State of Wisconsin
2019 - 2020 LEGISLATURE

LRBb0574/1
TD/SB/KP/MM:all

SENATE AMENDMENT 2,

TO ASSEMBLY BILL 56

June 26, 2019 – Offered by Senators ERPENBACH, SHILLING, BEWLEY, MILLER, RINGHAND, SCHACHTNER, HANSEN, WIRCH, JOHNSON, SMITH, RISSER, CARPENTER, L. TAYLOR and LARSON.

At the locations indicated, amend the bill, as shown by assembly substitute amendment 1, as follows:

1. Page 30, line 10: increase the dollar amount for fiscal year 2019–20 by $100,000 and increase the dollar amount for fiscal year 2020–21 by $100,000 for the purpose of providing mental health assistance to farmers and farm families.

2. Page 36, line 5: increase the dollar amount for fiscal year 2019–20 by $127,900 and increase the dollar amount for fiscal year 2020–21 by $127,900 for the purpose of funding 1.07 FTE positions to administer the Wisconsin healthcare stability plan.

3. Page 36, line 5: increase the dollar amount for fiscal year 2019–20 by $541,300 and increase the dollar amount for fiscal year 2020–21 by $541,300 for the purpose of funding 5.10 FTE positions to provide health insurance education and

outreach activities, including assisting individuals with enrolling in the health insurance exchange.

4. Page 134, line 4: increase the dollar amount for fiscal year 2019–20 by $172,500 and increase the dollar amount for fiscal year 2020–21 by $222,900 for the purpose of lead exposure and poisoning prevention activities.

5. Page 134, line 12: after that line insert:

"(bk) Healthy aging grant program GPR A 250,000 250,000".

6. Page 135, line 20: increase the dollar amount for fiscal year 2019–20 by $489,500 and increase the dollar amount for fiscal year 2020–21 by $489,500 for the purpose of increasing the authorized FTE positions for the department of health services by 4.6 GPR positions, beginning in fiscal year 2019–20, in the division of public health, to expand dental services to recipients under the Medical Assistance program, BadgerCare Plus, and other low–income patients.

7. Page 136, line 10: increase the dollar amount for fiscal year 2019–20 by $1,687,100 and increase the dollar amount for fiscal year 2020–21 by $4,821,500 for the purpose of lead abatement grants, training, and outreach.

8. Page 136, line 19: increase the dollar amount for fiscal year 2019–20 by $193,600 and increase the dollar amount for fiscal year 2020–21 by $193,600 for the purpose of increasing funding for the women's health block grant program.

9. Page 137, line 4: increase the dollar amount for fiscal year 2019–20 by $3,300,000 and increase the dollar amount for fiscal year 2020–21 by $3,300,000 for the purpose of awarding tobacco use control grants.

10. Page 138, line 18: increase the dollar amount for fiscal year 2019–20 by $3,871,700 and increase the dollar amount for fiscal year 2020–21 by $11,014,200 for the purpose of lead abatement grants, training, and outreach.

11. Page 139, line 22: increase the dollar amount for fiscal year 2019–20 by $1,076,900 for the purpose of creating a separate admissions unit and increasing evening and nighttime supervisory staff at Winnebago Mental Health Institute.

12. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $1,422,800 and increase the dollar amount for fiscal year 2020–21 by $1,422,800 for the purpose of increasing pay–for–performance incentives to BadgerCare Plus health maintenance organizations to conduct blood–lead testing for children.

13. Page 140, line 19: decrease the dollar amount for fiscal year 2019–20 by $159,473,300 and decrease the dollar amount for fiscal year 2020–21 by $165,011,600 for the purpose of expanding eligibility under the Medical Assistance program under s. 49.471 (4) (a) 4. and 8.

14. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $5,760,000 and increase the dollar amount for fiscal year 2020–21 by $12,437,600 for the purpose of dental access incentive payments under s. 49.45 (24L) beginning January 1, 2020.

15. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 only by $192,000 to provide onetime grants for community–based doulas under SECTION 9119 (8m) and increase the dollar amount for fiscal year 2020–21 by $426,700 for the purpose of providing reimbursement for certified doula services provided through the Medical Assistance program in select counties, beginning in fiscal year 2020–21.

16. Page 140, line 19: decrease the dollar amount for fiscal year 2019–20 by $1,750,000 and decrease the dollar amount for fiscal year 2020–21 by $1,750,000 for the purpose of making payments to rural critical care hospitals.

17. Page 140, line 19: decrease the dollar amount for fiscal year 2019–20 by $7,700,000 and decrease the dollar amount for fiscal year 2020–21 by $7,700,000 for the purpose of making hospital access payments and critical access hospital payments.

18. Page 140, line 19: increase the dollar amount for fiscal year 2020–21 by $22,500,000 for the purpose of providing as a benefit in the Medical Assistance program nonmedical services that contribute to the determinants of health under s. 49.46 (2) (b) 21.

19. Page 140, line 19: increase the dollar amount for fiscal year 2020–21 by $9,255,000 for the purpose of extending Medical Assistance eligibility for post–partum women.

20. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $2,454,300 and increase the dollar amount for fiscal year 2020–21 by $2,454,300 for the purpose of eliminating copayments for prescription drugs for Medical Assistance enrollees.

21. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $8,732,100 and increase the dollar amount for fiscal year 2020–21 by $18,217,800 for the purpose of funding an increase of Medical Assistance reimbursement rates for mental health, behavioral health, and psychiatric services provided by physicians and medical clinics, effective January 1, 2020.

22. Page 140, line 19: increase the dollar amount for fiscal year 2020–21 by $2,000,000 for the purpose of funding incentive grants to behavioral health providers that adopt electronic health records systems or participate in the state's health information exchange.

23. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $6,613,900 and decrease the dollar amount for fiscal year 2020–21 by $872,700 for the purpose of providing the cost to continue Medical Assistance benefits.

24. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $1,088,200 and increase the dollar amount for fiscal year 2020–21 by $1,692,900 for the purpose of telehealth reimbursement under the Medical Assistance program.

25. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $406,000 and increase the dollar amount for fiscal year 2020–21 by $609,000 for the purpose of providing dental services to Medical Assistance recipients who have disabilities.

26. Page 140, line 19: decrease the dollar amount for fiscal year 2019–20 by $6,000,000 and decrease the dollar amount for fiscal year 2020–21 by $9,000,000 for the purpose of funding the direct care and services portion of the capitation rates provided to care management organizations that administer Family Care in recognition of the direct caregiver workforce challenges facing the state.

27. Page 140, line 19: increase the dollar amount for fiscal year 2019–20 by $10,000,000 and increase the dollar amount for fiscal year 2020–21 by $10,000,000 for the purpose of funding a pediatric supplemental hospital payment under s. 49.45 (6xm).

28. Page 140, line 19: increase the dollar amount for fiscal year 2020–21 by $89,900 for the purpose of providing supportive services delivered under the Medical Assistance medical home health benefit for persons with substance abuse disorders.

29. Page 140, line 20: increase the dollar amount for fiscal year 2019–20 by $687,800 and increase the dollar amount for fiscal year 2020–21 by $874,600 for the purpose of implementing a statewide contract for children's long–term care intake, application, and screening function for the Katie Beckett program, children's long–term supports waiver program, and children's communication options program and specifically to fund 5 children's services navigators, 2 children's disability resource specialists to assist families with complex or multisystem concerns, and 2 children's disability ombudsmen to provide advocacy services.

30. Page 141, line 7: increase the dollar amount for fiscal year 2019–20 by $4,380,900 and increase the dollar amount for fiscal year 2020–21 by $1,550,500 for the purpose of supporting contracted services and general program operations for the division of Medicaid services in the department of health services, including projects to modify claims and eligibility information systems to implement state and federal law and policy changes and rate increases incorporated into current contracts.

31. Page 141, line 12: increase the dollar amount for fiscal year 2019–20 by $1,039,800 and increase the dollar amount for fiscal year 2020–21 by $767,500 for the purpose of providing funding necessary to support payments under the Wisconsin funeral and cemetery aids program.

32. Page 141, line 15: delete lines 15 and 16 and substitute:

"(bv)	Prescription drug assistance for elderly; aids	GPR	B	19,617,200	23,607,100"

33. Page 141, line 18: delete lines 18 to 20 and substitute:

"(ed)	State supplement to federal supplemental security income program	GPR	S	158,637,000	159,747,400 ".

34. Page 142, line 18: delete lines 18 and 19 and substitute:

"(j)	Prescription drug assistance for elderly; manufacturer rebates	PR	C	84,461,900	88,904,900"

35. Page 144, line 8: increase the dollar amount for fiscal year 2019–20 by $2,077,300 and increase the dollar amount for fiscal year 2020–21 by $2,077,300 for the purpose of increasing pay–for–performance incentives to BadgerCare Plus health maintenance organizations to conduct blood–lead testing for children.

36. Page 144, line 14: delete lines 14 and 15 and substitute:

"(pg)	Federal aid; prescription drug assistance for elderly	PR–F	C	19,928,100	23,457,100"

37. Page 144, line 16: increase the dollar amount for fiscal year 2019–20 by $7,700,000 and increase the dollar amount for fiscal year 2020–21 by $7,700,000 for the purpose of making hospital access payments and critical access hospital payments.

38. Page 144, line 16: decrease the dollar amount for fiscal year 2019–20 by $2,316,200 and increase the dollar amount for fiscal year 2020–21 by $5,359,700 for the purpose of providing the cost to continue Medical Assistance benefits.

39. Page 144, line 24: decrease the dollar amount for fiscal year 2019–20 by $7,400,000 and decrease the dollar amount for fiscal year 2020–21 by $7,400,000 for the purpose of making hospital access payments.

40. Page 145, line 3: decrease the dollar amount for fiscal year 2019–20 by $300,000 and decrease the dollar amount for fiscal year 2020–21 by $300,000 for the purpose of making critical access hospital payments.

41. Page 145, line 16: delete lines 16 to 17 and substitute:

"(cf)	Crisis program enhancement grants	GPR	B	125,000	125,000".

42. Page 146, line 4: after that line insert:

"(dg)	Regional crisis stabilization facilities	GPR	A	–0–	2,500,000".

43. Page 148, line 10: increase the dollar amount for fiscal year 2019–20 by $264,900 and increase the dollar amount for fiscal year 2020–21 by $365,800 for the purpose of funding an additional 3.78 FTE PR positions within the bureau of assisted living.

44. Page 148, line 21: increase the dollar amount for fiscal year 2019–20 by $155,500 and increase the dollar amount for fiscal year 2020–21 by $214,800 for the purpose of funding an additional 2.22 FTE FED positions in the bureau of assisted living.

45. Page 149, line 3: increase the dollar amount for fiscal year 2019–20 by $1,680,000 and increase the dollar amount for fiscal year 2020–21 by $1,680,000 for

the purpose of grants to aging and disability resource centers and tribes to fund 27 additional dementia care specialists and 3 new tribal dementia care specialists.

46. Page 149, line 3: increase the dollar amount for fiscal year 2019–20 only by $61,600 and increase the dollar amount for fiscal year 2020–21 only by $78,200 for the purpose of funding a 2–year academic detailing primary care clinic dementia training pilot program under SECTION 9119 (3g).

