is not relieved of liability for those costs.

(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 1606. 49.472 (6) (a) of the statutes is amended to read:

49.472 **(6)** (a) Notwithstanding sub. (4) (a) 3., from the appropriation account under s. 20.435 (4) (b), ~~(gp), or~~ (w), or (xd), the department shall, on the part of an individual who is eligible for medical assistance under sub. (3), pay premiums for or purchase individual coverage offered by the individual's employer if the department determines that paying the premiums for or purchasing the coverage will not be more costly than providing medical assistance.

SECTION 1607. 49.472 (6) (b) of the statutes is amended to read:

49.472 **(6)** (b) If federal financial participation is available, from the appropriation account under s. 20.435 (4) (b), ~~(gp), or~~ (w), or (xd), the department may pay medicare Part A and Part B premiums for individuals who are eligible for medicare and for medical assistance under sub. (3).

SECTION 1608. 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 1609. 49.473 (5) of the statutes is amended to read:

49.473 **(5)** The department shall audit and pay, from the appropriation accounts under s. 20.435 (4) (b), ~~(gp), and~~ (o), and (xd), allowable charges to a provider who is certified under s. 49.45 (2) (a) 11. for medical assistance on behalf of a woman who meets the requirements under sub. (2) for all benefits and services specified under s. 49.46 (2).

SECTION 1610. 49.475 (1) (a) of the statutes is renumbered 49.475 (1) (ar).