47. Page 149, line 7: increase the dollar amount for fiscal year 2019–20 by $1,550,000 and increase the dollar amount for fiscal year 2020–21 by $7,600,000 for the purpose of increasing funding for the Birth to 3 Program.

48. Page 157, line 4: increase the dollar amount for fiscal year 2019–20 by $512,500 and increase the dollar amount for fiscal year 2020–21 by $675,000 for the purpose of funding services to prevent child abuse or neglect.

49. Page 231, line 6: decrease the dollar amount for fiscal year 2019–20 by $444,700 and decrease the dollar amount for fiscal year 2020–21 by $416,500 for the purpose of transferring the moneys for children's long–term care program.

50. Page 231, line 6: decrease the dollar amount for fiscal year 2020–21 by $89,900 for the purpose of providing supportive services delivered under the Medical Assistance medical home health benefit for persons with substance abuse disorders.

51. Page 231, line 6: decrease the dollar amount for fiscal year 2019–20 by $1,088,200 and decrease the dollar amount for fiscal year 2020–21 by $1,692,900 for the purpose of telehealth reimbursement under the Medical Assistance program.

52. Page 231, line 6: decrease the dollar amount for fiscal year 2019–20 by $100,000 and decrease the dollar amount for fiscal year 2020–21 by $100,000 for the

purpose of providing mental health assistance to farmers and farm families under the appropriation to the department of agriculture, trade and consumer protection.

53. Page 249, line 15: after that line insert:

"**SECTION 188m.** 20.435 (1) (bk) of the statutes is created to read:

20.435 **(1)** (bk) *Healthy aging grant program.* The amounts in the schedule for grants to an entity that conducts programs in healthy aging.".

54. Page 249, line 16: delete lines 16 to 18 and substitute:

"**SECTION 189b.** 20.435 (1) (cr) of the statutes is created to read:

20.435 **(1)** (cr) *Minority health grants.* The amounts in the schedule for the minority health program under s. 250.20 (3) and (4).".

55. Page 249, line 24: delete that line and substitute:

"**SECTION 190b.** 20.435 (1) (fj) of the statutes is repealed.".

56. Page 249, line 25: delete that line and substitute:

"**SECTION 191b.** 20.435 (1) (kb) of the statutes is repealed.".

57. Page 252, line 3: delete that line and substitute:

"49.685, ~~for distributing grants under s. 146.64,~~ and for reduction of any operating".

58. Page 253, line 1: delete lines 1 to 4 and substitute:

"**SECTION 195b.** 20.435 (4) (bf) of the statutes is amended to read:

20.435 **(4)** (bf) *Graduate medical training support grants.* As a continuing appropriation, the amounts in the schedule to award grants to rural hospitals under s. 146.63 and to support graduate medical training programs under s. 146.64.".

59. Page 255, line 2: after that line insert:

"**SECTION 201c.** 20.435 (4) (jw) of the statutes is amended to read:

20.435 **(4)** (jw) *BadgerCare Plus and hospital assessment.* All ~~moneys received from payment of enrollment fees under the program under s. 49.45 (23), all~~ moneys transferred under s. 50.38 (9), all moneys transferred from the appropriation account under par. (jz), and 10 percent of all moneys received from penalty assessments under s. 49.471 (9) (c), ~~for administration of the program under s. 49.45 (23),~~ to provide a portion of the state share of administrative costs for the BadgerCare Plus Medical Assistance program under s. 49.471~~,~~ and for administration of the hospital assessment under s. 50.38.".

60. Page 255, line 10: delete lines 10 to 14 and substitute:

"**SECTION 203b.** 20.435 (5) (cf) of the statutes is amended to read:

20.435 **(5)** (cf) ~~*Mobile crisis team*~~ *Crisis program enhancement grants.* Biennially, the amounts in the schedule for awarding grants to counties or regions to establish ~~certified~~ or enhance crisis programs ~~that create mental health mobile crisis teams~~ under s. 46.536.".

61. Page 255, line 15: delete lines 15 to 18 and substitute:

"**SECTION 204b.** 20.435 (5) (ct) of the statutes is created to read:

20.435 **(5)** (ct) *Mental health consultation program.* The amounts in the schedule for developing a plan for a mental health consultation program under s. 51.441. No moneys may be encumbered under this paragraph after June 30, 2021.".

62. Page 255, line 18: after that line insert:

"**SECTION 205c.** 20.435 (5) (dg) of the statutes is created to read:

20.435 **(5)** (dg) *Regional crisis stabilization facilities.* The amounts in the schedule to provide grants to regional crisis stabilization facilities under s. 51.03 (7).".

63. Page 265, line 17: delete that line and substitute:

"**SECTION 179b.** 20.505 (8) (hm) 6e. of the statutes is repealed.".

64. Page 279, line 8: after that line insert:

"**SECTION 318f.** 20.940 of the statutes is repealed.".

65. Page 292, line 25: after that line insert:

"**SECTION 414i.** 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.728, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 415i. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.728, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, and 632.895 ~~(11)~~ (8) and (10) to (17).".

66. Page 295, line 23: delete the material beginning with that line and ending with page 304, line 9, and substitute:

"**SECTION 441b.** 46.10 (16) of the statutes is amended to read:

46.10 **(16)** The department shall delegate to county departments under ss. 51.42 and 51.437 or the local providers of care and services meeting the standards established by the department under s. 46.036, the responsibilities vested in the department under this section for collection of patient fees for services other than those provided at state facilities, those provided to children that are reimbursed

under a waiver under s. ~~46.27 (11),~~ 46.275, 46.278, or 46.2785, or those provided under the disabled children's long–term support program if the county departments or providers meet the conditions that the department determines are appropriate. The department may delegate to county departments under ss. 51.42 and 51.437 the responsibilities vested in the department under this section for collection of patient fees for services provided at the state facilities if the necessary conditions are met.

SECTION 442b. 46.21 (2m) (b) 1. a. of the statutes is amended to read:

46.21 **(2m)** (b) 1. a. The powers and duties of the county departments under ss. 46.215, 51.42 and 51.437~~, including the administration of the long–term support community options program under s. 46.27, if the county department under s. 46.215 is designated as the administering agency under s. 46.27 (3) (b) 1~~.

SECTION 443b. 46.21 (2m) (b) 1. b. of the statutes is repealed.

SECTION 444b. 46.215 (1) (m) of the statutes is repealed.

SECTION 445b. 46.22 (1) (b) 1. e. of the statutes is repealed.

SECTION 446b. 46.23 (3) (bm) of the statutes is repealed.

SECTION 447b. 46.269 of the statutes is amended to read:

46.269 Determining financial eligibility for long–term care programs. To the extent approved by the federal government, the department or its designee shall exclude any assets accumulated in a person's independence account, as defined in s. 49.472 (1) (c), and any income or assets from retirement benefits earned or accumulated from income or employer contributions while employed and receiving ~~state–funded benefits under s. 46.27 or~~ medical assistance under s. 49.472 in determining financial eligibility and cost–sharing requirements, if any, for a long–term care program under s. ~~46.27,~~ 46.275~~,~~ or 46.277, for the family care program that provides the benefit defined in s. 46.2805 (4), for the Family Care

Partnership program, or for the self–directed services option, as defined in s. 46.2897 (1).

SECTION 448b. 46.27 of the statutes is repealed.

SECTION 449b. 46.271 (1) (c) of the statutes is amended to read:

46.271 **(1)** (c) The department may contract with an aging unit, as defined in s. ~~46.27~~ 46.82 (1) (a), for administration of services under par. (a) if, by resolution, the county board of supervisors of that county so requests the department.

SECTION 450b. 46.275 (3) (e) of the statutes is repealed.

SECTION 451b. 46.275 (5) (b) 7. of the statutes is amended to read:

46.275 **(5)** (b) 7. Provide services in any community–based residential facility unless the county or department uses as a service contract the approved model contract developed under s. 46.27 (2) (j), 2017 stats., or a contract that includes all of the provisions of the approved model contract.

SECTION 452b. 46.277 (1m) (at) of the statutes is amended to read:

46.277 **(1m)** (at) "Private nonprofit agency" ~~has the meaning specified in s. 46.27 (1) (bm)~~ means a nonprofit corporation, as defined in s. 181.0103 (17), that provides a program of all–inclusive care for the elderly under 42 USC 1395eee or 1396u–4.

SECTION 453b. 46.277 (3) (a) of the statutes is amended to read:

46.277 **(3)** (a) ~~Sections 46.27 (3) (b) and~~ Section 46.275 (3) (a) and (c) to (e) ~~apply~~ applies to county participation in this program, except that services provided in the program shall substitute for care provided a person in a skilled nursing facility or intermediate care facility who meets the level of care requirements for medical assistance reimbursement to that facility rather than for care provided at a state center for the developmentally disabled. The number of persons who receive services

provided by the program under this paragraph may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

SECTION 454b. 46.277 (5) (d) 2. (intro.) and b. of the statutes are consolidated, renumbered 46.277 (5) (d) 2. and amended to read:

46.277 **(5)** (d) 2. No county may use funds received under this section to provide residential services in any community–based residential facility, as defined in s. 50.01 (1g), unless ~~one of the following applies: b. The~~ the department approves the provision of services in a community–based residential facility that entirely consists of independent apartments, each of which has an individual lockable entrance and exit and individual separate kitchen, bathroom, sleeping and living areas, to individuals who are eligible under this section and are physically disabled or are at least 65 years of age.

SECTION 455b. 46.277 (5) (d) 2. a. of the statutes is repealed.

SECTION 456b. 46.277 (5) (d) 3. of the statutes is amended to read:

46.277 **(5)** (d) 3. If subd. 2. ~~a. or b.~~ applies, no county may use funds received under this section to pay for services provided to a person who resides or intends to reside in a community–based residential facility and who is initially applying for the services, if the projected cost of services for the person, plus the cost of services for existing participants, would cause the county to exceed the limitation under sub. (3) (c). The department may grant an exception to the requirement under this subdivision, under the conditions specified by rule, to avoid hardship to the person.

SECTION 457b. 46.277 (5) (f) of the statutes is amended to read:

46.277 **(5)** (f) No county or private nonprofit agency may use funds received under this subsection to provide services in any community–based residential

facility unless the county or agency uses as a service contract the approved model contract developed under s. 46.27 (2) (j), 2017 stats., or a contract that includes all of the provisions of the approved model contract.

SECTION 458b. 46.278 (4) (a) of the statutes is amended to read:

46.278 **(4)** (a) ~~Sections 46.27 (3) (b) and~~ Section 46.275 (3) (a) and (c) to (e) ~~apply~~ applies to county participation in a program, except that services provided in the program shall substitute for care provided a person in an intermediate care facility for persons with an intellectual disability or in a brain injury rehabilitation facility who meets the intermediate care facility for persons with an intellectual disability or brain injury rehabilitation facility level of care requirements for medical assistance reimbursement to that facility rather than for care provided at a state center for the developmentally disabled.

SECTION 459b. 46.2803 of the statutes is repealed.

SECTION 460b. 46.2805 (1) (b) of the statutes is amended to read:

46.2805 **(1)** (b) A demonstration program known as the ~~Wisconsin partnership~~ Family Care Partnership program under a federal waiver authorized under 42 USC ~~1315~~ 1396n.

SECTION 461b. 46.281 (1d) of the statutes is amended to read:

46.281 **(1d)** WAIVER REQUEST. The department shall request from the secretary of the federal department of health and human services any waivers of federal medicaid laws necessary to permit the use of federal moneys to provide the family care benefit and the self-directed services option to recipients of medical assistance. The department shall implement any waiver that is approved and that is consistent with ss. 46.2805 to 46.2895. Regardless of whether a waiver is approved, the

department may implement operation of resource centers, care management organizations, and the family care benefit.

SECTION 462b. 46.281 (1n) (d) of the statutes is repealed.

SECTION 463b. 46.281 (3) of the statutes is repealed.

SECTION 464b. 46.2825 of the statutes is repealed.

SECTION 465b. 46.283 (3) (f) of the statutes is amended to read:

46.283 **(3)** (f) Assistance to a person ~~who is eligible for the family care benefit~~ with respect to the person's choice of whether or not to enroll in the self–directed services option, as defined in s. 46.2899 (1), a care management organization for the family care benefit or the Family Care Partnership program, or the program of all–inclusive care for the elderly and, if so, which available long–term care program or care management organization would best meet his or her needs.

SECTION 466b. 46.283 (4) (e) of the statutes is repealed.

SECTION 467b. 46.283 (4) (f) of the statutes is amended to read:

46.283 **(4)** (f) Perform a functional screening and a financial and cost–sharing screening for any resident~~, as specified in par. (e),~~ who requests a screening and assist any resident who is eligible and chooses to enroll in a care management organization or the self–directed services option to do so.

SECTION 468b. 46.283 (6) (b) 7. of the statutes is repealed.

SECTION 469b. 46.283 (6) (b) 9. of the statutes is amended to read:

46.283 **(6)** (b) 9. Review the number and types of grievances and appeals ~~concerning the long–term care system in the area served by~~ related to the resource center~~,~~ to determine if a need exists for system changes~~,~~ and recommend system or other changes if appropriate.

SECTION 470b. 46.283 (6) (b) 10. of the statutes is repealed.

SECTION 471b. 46.285 (intro.) of the statutes is renumbered 46.285 and amended to read:

46.285 Operation of resource center and care management organization. In order to meet federal requirements and assure federal financial participation in funding of the family care benefit, a county, a tribe or band, a long–term care district or an organization, including a private, nonprofit corporation, may not directly operate both a resource center and a care management organization~~, except as follows:~~.

SECTION 472b. 46.285 (1) of the statutes is repealed.

SECTION 473b. 46.285 (2) of the statutes is repealed.

SECTION 474b. 46.286 (3) (b) 2. a. of the statutes is repealed.

SECTION 475b. 46.287 (2) (a) 1. (intro.) of the statutes is amended to read:

46.287 **(2)** (a) 1. (intro.) Except as provided in subd. 2., a client may contest any of the following applicable matters by filing, within 45 days of the failure of a resource center or ~~care management organization~~ county to act on the contested matter within the time frames specified by rule by the department or within 45 days after receipt of notice of a decision in a contested matter, a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1):

SECTION 476b. 46.287 (2) (a) 1. d. of the statutes is renumbered 46.287 (2) (a) 1m. b.

SECTION 477b. 46.287 (2) (a) 1. e. of the statutes is repealed.

SECTION 478b. 46.287 (2) (a) 1. f. of the statutes is repealed.

SECTION 479b. 46.287 (2) (a) 1m. of the statutes is created to read:

46.287 **(2)** (a) 1m. Except as provided in subd. 2., a client may contest any of the following adverse benefit determinations by filing, within 90 days of the failure

of a care management organization to act on a contested adverse benefit determination within the time frames specified by rule by the department or within 90 days after receipt of notice of a decision upholding the adverse benefit determination, a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1):

a. Denial of functional eligibility under s. 46.286 (1) as a result of the care management organization's administration of the long–term care functional screen, including a change from a nursing home level of care to a non–nursing home level of care.

c. Denial or limited authorization of a requested service, including determinations based on type or level of service, requirements or medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

d. Reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

e. Denial, in whole or in part, of payment for a service.

f. The failure of a care management organization to act within the time frames provided in 42 CFR 438.408 (b) (1) and (2) regarding the standard resolution of grievances and appeals.

g. Denial of an enrollee's request to dispute financial liability, including copayments, premiums, deductibles, coinsurance, other cost sharing, and other member financial liabilities.

h. Denial of an enrollee, who is a resident of a rural area with only one care management organization, to obtain services outside the care management organization's network of contracted providers.

i. Development of a plan of care that is unacceptable to the enrollee because the plan of care requires the enrollee to live in a place that is unacceptable to the enrollee; the plan of care does not provide sufficient care, treatment, or support to meet the enrollee's needs and support the enrollee's identified outcomes; or the plan of care requires the enrollee to accept care, treatment, or support that is unnecessarily restrictive or unwanted by the enrollee.

j. Involuntary disenrollment from the care management organization.

SECTION 480b. 46.287 (2) (b) of the statutes is amended to read:

46.287 **(2)** (b) An enrollee may contest a decision, omission or action of a care management organization other than those specified in par. (a)~~, or may contest the choice of service provider. In these instances, the enrollee shall first send a written request for review by the unit of the department that monitors care management organization contracts. This unit shall review and attempt to resolve the dispute.~~ 1m. by filing a grievance with the care management organization. If the ~~dispute~~ grievance is not resolved to the satisfaction of the enrollee, he or she may request ~~a hearing under the procedures specified in par. (a) 1. (intro.)~~ that the department review the decision of the care management organization.

SECTION 481b. 46.288 (2) (intro.) of the statutes is renumbered 46.288 (2) and amended to read:

46.288 **(2)** Criteria and procedures for determining functional eligibility under s. 46.286 (1) (a), financial eligibility under s. 46.286 (1) (b), and cost sharing under s. 46.286 (2) (a). ~~The rules for determining functional eligibility under s. 46.286 (1) (a) 1m. shall be substantially similar to eligibility criteria for receipt of the long–term support community options program under s. 46.27. Rules under this subsection shall include definitions of the following terms applicable to s. 46.286:~~

SECTION 482b. 46.288 (2) (d) to (j) of the statutes are repealed.

SECTION 483b. 46.2896 (1) (a) of the statutes is amended to read:

46.2896 **(1)** (a) "Long–term care program" means the long–term care program under s. ~~46.27,~~ 46.275, 46.277, 46.278, or 46.2785; the family care program providing the benefit under s. 46.286; the Family Care Partnership program; or the long–term care program defined in s. 46.2899 (1).".

67. Page 304, line 10: delete lines 10 to 18 and substitute:

"**SECTION 484p.** 46.536 of the statutes is amended to read:

46.536 ~~Mobile crisis team~~ Crisis program enhancement grants. From the appropriation under s. 20.435 (5) (cf), the department shall award grants in the total amount of $250,000 in each fiscal biennium to counties or regions comprised of multiple counties to establish ~~certified~~ or enhance crisis programs ~~that create mental health mobile crisis teams~~ to serve individuals having ~~mental health~~ crises in rural areas. The department shall award a grant under this section in an amount equal to one–half the amount of money the county or region provides to establish ~~certified~~ or enhance crisis programs ~~that create mobile crisis teams~~.".

68. Page 304, line 19: after that line insert:

"**SECTION 485m.** 46.854 of the statutes is created to read:

46.854 Healthy aging grant program. From the appropriation under s. 20.435 (1) (bk), the department shall award in each fiscal year a grant of $250,000 to an entity that conducts programs in healthy aging.

SECTION 485w. 46.995 (4) of the statutes is created to read:

46.995 **(4)** The department shall ensure that any child who is eligible and who applies for the disabled children's long–term support program that is operating

under a waiver of federal law receives services under the disabled children's long–term support program that is operating under a waiver of federal law.".

69. Page 346, line 3: delete lines 3 to 5 and substitute:

"(u) *Prevention services.* For services to prevent child abuse or neglect, ~~$5,289,600 in each fiscal year~~ $6,302,100 in fiscal year 2019–20 and $7,464,600 in fiscal year 2020–21.".

70. Page 348, line 15: after that line insert:

"**SECTION 652c.** 49.45 (2p) of the statutes is repealed.

SECTION 653t. 49.45 (2t) of the statutes is repealed.".

71. Page 348, line 21: after that line insert:

"**SECTION 654f.** 49.45 (3) (e) 11. of the statutes is amended to read:

49.45 **(3)** (e) 11. The department shall use a portion of the moneys collected under s. 50.38 (2) (a) to pay for services provided by eligible hospitals, as defined in s. 50.38 (1), other than critical access hospitals, under the Medical Assistance Program under this subchapter, including services reimbursed on a fee–for–service basis and services provided under a managed care system. For state fiscal year 2008–09, total payments required under this subdivision, including both the federal and state share of Medical Assistance, shall equal the amount collected under s. 50.38 (2) (a) for fiscal year 2008–09 divided by 57.75 percent. For each state fiscal year after state fiscal year 2008–09, total payments required under this subdivision, including both the federal and state share of Medical Assistance, shall equal the amount collected under s. 50.38 (2) (a) for the fiscal year divided by ~~61.68~~ 53.69 percent.

SECTION 654h. 49.45 (3) (e) 12. of the statutes is amended to read:

49.45 **(3)** (e) 12. The department shall use a portion of the moneys collected under s. 50.38 (2) (b) to pay for services provided by critical access hospitals under the Medical Assistance Program under this subchapter, including services reimbursed on a fee–for–service basis and services provided under a managed care system. For each state fiscal year, total payments required under this subdivision, including both the federal and state share of Medical Assistance, shall equal the amount collected under s. 50.38 (2) (b) for the fiscal year divided by ~~61.68~~ 53.69 percent.

SECTION 657b. 49.45 (3m) (a) (intro.) of the statutes is amended to read:

49.45 **(3m)** (a) (intro.) Subject to par. (c) and notwithstanding sub. (3) (e), from the appropriations under s. 20.435 (4) (b) and (o), in each fiscal year, the department shall pay to hospitals that serve a disproportionate share of low–income patients an amount equal to the sum of ~~$27,500,000~~ $56,500,000, as the state share of payments, and the matching federal share of payments. The department may make a payment to a hospital under this subsection under the calculation method described in par. (b) if the hospital meets all of the following criteria:

SECTION 658b. 49.45 (3m) (b) 3. a. of the statutes is amended to read:

49.45 **(3m)** (b) 3. a. No single hospital receives more than ~~$4,600,000~~ $9,200,000, except that a hospital that is a free–standing pediatric teaching hospital located in Wisconsin that has a percentage calculated under subd. 1. a. greater than 50 percent may receive up to $12,000,000 each fiscal year.".

72. Page 348, line 23: delete the material beginning with that line and ending with page 349, line 11, and substitute:

"49.45 **(3p)** (a) Subject to par. (c) and notwithstanding sub. (3) (e), from the appropriations under s. 20.435 (4) (b) and (o), in each fiscal year, the department shall pay to hospitals that ~~would~~ are not eligible for payments under sub. (3m) but that meet the criteria under sub. (3m) (a) ~~except that the hospitals do not provide obstetric services~~ 1. and 2. and that, in the most recent year for which information is available, charged at least 6 percent of overall charges for services to the Medical Assistance program for services provided to Medical Assistance recipients an amount equal to the sum of ~~$250,000~~ $500,000, as the state share of payments, and the matching federal share of payments. The department may make a payment to a hospital under this subsection under a calculation method determined by the department that provides a fee–for–service supplemental payment that increases as the ~~hospital's~~ percentage of ~~inpatient days for Medical Assistance recipients at the hospital~~ the total amount of the hospital's overall charges for services that are charges to the Medical Assistance program increases.".

73. Page 349, line 12: delete the material beginning with that line and ending with page 351, line 15, and substitute:

"**SECTION 660b.** 49.45 (5) (a) of the statutes is amended to read:

49.45 **(5)** (a) Any person whose application for medical assistance is denied or is not acted upon promptly or who believes that the payments made in the person's behalf have not been properly determined or that his or her eligibility has not been properly determined may file an appeal with the department pursuant to par. (b). Review is unavailable if the decision or failure to act arose more than 45 days before submission of the petition for a hearing, except as provided in par. (ag) or (ar).

SECTION 661b. 49.45 (5) (ag) of the statutes is created to read:

49.45 **(5)** (ag) A person shall request a hearing within 90 days of the date of receipt of a notice from a care management organization or managed care organization upholding its adverse benefit determination relating to any of the following or within 90 days of the date the care management organization or managed care organization failed to act on the contested matter within the time specified by the department:

1. Denial or limited authorization of a requested services, including a determination based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

2. Reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

3. Denial, in whole or in part, of payment for a service.

4. Failure to provide services in a timely manner.

5. Failure of a care management organization or managed care organization to act within the time frames provided in 42 CFR 438.408 (b) (1) and (2) regarding the standard resolution of grievances and appeals.

6. Denial of an enrollee's request to dispute financial liability, including copayments, premiums, deductibles, coinsurance, other cost sharing, and other member financial liabilities.

7. Denial of an enrollee, who is a resident of a rural area with only one care management organization or managed care organization, to obtain services outside the organization's network of contracted providers.

SECTION 662b. 49.45 (5) (ar) of the statutes is created to read:

49.45 **(5)** (ar) If a federal regulation specifies a different time limit to request a hearing than par. (a) or (ag), the time limit in the federal regulation shall apply.

Section 663b. 49.45 (5) (b) 1. (intro.) of the statutes is amended to read:

49.45 **(5)** (b) 1. (intro.) Upon receipt of a timely petition under par. (a) the department shall give the applicant or recipient reasonable notice and opportunity for a fair hearing. The department may make such additional investigation as it considers necessary. Notice of the hearing shall be given to the applicant or recipient and, if a county department under s. 46.215, 46.22, or 46.23 is responsible for making the medical assistance determination, to the county clerk of the county. The county may be represented at such hearing. The department shall render its decision as soon as possible after the hearing and shall send a ~~certified~~ copy of its decision to the applicant or recipient, to the county clerk, and to any county officer charged with administration of the Medical Assistance program. The decision of the department shall have the same effect as an order of a county officer charged with the administration of the Medical Assistance program. The decision shall be final, but may be revoked or modified as altered conditions may require. The department shall deny a petition for a hearing or shall refuse to grant relief if:

Section 664b. 49.45 (5) (b) 1. d. of the statutes is created to read:

49.45 **(5)** (b) 1. d. The issue is an adverse benefit determination described in par. (ag) 1. to 7. made by a care management organization or managed care organization and the person requesting the hearing has not exhausted the internal appeal procedure with the organization.".

74. Page 352, line 22: after that line insert:

"**Section 667b.** 49.45 (6xm) of the statutes is created to read:

49.45 **(6xm)** PEDIATRIC INPATIENT SUPPLEMENT. (a) From the appropriations under s. 20.435 (4) (b), (o), and (w), the department shall, using a method determined by the department, distribute a total sum of $2,000,000 each state fiscal year to hospitals that meet all of the following criteria:

1. The hospital is an acute care hospital located in this state.

2. During the hospital's fiscal year, the inpatient days in the hospital's acute care pediatric units and intensive care pediatric units totaled more than 12,000 days, not including neonatal intensive care units. For purposes of this subsection, the hospital's fiscal year is the hospital's fiscal year that ended in the 2nd calendar year preceding the beginning of the state fiscal year.

(b) Notwithstanding par. (a), from the appropriations under s. 20.435 (4) (b), (o), and (w), the department may, using a method determined by the department, distribute an additional total sum of $10,000,000 in each state fiscal year to hospitals that are free–standing pediatric teaching hospitals located in Wisconsin that have a percentage calculated under s. 49.45 (3m) (b) 1. a. greater than 45 percent.

SECTION 668h. 49.45 (19) (title) of the statutes is amended to read:

49.45 **(19)** (title) ~~ASSIGNING~~ ESTABLISHING PATERNITY AND ASSIGNING MEDICAL SUPPORT RIGHTS.

SECTION 669m. 49.45 (19) (a) of the statutes is amended to read:

49.45 **(19)** (a) ~~As~~ Except as provided in par. (c), as a condition of eligibility for medical assistance, a person shall, notwithstanding other provisions of the statutes, be deemed to have assigned to the state, by applying for or receiving medical assistance, any rights to medical support or other payment of medical expenses from any other person, including rights to unpaid amounts accrued at the time of

application for medical assistance as well as any rights to support accruing during the time for which medical assistance is paid.

SECTION 670h. 49.45 (19) (am) of the statutes is created to read:

49.45 **(19)** (am) As a condition of eligibility for medical assistance, a person shall cooperate in good faith with efforts directed at establishing the paternity of a nonmarital child and obtaining support payments or any other payments or property to which the person and the dependent child or children may have rights. This cooperation shall be in accordance with federal law and regulations applying to paternity establishment and collection of support payments and may not be required if the person has good cause for refusing to cooperate, as determined by the department in accordance with federal law and regulations.

SECTION 671m. 49.45 (19) (c) of the statutes is amended to read:

49.45 **(19)** (c) ~~If the mother of a child was enrolled in a health maintenance organization or other prepaid health care plan under medical assistance at the time of the child's birth,~~ The state may not seek recovery of birth expenses ~~that may be recovered by the state under this subsection are the birth expenses incurred by the health maintenance organization or other prepaid health care plan~~.

SECTION 672c. 49.45 (23) of the statutes is repealed.

SECTION 673g. 49.45 (23) (g) of the statutes is repealed.

SECTION 674g. 49.45 (23b) of the statutes is repealed.

SECTION 676m. 49.45 (24L) of the statutes is created to read:

49.45 **(24L)** CRITICAL ACCESS REIMBURSEMENT PAYMENTS TO DENTAL PROVIDERS. (a) Based on the criteria in pars. (b) and (c), the department shall increase reimbursements to dental providers that meet quality of care standards, as established by the department.

(b) In order to be eligible for enhanced reimbursement under this subsection, the provider must meet one of the following qualifications:

1. For a nonprofit or public provider, 50 percent or more of the individuals served by the provider are individuals who are without dental insurance or are enrolled in the Medical Assistance program.

2. For a for–profit provider, 5 percent or more of the individuals served by the provider are enrolled in the Medical Assistance program.

(c) For dental services rendered on or after January 1, 2020, by a qualified nonprofit critical access dental provider, the department shall increase reimbursement by 50 percent above the reimbursement rate that would otherwise be paid to that provider. For dental services rendered on or after January 1, 2020, by a qualified for–profit critical access dental provider, the department shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to that provider. For dental providers rendering services to individuals in managed care under the Medical Assistance program, for services rendered on or after January 1, 2020, the department shall increase reimbursement to pay an additional amount on the basis of the rate that would have been paid to the dental provider had the individual not been enrolled in managed care.

(d) If a provider has more than one service location, the thresholds described under par. (b) apply to each location, and payment for each service location would be determined separately.".

75. Page 352, line 24: delete the material beginning with that line and ending with page 353, line 8, and substitute:

"49.45 **(29w)** (b) 1. b. "Telehealth" ~~is~~ means a service provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between an individual or a provider at an originating site and a provider at a remote location with the service being of sufficient audio and visual fidelity and clarity as to be functionally equivalent to face–to–face contact; or, in circumstances determined by the department, an asynchronous transmission of digital clinical information through a secure electronic communications system from one provider to another provider. "Telehealth" does not include telephone conversations or Internet–based communications between providers or between providers and individuals.".

76. Page 353, line 9: delete that line and substitute:

"**SECTION 678b.** 49.45 (29y) (d) of the statutes is repealed.

SECTION 679p. 49.45 (30y) of the statutes is created to read:

49.45 **(30y)** CERTIFIED DOULA SERVICES; PILOT PROJECT. (a) In this subsection, "certified doula" means an individual who has received certification from a doula certifying organization recognized by the department.

(b) For purposes of this subsection, services provided by certified doulas include continuous emotional and physical support during labor and birth of a child and intermittent services during the prenatal and postpartum periods.

(c) Subject to par. (d), the department shall reimburse under the Medical Assistance program benefits as provided under this subsection for pregnant women enrolled in the Medical Assistance program who reside in the counties of Brown, Dane, Milwaukee, Rock, or Sheboygan, or another county as determined by the department.

(d) The department shall request from the secretary of the federal department of health and human services any approval necessary to allow reimbursement under the Medical Assistance program for services provided by a certified doula. The department may not pay reimbursement unless federal approval is not required or any required federal approval allowing reimbursement under s. 49.46 (2) (b) 12p. is approved and in effect.".

77. Page 353, line 11: delete the material beginning with that line and ending with page 354, line 17, and substitute:

"49.45 **(41)** ~~MENTAL HEALTH CRISIS~~ CRISIS INTERVENTION SERVICES. (a) In this subsection, "~~mental health~~ crisis intervention services" means crisis intervention services for the treatment of mental illness, intellectual disability, substance abuse, and dementia that are provided by a ~~mental health~~ crisis intervention program operated by, or under contract with, a county, if the county is certified as a medical assistance provider.

(b) If a county elects to become certified as a provider of ~~mental health~~ crisis intervention services, the county may provide ~~mental health~~ crisis intervention services under this subsection in the county to medical assistance recipients through the medical assistance program. A county that elects to provide the services shall pay the amount of the allowable charges for the services under the medical assistance program that is not provided by the federal government. The department shall reimburse the county under this subsection only for the amount of the allowable charges for those services under the medical assistance program that is provided by the federal government.

SECTION 681b. 49.45 (41) (c) of the statutes is created to read:

49.45 **(41)** (c) Notwithstanding par. (b), if a county elects to deliver crisis intervention services under the Medical Assistance program on a regional basis according to criteria established by the department, all of the following apply:

1. After January 1, 2020, the department shall require the county to annually contribute for the crisis intervention services an amount equal to 75 percent of the county's expenditures for crisis intervention services under this subsection in calendar year 2017, as determined by the department.

2. The department shall reimburse the provider of crisis intervention services in the county the amount of allowable charges for those services under the Medical Assistance program, including both the federal share and nonfederal share of those charges, that exceeds the amount of the county contribution required under subd. 1.

3. If a county submits a certified cost report under s. 49.45 (52) (b) to claim federal medical assistance funds, the claim based on certified costs made by a county for amounts under subd. 2. may not include any part of the nonfederal share of the amount under subd. 2.".

78. Page 354, line 23: delete the material beginning with that line and ending with page 355, line 6, and substitute:

"**SECTION 683b.** 49.45 (47) (dm) of the statutes is created to read:

49.45 **(47)** (dm) Every 24 months, on a schedule determined by the department, an adult day care center shall submit through an online system prescribed by the department a report in the form and containing the information that the department requires, including payment of any fee due under par. (c). If a complete report is not timely filed, the department shall issue a warning to the operator of the adult day care center. The department may revoke an adult day care center's certification for

failure to timely and completely report within 60 days after the report date established under the schedule determined by the department.".

79. Page 355, line 6: after that line insert:

"**SECTION 685b.** 49.46 (1) (a) 1m. of the statutes is amended to read:

49.46 **(1)** (a) 1m. Any pregnant woman whose income does not exceed the standard of need under s. 49.19 (11) and whose pregnancy is medically verified. Eligibility continues to the last day of the month in which the 60th day or, if approved by the federal government, the 365th day after the last day of the pregnancy falls.".

80. Page 355, line 21: after that line insert:

"**SECTION 688b.** 49.46 (1) (j) of the statutes is amended to read:

49.46 **(1)** (j) An individual determined to be eligible for benefits under par. (a) 9. remains eligible for benefits under par. (a) 9. for the balance of the pregnancy and to the last day of the month in which the 60th day or, if approved by the federal government, the 365th day after the last day of the pregnancy falls without regard to any change in the individual's family income.".

81. Page 356, line 2: after that line insert:

"**SECTION 690p.** 49.46 (2) (b) 12p. of the statutes is created to read:

49.46 **(2)** (b) 12p. Subject to the limitations under s. 49.45 (30y), services provided by a certified doula.".

82. Page 356, line 4: delete lines 4 and 5 and substitute:

"49.46 **(2)** (b) 15. ~~Mental health crisis~~ Crisis intervention services under s. 49.45 (41).".

83. Page 356, line 5: after that line insert:

"**SECTION 691d.** 49.46 (2) (b) 21. of the statutes is created to read:

49.46 **(2)** (b) 21. Subject to par. (bv), nonmedical services that contribute to the determinants of health.

SECTION 691g. 49.46 (2) (bv) of the statutes is created to read:

49.46 **(2)** (bv) The department shall determine those services under par. (b) 21. that contribute to the determinants of health. The department shall seek any necessary state plan amendment or request any waiver of federal Medicaid law to implement this paragraph. The department is not required to provided the services under this paragraph as a benefit under the Medical Assistance program if the federal department of health and human services does not provide federal financial participation for the services under this paragraph.

SECTION 694h. 49.463 of the statutes is repealed.

SECTION 695b. 49.47 (4) (ag) 2. of the statutes is amended to read:

49.47 **(4)** (ag) 2. Pregnant and the woman's pregnancy is medically verified Eligibility continues to the last day of the month in which the 60th day or, if approved by the federal government, the 365th day after the last day of the pregnancy falls.".

84. Page 356, line 23: after that line insert:

"**SECTION 699c.** 49.471 (1) (cr) of the statutes is created to read:

49.471 **(1)** (cr) "Enhanced federal medical assistance percentage" means a federal medical assistance percentage described under 42 USC 1396d (y) or (z).

SECTION 700c. 49.471 (4) (a) 4. b. of the statutes is amended to read:

49.471 **(4)** (a) 4. b. The individual's family income does not exceed ~~100~~ 133 percent of the poverty line ~~before application of the 5 percent income disregard under 42 CFR 435.603 (d)~~.

SECTION 701c. 49.471 (4) (a) 8. of the statutes is created to read:

49.471 **(4)** (a) 8. An individual who meets all of the following criteria:

a. The individual is an adult under the age of 65.

b. The adult has a family income that does not exceed 133 percent of the poverty line, except as provided in sub. (4g).

c. The adult is not otherwise eligible for the Medical Assistance program under this subchapter or the Medicare program under 42 USC 1395 et seq.

SECTION 702c. 49.471 (4g) of the statutes is created to read:

49.471 **(4g)** MEDICAID EXPANSION; FEDERAL MEDICAL ASSISTANCE PERCENTAGE. For services provided to individuals described under sub. (4) (a) 8., the department shall comply with all federal requirements to qualify for the highest available enhanced federal medical assistance percentage. The department shall submit any amendment to the state medical assistance plan, request for a waiver of federal Medicaid law, or other approval request required by the federal government to provide services to the individuals described under sub. (4) (a) 8. and qualify for the highest available enhanced federal medical assistance percentage.

SECTION 703b. 49.471 (6) (b) of the statutes is amended to read:

49.471 **(6)** (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 or, if approved by the federal government, the 365th day after the last day of the pregnancy falls without regard to any change in the woman's family income.

SECTION 704b. 49.471 (6) (L) of the statutes is created to read:

49.471 **(6)** (L) The department shall request from the federal department of health and human services approval of a state plan amendment, a waiver of federal Medicaid law, or approval of a demonstration project to maintain eligibility for

post–partum women to the last day of the month in which the 365th day after the last day of the pregnancy falls under ss. 49.46 (1) (a) 1m. and 9. and (j), 49.47 (4) (ag) 2., and 49.471 (4) (a) 1g. and 1m., (6) (b), and (7) (b) 1.

SECTION 705b. 49.471 (7) (b) 1. of the statutes is amended to read:

49.471 **(7)** (b) 1. A pregnant woman 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 family income and the applicable income limit under sub. (4) (a) is obligated or expended for any member of the pregnant woman'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 to the last day of the month in which the 60th day or, if approved by the federal government, the 365th 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.".

85. Page 357, line 18: after that line insert:

"**SECTION 711c.** 49.686 (3) (d) of the statutes is amended to read:

49.686 **(3)** (d) Has applied for coverage under and has been denied eligibility for medical assistance within 12 months prior to application for reimbursement under sub. (2). This paragraph does not apply to an individual who is eligible for benefits under ~~the demonstration project for childless adults under s. 49.45 (23)~~ BadgerCare Plus under s. 49.471 (4) (a) 8. or to an individual who is eligible for benefits under BadgerCare Plus under s. 49.471 (11).".

86. Page 358, line 10: after that line insert:

"**SECTION 726m.** 49.855 (3) of the statutes is amended to read:

49.855 **(3)** Receipt of a certification by the department of revenue shall constitute a lien, equal to the amount certified, on any state tax refunds or credits owed to the obligor. The lien shall be foreclosed by the department of revenue as a setoff under s. 71.93 (3), (6), and (7). When the department of revenue determines that the obligor is otherwise entitled to a state tax refund or credit, it shall notify the obligor that the state intends to reduce any state tax refund or credit due the obligor by the amount the obligor is delinquent under the support, maintenance, or receiving and disbursing fee order or obligation, by the outstanding amount for past support~~,~~ or medical expenses~~, or birth expenses~~ under the court order, or by the amount due under s. 46.10 (4), 49.345 (4), or 301.12 (4). The notice shall provide that within 20 days the obligor may request a hearing before the circuit court rendering the order under which the obligation arose. Within 10 days after receiving a request for hearing under this subsection, the court shall set the matter for hearing. Pending further order by the court or a circuit court commissioner, the department of children and families or its designee, whichever is appropriate, is prohibited from disbursing the obligor's state tax refund or credit. A circuit court commissioner may conduct the hearing. The sole issues at that hearing shall be whether the obligor owes the amount certified and, if not and it is a support or maintenance order, whether the money withheld from a tax refund or credit shall be paid to the obligor or held for future support or maintenance, except that the obligor's ability to pay shall also be an issue at the hearing if the obligation relates to an order ~~under s. 767.805 (4) (d) 1. or 767.89 (3) (e) 1.~~ regarding birth expenses and the order specifies that the court found that the obligor's income was at or below the poverty line established under 42 USC 9902 (2).

SECTION 727m. 49.855 (4m) (b) of the statutes is amended to read:

49.855 **(4m)** (b) The department of revenue may provide a certification that it receives under sub. (1), (2m), (2p), or (2r) to the department of administration. Upon receipt of the certification, the department of administration shall determine whether the obligor is a vendor or is receiving any other payments from this state, except for wages, retirement benefits, or assistance under s. 45.352, 1971 stats., s. 45.40 (1m), this chapter, or ch. 46, 108, or 301. If the department of administration determines that the obligor is a vendor or is receiving payments from this state, except for wages, retirement benefits, or assistance under s. 45.352, 1971 stats., s. 45.40 (1m), this chapter, or ch. 46, 108, or 301, it shall begin to withhold the amount certified from those payments and shall notify the obligor that the state intends to reduce any payments due the obligor by the amount the obligor is delinquent under the support, maintenance, or receiving and disbursing fee order or obligation, by the outstanding amount for past support~~,~~ or medical expenses~~, or birth expenses~~ under the court order, or by the amount due under s. 46.10 (4), 49.345 (4), or 301.12 (4). The notice shall provide that within 20 days after receipt of the notice the obligor may request a hearing before the circuit court rendering the order under which the obligation arose. An obligor may, within 20 days after receiving notice, request a hearing under this paragraph. Within 10 days after receiving a request for hearing under this paragraph, the court shall set the matter for hearing. A circuit court commissioner may conduct the hearing. Pending further order by the court or circuit court commissioner, the department of children and families or its designee, whichever is appropriate, may not disburse the payments withheld from the obligor. The sole issues at the hearing are whether the obligor owes the amount certified and, if not and it is a support or maintenance order, whether the money withheld shall be

paid to the obligor or held for future support or maintenance, except that the obligor's ability to pay is also an issue at the hearing if the obligation relates to an order ~~under s. 767.805 (4) (d) 1. or 767.89 (3) (e) 1.~~ regarding birth expenses and the order specifies that the court found that the obligor's income was at or below the poverty line established under 42 USC 9902 (2).".

87. Page 358, line 11: delete the material beginning with that line and ending with page 359, line 11, and substitute:

"**SECTION 728b.** 50.03 (3) (b) (intro.) of the statutes is amended to read:

50.03 **(3)** (b) (intro.) The application for a license and, except as otherwise provided in this subchapter, the report of a licensee shall be in writing upon forms provided by the department and shall contain such information as the department requires, including the name, address and type and extent of interest of each of the following persons:

SECTION 729b. 50.03 (4) (c) 1. of the statutes is amended to read:

50.03 **(4)** (c) 1. A community–based residential facility license is valid until it is revoked or suspended under this section. Every 24 months, on a schedule determined by the department, a community–based residential facility licensee shall submit through an online system prescribed by the department a ~~biennial~~ report in the form and containing the information that the department requires, including payment of ~~the fees required~~ any fee due under s. 50.037 (2) (a). If a complete biennial report is not timely filed, the department shall issue a warning to the licensee. The department may revoke a community–based residential facility license for failure to timely and completely report within 60 days after the report date established under the schedule determined by the department.

SECTION 730b. 50.033 (2m) of the statutes is amended to read:

50.033 **(2m)** REPORTING. Every 24 months, on a schedule determined by the department, a licensed adult family home shall submit through an online system prescribed by the department a biennial report in the form and containing the information that the department requires, including payment of ~~the~~ any fee ~~required~~ due under sub. (2). If a complete biennial report is not timely filed, the department shall issue a warning to the licensee. The department may revoke the license for failure to timely and completely report within 60 days after the report date established under the schedule determined by the department.".

88. Page 359, line 22: delete the material beginning with that line and ending with page 360, line 9, and substitute:

"**SECTION 732b.** 50.034 (2m) of the statutes is created to read:

50.034 **(2m)** REPORTING. Every 24 months, on a schedule determined by the department, a residential care apartment complex shall submit through an online system prescribed by the department a report in the form and containing the information that the department requires, including payment of any fee required under sub. (1). If a complete report is not timely filed, the department shall issue a warning to the operator of the residential care apartment complex. The department may revoke a residential care apartment complex's certification or registration for failure to timely and completely report within 60 days after the report date established under the schedule determined by the department.".

89. Page 363, line 8: after that line insert:

"**SECTION 746t.** 51.03 (7) of the statutes is created to read:

51.03 **(7)** From the appropriation under s. 20.435 (5) (dg), the department shall award grants to regional crisis stabilization facilities for adults. The department shall establish criteria for a regional crisis stabilization facility to receive a grant under this subsection.".

90. Page 364, line 14: delete the material beginning with that line and ending with page 365, line 8, and substitute:

"**SECTION 750b.** 51.422 (1) of the statutes is amended to read:

51.422 **(1)** PROGRAM CREATION. The department shall create 2 or 3 new, regional comprehensive opioid treatment programs, and in the 2017–19 fiscal biennium, shall create 2 or 3 additional regional comprehensive opioid and methamphetamine treatment programs, to provide treatment for opioid and opiate addiction and methamphetamine addiction in underserved, high–need areas. The department shall obtain and review proposals for opioid and methamphetamine treatment programs in accordance with its request–for–proposal procedures. ~~A program under this section may not offer methadone treatment.~~

SECTION 751b. 51.422 (2) of the statutes is amended to read:

51.422 **(2)** PROGRAM COMPONENTS. An opioid or methamphetamine treatment program created under this section shall offer an assessment to individuals in need of service to determine what type of treatment is needed. The program shall transition individuals to a certified residential program, if that level of treatment is necessary. The program shall provide counseling, medication–assisted treatment, including ~~both long–acting opioid antagonist and partial agonist~~ medications that have been approved by the federal food and drug administration ~~if~~ for treating opioid addiction, and abstinence–based treatment. The program shall transition

individuals who have completed treatment to county–based or private post–treatment care.".

91. Page 365, line 9: delete lines 9 to 16 and substitute:

"**SECTION 752b.** 51.441 of the statutes is created to read:

51.441 Comprehensive mental health consultation program. The department shall convene a statewide group of interested persons, including at least one representative of the Medical College of Wisconsin, to develop a concept paper, business plan, and standards for a comprehensive mental health consultation program that incorporates general psychiatry, geriatric psychiatry, addiction medicine and psychiatry, a perinatal psychiatry consultation program, and the child psychiatry consultation program under s. 51.442.".

92. Page 369, line 19: after that line insert:

"**SECTION 775i.** 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1) and (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).".

93. Page 418, line 7: after that line insert:

"**SECTION 1686i.** 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1) and (10) (a) 2. and (b)

2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).".

94. Page 427, line 19: delete the material beginning with that line and ending with page 428, line 18, and substitute:

"**SECTION 1764b.** 146.63 (2) (a) of the statutes is amended to read:

146.63 **(2)** (a) Subject to subs. (4) and (5), the department shall distribute grants from the appropriation under s. 20.435 ~~(1) (fj)~~ (4) (bf) to assist rural hospitals and groups of rural hospitals in procuring infrastructure and increasing case volume to the extent necessary to develop accredited graduate medical training programs. The department shall distribute the grants under this paragraph to rural hospitals and groups of rural hospitals that apply to receive a grant under sub. (3) and that satisfy the criteria established by the department under par. (b) and the eligibility requirement under sub. (6).

SECTION 1765b. 146.63 (6) (intro.) of the statutes is amended to read:

146.63 **(6)** ELIGIBILITY. (intro.) A rural hospital or group of rural hospitals may only receive a grant under sub. (3) if the plan to use the funds involves developing an accredited graduate medical training program in ~~any of the following specialties~~ a specialty, including any of the following:

SECTION 1766b. 146.64 (2) (c) 1. of the statutes is amended to read:

146.64 **(2)** (c) 1. The department shall distribute funds for grants under par. (a) from the appropriation under s. 20.435 (4) ~~(b)~~ (bf). The department may not distribute more than $225,000 from the appropriation under s. 20.435 (4) ~~(b)~~ (bf) to a particular hospital in a given state fiscal year and may not distribute more than

$75,000 from the appropriation under s. 20.435 (4) ~~(b)~~ (bf) to fund a given position in a graduate medical training program in a given state fiscal year.

SECTION 1767b. 146.64 (4) (intro.) of the statutes is amended to read:

146.64 **(4)** ELIGIBILITY. (intro.) A hospital that has an accredited graduate medical training program in ~~any of the following specialties~~ a specialty, including any of the following, may apply to receive a grant under sub. (3):".

95. Page 430, line 15: after that line insert:

"**SECTION 1801i.** 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.728, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (2) to (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:".

96. Page 433, line 4: after that line insert:

"**SECTION 1891b.** 250.048 of the statutes is created to read:

250.048 Prescription drug importation program. (1) IMPORTATION PROGRAM REQUIREMENTS. The department, in consultation with persons interested in the sale and pricing of prescription drugs and appropriate officials and agencies of the federal government, shall design and implement a prescription drug importation program for the benefit of residents of this state, that generates savings for residents, and that satisfies all of the following:

(a) The department shall designate a state agency to become a licensed wholesale distributor or to contract with a licensed wholesale distributor and shall seek federal certification and approval to import prescription drugs.

(b) The prescription drug importation program under this section shall comply with relevant requirements of 21 USC 384, including safety and cost savings requirements.

(c) The prescription drug importation program under this section shall import prescription drugs from Canadian suppliers regulated under any appropriate Canadian or provincial laws.

(d) The prescription drug importation program under this section shall have a process to sample the purity, chemical composition, and potency of imported prescription drugs.

(e) The prescription drug importation program under this section shall import only those prescription drugs for which importation creates substantial savings for residents of the state and only those prescription drugs that are not brand–name drugs and that have fewer than 4 competitor prescription drugs in the United States.

(f) The department shall ensure that prescription drugs imported under the program under this section are not distributed, dispensed, or sold outside of the state.

(g) The prescription drug importation program under this section shall ensure all of the following:

1. Participation by any pharmacy or health care provider in the program is voluntary.

2. Any pharmacy or health care provider participating in the program has the appropriate license or other credential in this state.

3. Any pharmacy or health care provider participating in the program charges a consumer or health plan the actual acquisition cost of the imported prescription drug that is dispensed.

(h) The prescription drug importation program under this section shall ensure that a payment by a health plan or health insurance policy for a prescription drug imported under the program reimburses no more than the actual acquisition cost of the imported prescription drug that is dispensed.

(i) The prescription drug importation program under this section shall ensure that any health plan or health insurance policy participating in the program does all of the following:

1. Maintains a formulary and claims payment system with current information on prescription drugs imported under the program.

2. Bases cost–sharing amounts for participants or insureds under the plan or policy on no more than the actual acquisition cost of the prescription drug imported under the program that is dispensed to the participant or insured.

3. Demonstrates to the department or a state agency designated by the department how premiums under the policy or plan are affected by savings on prescription drugs imported under the program.

(j) Any wholesale distributor importing prescription drugs under the program under this section shall limit its profit margin to the amount established by the department or a state agency designated by the department.

(k) The prescription drug importation program under this section may not import any generic prescription drug that would violate federal patent laws on branded products in this country.

(L) The prescription drug importation program under this section shall comply to the extent practical and feasible before the prescription drug to be imported comes into possession of the state's wholesale distributor and fully after the prescription drug to be imported is in possession of the state's wholesale distributor with tracking and tracing requirements of 21 USC 360eee to 360eee–1.

(m) The prescription drug importation program under this section shall establish a fee or other approach to finance the program that does not jeopardize significant savings to residents of the state.

(n) The prescription drug importation program under this section shall have an audit function that ensures all of the following:

1. The department has a sound methodology to determine the most cost–effective prescription drugs to include in the importation program under this section.

2. The department has a process in place to select Canadian suppliers that are high quality, high performing, and in full compliance with Canadian laws.

3. Prescription drugs imported under the program are pure, unadulterated, potent, and safe.

4. The prescription drug importation program is complying with the requirements of this subsection.

5. The prescription drug importation program under this section is adequately financed to support administrative functions of the program while generating significant cost savings to residents of the state.

6. The prescription drug importation program under this section does not put residents of the state at a higher risk than if the program did not exist.

7. The prescription drug importation program under this section provides and is projected to continue to provide substantial cost savings to residents of the state.

(2) ANTICOMPETITIVE BEHAVIOR. The department, in consultation with the attorney general, shall identify the potential for and monitor anticompetitive behavior in industries affected by a prescription drug importation program.

(3) APPROVAL OF PROGRAM DESIGN; CERTIFICATION. No later than the first day of the 7th month beginning after the effective date of this subsection .... [LRB inserts date], the department shall submit to the joint committee on finance a report that includes the design of the prescription drug importation program in accordance with this section. The department may not submit the proposed prescription drug importation program to the federal department of health and human services unless the joint committee on finance approves the proposed prescription drug implementation program. Within 14 days of the date of approval by the joint committee on finance of the proposed prescription drug importation program, the department shall submit to the federal department of health and human services a request for certification of the approved prescription drug importation program.

(4) IMPLEMENTATION OF CERTIFIED PROGRAM. After the federal department of health and human services certifies the prescription drug importation program submitted under sub. (3), the department shall begin implementation of the program and the program shall be fully operational by 180 days after the date of certification by the federal department of health and human services. The department shall do all of the following to implement the prescription drug importation program to the extent the action is in accordance with other state laws and the certification by the federal department of health and human services:

(a) Become a licensed wholesale distributor, designate another state agency to become a licensed wholesale distributor, or contract with a licensed wholesale distributor.

(b) Contract with one or more Canadian suppliers that meet the criteria in sub. (1) (c).

(c) Create an outreach and marketing plan to communicate with and provide information to health plans and health insurance policies, employers, pharmacies, health care providers, and residents of the state on participating in the prescription drug importation program.

(d) Develop and implement a registration process for health plans and health insurance policies, pharmacies, and health care providers interested in participating in the prescription drug importation program.

(e) Create a publicly accessible source for listing prices of prescription drugs imported under the program.

(f) Create, publicize, and implement a method of communication to promptly answer questions from and address the needs of persons affected by the implementation of the program before the program is fully operational.

(g) Establish the audit functions under sub. (1) (n) with a timeline to complete each audit function every 2 years.

(h) Conduct any other activities determined by the department to be important to successful implementation of the prescription drug importation program under this section.

(5) REPORT. By January 1 and July 1 of each year, the department shall submit to the joint committee on finance a report including all of the following:

(a) A list of prescription drugs included in the importation program under this section.

(b) The number of pharmacies, health care providers, and health plans and health insurance policies participating in the prescription drug importation program under this section.

(c) The estimated amount of savings to residents of the state, health plans and health insurance policies, and employers resulting from the implementation of the prescription drug importation program under this section reported from the date of the previous report under this subsection and from the date the program was fully operational.

(d) Findings of any audit functions under sub. (1) (n) completed since the date of the previous report under this subsection.".

97. Page 433, line 5: delete lines 5 to 11 and substitute:

"**SECTION 1892b.** 250.10 (1m) (b) of the statutes is amended to read:

250.10 **(1m)** (b) Award in each fiscal year to qualified applicants grants totaling ~~$25,000~~ no less than $50,000 for fluoride ~~supplements, $25,000 for a fluoride mouth–rinse program~~ varnish and other evidence–based oral health activities, $700,000 for school–based preventive dental services, and ~~$120,000 for a school–based dental sealant program~~ $100,000 for school–based restorative dental services.".

98. Page 433, line 12: delete the material beginning with that line and ending with page 434, line 2, and substitute:

"**SECTION 1893b.** 250.20 (3) of the statutes is amended to read:

250.20 **(3)** From the appropriation account under s. 20.435 (1) ~~(kb)~~ (cr), the department shall annually award grants for activities to improve the health status of economically disadvantaged minority group members. A person may apply, in the manner specified by the department, for a grant of up to $50,000 in each fiscal year to conduct these activities. An awardee of a grant under this subsection shall provide, for at least 50 percent of the grant amount, matching funds that may consist of funding or an in–kind contribution. An applicant that is not a federally qualified health center, as defined under 42 CFR 405.2401 (b) shall receive priority for grants awarded under this subsection. An applicant that provides maternal and child health services shall receive priority for grants awarded under this subsection.

SECTION 1894b. 250.20 (4) of the statutes is amended to read:

250.20 **(4)** From the appropriation account under s. 20.435 (1) ~~(kb)~~ (cr), the department shall award a grant of up to $50,000 in each fiscal year to a private nonprofit corporation that applies, in the manner specified by the department, to conduct a public information campaign on minority health.".

99. Page 434, line 3: delete the material beginning with that line and ending with page 445, line 17, and substitute:

"**SECTION 1896b.** 253.06 (1) (a) of the statutes is renumbered 253.06 (1) (am) and amended to read:

253.06 **(1)** (am) "~~Authorized~~ Approved food" means food identified by the department as an authorized food in accordance with 7 CFR 246.10 as acceptable for use under the federal special supplemental ~~food~~ nutrition program for women, infants and children under 42 USC 1786.

SECTION 1897b. 253.06 (1) (ag) of the statutes is created to read:

253.06 **(1)** (ag) "Alternate participant" means a person who has been authorized by a participant to request benefits, participate in nutrition education, bring an infant or child to a Women, Infants, and Children program appointment, and have access to information in the participant's file.

SECTION 1898b. 253.06 (1) (b) of the statutes is repealed.

SECTION 1899b. 253.06 (1) (br) of the statutes is created to read:

253.06 **(1)** (br) "Cardholder" means a participant; alternate participant; parent, legal guardian, or caretaker of a participant; or another person in possession of a Women, Infants, and Children program electronic benefit transfer card and the personal identification number for the card.

SECTION 1900b. 253.06 (1) (c) of the statutes is repealed.

SECTION 1901b. 253.06 (1) (cm) of the statutes is amended to read:

253.06 **(1)** (cm) "~~Food~~ Direct distribution center" means an entity, other than a vendor, that is under contract with the department under sub. (3m) to distribute ~~authorized~~ approved food to participants.

SECTION 1902b. 253.06 (1) (cp), (cr), (ct) and (cv) of the statutes are created to read:

253.06 **(1)** (cp) "Electronic benefit transfer" means a method that permits electronic access to Women, Infants, and Children program benefits using a device, approved by the department, with payments made in accordance with ch. 410.

(cr) "Food instrument" means a voucher, check, electronic benefit transfer card, electronic benefit transfer card number and personal identification number, coupon, or other method used by a participant to obtain Women, Infants, and Children program approved foods.

(ct) "Infant formula supplier" means a wholesaler, distributor, retailer, or manufacturer of infant formula.

(cv) "Local agency" means an entity that has a contract with the department to provide services under the Women, Infants, and Children program such as eligibility determination, benefit issuance, and nutritional counseling for participants.

SECTION 1903b. 253.06 (1) (dm) of the statutes is repealed.

SECTION 1904b. 253.06 (1) (dr) and (dv) of the statutes are created to read:

253.06 **(1)** (dr) "Summary suspension" means an emergency action taken by the department to suspend an authorization under the Women, Infants, and Children program.

(dv) "Trafficking" means doing any of the following:

1. Buying, selling, stealing, or otherwise exchanging for cash or consideration other than approved food Women, Infants, and Children program food instruments or benefits that are issued and accessed via a food instrument.

2. Exchanging firearms, ammunition, explosives, or controlled substances, as defined in 21 USC 802, for a food instrument.

3. Intentionally purchasing and reselling for cash or consideration other than approved food a product that is purchased with a food instrument.

4. Intentionally purchasing with cash or consideration other than approved food a product that was originally purchased with a food instrument.

SECTION 1905b. 253.06 (1) (e) of the statutes is amended to read:

253.06 **(1)** (e) "Vendor" means a ~~grocery store or pharmacy that sells authorized~~ person that operates one or more stores or pharmacies authorized by the department under sub. (3) to provide approved foods under a retail food delivery system.

SECTION 1906b. 253.06 (1) (f) of the statutes is repealed.

SECTION 1907b. 253.06 (1) (g) of the statutes is created to read:

253.06 **(1)** (g) "Women, Infants, and Children program" means the federal special supplemental nutrition program for women, infants and children under 42 USC 1786 and this section.

SECTION 1908b. 253.06 (1m) of the statutes is created to read:

253.06 **(1m)** PROGRAM ADMINISTRATION. (a) The department may identify an alternate participant as the Women, Infants, and Children program cardholder for purposes of electronic administration of the Women, Infants, and Children program.

SECTION 1909b. 253.06 (3) (a) (intro.) of the statutes is amended to read:

253.06 **(3)** (a) (intro.) The department may authorize a vendor ~~to accept drafts~~ only if the vendor meets all of the following conditions:

SECTION 1910b. 253.06 (3) (a) 5. of the statutes is created to read:

253.06 **(3)** (a) 5. The vendor has an electronic benefit transfer–capable cash register system or payment device, approved by the department, that is able to accurately and securely obtain Women, Infants, and Children program food balances associated with the electronic benefit transfer card, maintain the necessary electronic files such as the approved food list, successfully complete Women, Infants, and Children program electronic benefit transfer purchases, and process Women, Infants, and Children program electronic benefit transfer payments.

SECTION 1911b. 253.06 (3) (bg) of the statutes is amended to read:

253.06 **(3)** (bg) The department may limit the number of vendors that it authorizes under this subsection if the department determines that the number of vendors already authorized under this subsection is sufficient to permit participants to obtain ~~authorized~~ approved food conveniently.

SECTION 1912b. 253.06 (3) (c) of the statutes is amended to read:

253.06 **(3)** (c) The department may ~~not~~ redeem ~~drafts~~ food instruments only when submitted by a person who is ~~not~~ an authorized vendor under this subsection except as provided in sub. (3m).

SECTION 1913b. 253.06 (3) (d) of the statutes is created to read:

253.06 **(3)** (d) Each store operated by a business entity is a separate vendor for purposes of this section and is required to have a single, fixed location, except when the authorization of mobile stores is necessary to meet special needs in accordance with 7 CFR 246.4 (1) (14) (xiv). The department shall require that each store be authorized as a vendor separately from other stores operated by the business entity.

SECTION 1914b. 253.06 (3m) (title) and (a) (intro.) of the statutes are amended to read:

253.06 **(3m)** (title) ~~FOOD~~ DIRECT DISTRIBUTION CENTERS. (a) (intro.) The department may contract for an alternative system of ~~authorized~~ approved food distribution with an entity other than a vendor only if the entity meets all of the following requirements:

SECTION 1915b. 253.06 (3m) (a) 4. of the statutes is created to read:

253.06 **(3m)** (a) 4. The entity has an electronic benefit transfer–capable cash register system or payment device, approved by the department, that is able to accurately and securely obtain Women, Infants, and Children program food balances associated with the electronic benefit transfer card, maintain the necessary files, successfully complete Women, Infants, and Children program electronic benefit transfer purchases, and process Women, Infants, and Children program electronic benefit transfer payments.

SECTION 1916b. 253.06 (3m) (b) of the statutes is amended to read:

253.06 **(3m)** (b) The department ~~shall redeem valid drafts~~ may process a payment if submitted by a ~~food~~ direct distribution center that is authorized by the department under this subsection.

SECTION 1917b. 253.06 (4) (a) 1. of the statutes is amended to read:

253.06 **(4)** (a) 1. Accept ~~drafts or submit drafts~~ a food instrument or submit a request to the department for redemption without authorization.

SECTION 1918b. 253.06 (4) (a) 2. of the statutes is repealed.

SECTION 1919b. 253.06 (4) (a) 2m. of the statutes is created to read:

253.06 **(4)** (a) 2m. Engage in trafficking.

SECTION 1920b. 253.06 (4) (a) 3. to 4. of the statutes are amended to read:

253.06 **(4)** (a) 3. Accept a ~~draft~~ food instrument other than in exchange for ~~authorized~~ approved food that is ~~provided by the person~~ selected by the electronic benefit transfer cardholder.

3m. Provide ~~authorized~~ approved food or other commodities to ~~a participant or proxy~~ an electronic benefit transfer cardholder in exchange for a ~~draft~~ food instrument accepted by a 3rd party.

4. ~~Enter on a draft~~ Submit a payment request for a dollar amount that is higher than the actual retail price of the item for which ~~the draft~~ a food instrument was used.

SECTION 1921b. 253.06 (4) (a) 5. of the statutes is repealed.

SECTION 1922b. 253.06 (4) (a) 5m. of the statutes is created to read:

253.06 **(4)** (a) 5m. Confiscate a food instrument or ask for or enter the electronic benefit transfer cardholder's personal identification number.

SECTION 1923b. 253.06 (4) (a) 6. and 8. of the statutes are repealed.

SECTION 1924b. 253.06 (4) (a) 9. of the statutes is amended to read:

253.06 **(4)** (a) 9. ~~Submit for redemption a draft~~ Provide to someone other than the department a food instrument; a Women, Infants, and Children program electronic benefit transfer card; or food purchased with a food instrument for something of value.

SECTION 1925b. 253.06 (4) (a) 10. of the statutes is repealed.

SECTION 1926b. 253.06 (5) (a) 1. and 2. of the statutes are amended to read:

253.06 **(5)** (a) 1. Minimum qualification standards for the authorization of vendors and infant formula suppliers and for the awarding of a contract to an entity under sub. (3m).

2. Standards of operation for authorized vendors and infant formula suppliers and ~~food~~ direct distribution centers, including prohibited practices.

SECTION 1927b. 253.06 (5) (b) 1. to 3. of the statutes are amended to read:

253.06 **(5)** (b) 1. Denial of the application to be a participant or authorized vendor or infant formula supplier.

2. ~~Suspension~~ Summary suspension or termination of authorization for an authorized vendor or infant formula supplier or, in the case of a ~~food~~ direct distribution center, termination of the contract.

3. Disqualification from the program under this section for a vendor, infant formula supplier, or participant.

SECTION 1928b. 253.06 (5) (b) 6. to 8. of the statutes are created to read:

253.06 **(5)** (b) 6. Civil monetary penalty.

7. Warning letter.

8. Implementation of a corrective action plan.

SECTION 1929b. 253.06 (5) (d) (intro.) and 6. of the statutes are amended to read:

253.06 **(5)** (d) (intro.) The department may directly assess a forfeiture provided for under par. (b) 4., recoupment provided for under par. (b) 5. and an enforcement assessment provided for under par. (c). If the department determines that a forfeiture, recoupment or enforcement assessment should be levied, or that authorization or eligibility should be summarily suspended or terminated, for a particular violation or for failure to correct it, the department shall send a notice of assessment, summary suspension or termination to the vendor, ~~food~~ infant formula supplier, direct distribution center or participant. The notice shall inform the vendor, ~~food~~ infant formula supplier, direct distribution center or participant of the right to a hearing under sub. (6) and shall specify all of the following:

6. If applicable, ~~that~~ the ~~suspension or termination of authorization of the vendor or eligibility of the participant is~~ effective ~~beginning on the 15th day after receipt~~ date of the ~~notice of~~ summary suspension or termination.

SECTION 1930b. 253.06 (5) (e) of the statutes is renumbered 253.06 (5) (e) 1. and amended to read:

253.06 **(5)** (e) 1. The ~~suspension or~~ termination of authorization of a vendor, infant formula supplier, or direct distribution center or eligibility of a participant shall be effective beginning on the 15th day after receipt of the notice of ~~suspension or~~ termination.

2. All forfeitures, recoupments, and enforcement assessments shall be paid to the department within 15 days after receipt of notice of assessment or, if the forfeiture, recoupment, or enforcement assessment is contested under sub. (6), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is adverse to the department or unless the final decision is appealed and the decision is stayed by court order under sub. (7). The

department shall remit all forfeitures paid to the secretary of administration for deposit in the school fund. The department shall deposit all enforcement assessments in the appropriation under s. 20.435 (1) (gr).

SECTION 1931b. 253.06 (5) (e) 3. of the statutes is created to read:

253.06 **(5)** (e) 3. The summary suspension of authorization of a vendor, infant formula supplier, or direct distribution center shall be effective immediately upon receipt of the notice under par. (d).

SECTION 1932b. 253.06 (6) (b) of the statutes is amended to read:

253.06 **(6)** (b) A person may contest an assessment of forfeiture, recoupment or enforcement assessment, a denial~~, suspension~~ or termination of authorization, a civil monetary penalty assessed in lieu of disqualification, a summary suspension, or a ~~suspension or~~ termination of eligibility by sending a written request for hearing under s. 227.44 to the division of hearings and appeals in the department of administration within 10 days after the receipt of the notice issued under sub. (3) (bm) or (5) (d). The administrator of the division of hearings and appeals may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division of hearings and appeals shall be the final administrative decision. The division of hearings and appeals shall commence the hearing and issue a final decision within 60 days after receipt of the request for hearing unless all of the parties consent to a later date. Proceedings before the division of hearings and appeals are governed by ch. 227. In any petition for judicial review of a decision by the division of hearings and appeals, the department, if not the petitioner who was in the proceeding before the division of hearings and appeals, shall be the named respondent.

SECTION 1933b. 253.06 (8) of the statutes is amended to read:

253.06 **(8)** INSPECTION OF PREMISES. The department may visit and inspect each authorized vendor and infant formula supplier and each ~~food~~ direct distribution center, and for such purpose shall be given unrestricted access to the premises described in the authorization or contract.

SECTION 1934b. 253.06 (9) and (10) of the statutes are created to read:

253.06 **(9)** CONFIDENTIALITY OF APPLICANT AND PARTICIPANT INFORMATION. (a) Any information about an applicant or participant, whether it is obtained from the applicant or participant or another source or is generated as a result of application for the Women, Infants, and Children program, that identifies the applicant or participant or a family member of the applicant or participant is confidential.

(b) Except as explicitly permitted under this section, the department shall restrict the use and disclosure of confidential applicant and participant information to any person directly connected with the administration or enforcement of the Women, Infants, and Children program that the department determines has a need to know the information for Women, Infants, and Children program purposes. Persons who may be allowed to access confidential information under this paragraph include personnel from the local agencies, persons under contract with the department to perform research regarding the Women, Infants, and Children program, and persons that are investigating or prosecuting Women, Infants, and Children program violations of federal, state, or local law.

(c) The department or any local agency may use or disclose to public organizations confidential applicant and participant information for the administration of other programs that serve individuals eligible for the Women, Infants, and Children program in accordance with 7 CFR 246.26 (h).

(d) Staff of the department and local agencies who are required by state law to report known or suspected child abuse or neglect may disclose confidential applicant and participant information without the consent of the participant or applicant to the extent necessary to comply with the law.

(e) Except in the case of subpoenas or search warrants, the department and local agencies may disclose confidential applicant and participant information to individuals or entities not listed in this section only if the affected applicant or participant signs a release form authorizing the disclosure and specifying the parties to which the information may be disclosed. The department or local agency shall allow applicants and participants to refuse to sign the release form and shall notify the applicant or participant that signing the form is not a condition of eligibility and refusing to sign the form will not affect the applicant's or participant's application or participation in the Women, Infants, and Children program. Release forms authorizing disclosure to private physicians or other health care providers may be included as part of the Women, Infants, and Children program application or certification process. All other requests for applicants or participants to sign voluntary release forms may occur only after the application and certification process is complete.

(f) The department or local agency shall provide to an applicant or participant access to all information he or she has provided to the Women, Infants, and Children program. In the case of an applicant or participant who is an infant or child, the access may be provided to a parent or guardian of the infant or child, assuming that any issues regarding custody or guardianship have been settled. The department or local agency is not required to provide the applicant or participant or parent or guardian of an infant or child applicant or participant access to any other

information in the file or record, including documentation of income provided by a 3rd party and staff assessments of an applicant or participant's condition or behavior, unless required by law or unless the information supports a state or local agency decision being appealed under 7 CFR 246.9.

(10) CONFIDENTIALITY OF VENDOR INFORMATION. (a) Any information about a vendor, whether it is obtained from the vendor or another source, that individually identifies the vendor except for the vendor's name, address, telephone number, Internet or electronic mail address, store type, and Women, Infants, and Children program authorization status is confidential. The department shall restrict the use or disclosure of confidential vendor information to any of the following:

1. Persons directly connected with the administration or enforcement of the Women, Infants, and Children program or the food stamp program under s. 49.79 that the department determines has a need to know the information for purposes of these programs. These persons may include personnel from local agencies and persons investigating or prosecuting violations of Women, Infants, and Children program or food stamp program federal, state, or local laws.

2. Persons directly connected with the administration or enforcement of any federal or state law or local ordinance. Before releasing information to a state or local entity, the department shall enter into a written agreement with the requesting party specifying that the information may not be used or redisclosed except for purposes directly connected with the administration or enforcement of the federal or state law or local ordinance.

3. A vendor that is subject to an adverse action under sub. (5), including a claim, to the extent that the confidential information concerns the vendor that is subject to the adverse action and is related to the adverse action.

(b) The department may disclose to all authorized vendors and applicants to be a vendor sanctions that have been imposed on vendors if the disclosure identifies only the vendor's name, address, length of the disqualification or amount of the monetary penalty, and a summary of the reason for the sanction provided in the notice of adverse action under sub. (5). The information under this paragraph may be disclosed only after all administrative and judicial review is exhausted and the department has prevailed regarding the sanction imposed on the vendor or after the time period for requesting administrative and judicial review has expired.".

100. Page 445, line 17: after that line insert:

"**SECTION 1935w.** 253.07 (1) (a) 3. of the statutes is created to read:

253.07 **(1)** (a) 3. Pregnancy termination.

SECTION 1936w. 253.07 (1) (b) 3. of the statutes is created to read:

253.07 **(1)** (b) 3. Pregnancy termination.

SECTION 1937w. 253.07 (5) (b) (intro.) of the statutes is renumbered 253.07 (5) (b) and amended to read:

253.07 **(5)** (b) ~~Subject to par. (c), a~~ A public entity that receives women's health funds under this section may provide some or all of the funds to other public or private entities ~~provided that the recipient of the funds does not do any of the following:~~.

SECTION 1938w. 253.07 (5) (b) 1. to 3. of the statutes are repealed.

SECTION 1939w. 253.07 (5) (c) of the statutes is repealed.

SECTION 1940w. 253.075 of the statutes is repealed.".

101. Page 446, line 1: delete lines 1 to 2 and substitute:

"254.151 **(2m)** Award grants for residential lead hazard abatement, residential lead hazard reduction, and lead abatement worker training.".

102. Page 448, line 25: delete the material beginning with that line and ending with page 449, line 2, and substitute:

"**SECTION 1950m.** 255.06 (2) (i) of the statutes is amended to read:

255.06 **(2)** (i) *Multiple sclerosis services.* Allocate and expend ~~at least~~ up to $60,000 as reimbursement for the provision of multiple sclerosis services to women.".

103. Page 454, line 2: after that line insert:

"**SECTION 2069f.** 601.83 (1) (a) of the statutes is amended to read:

601.83 **(1)** (a) The commissioner shall administer a state–based reinsurance program known as the healthcare stability plan in accordance with the specific terms and conditions approved by the federal department of health and human services dated July 29, 2018. Before December 31, 2023, the commissioner may not request from the federal department of health and human services a modification, suspension, withdrawal, or termination of the waiver under 42 USC 18052 under which the healthcare stability plan under this subchapter operates unless legislation has been enacted specifically directing the modification, suspension, withdrawal, or termination. Before December 31, 2023, the commissioner may request renewal, without substantive change, of the waiver under 42 USC 18052 under which the health care stability plan operates ~~in accordance with s. 20.940 (4)~~ unless legislation has been enacted that is contrary to such a renewal request. ~~The commissioner shall comply with applicable timing in and requirements of s. 20.940.~~".

SECTION 2070i. 609.713 of the statutes is created to read:

609.713 Essential health benefits; preventive services. Defined network plans and preferred provider plans are subject to s. 632.895 (13m) and (14m).

SECTION 2071i. 609.847 of the statutes is created to read:

609.847 Preexisting condition discrimination and certain benefit limits prohibited. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.728.

SECTION 2072i. 625.12 (1) (a) of the statutes is amended to read:

625.12 **(1)** (a) Past and prospective loss and expense experience within and outside of this state, except as provided in s. 632.728.

SECTION 2073i. 625.12 (1) (e) of the statutes is amended to read:

625.12 **(1)** (e) Subject to ~~s.~~ ss. 632.365 and 632.728, all other relevant factors, including the judgment of technical personnel.

SECTION 2074i. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Except as provided in s. 632.728, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 632.728, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 2075i. 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. ~~An~~ Except as provided in s. 632.728, an insurer may itself establish rates and supplementary rate information for one or more market

segments based on the factors in s. 625.12 and, if the rates are for motor vehicle liability insurance, subject to s. 632.365, or the insurer may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

SECTION 2076i. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.".

104. Page 454, line 12: after that line insert:

"**SECTION 2079i.** 632.728 of the statutes is created to read:

632.728 Coverage of persons with preexisting conditions; guaranteed issue; benefit limits. (1) DEFINITIONS. In this section:

(a) "Health benefit plan" has the meaning given in s. 632.745 (11).

(b) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) GUARANTEED ISSUE. (a) Every individual health benefit plan shall accept every individual in this state who, and every group health benefit plan shall accept every employer in this state that, applies for coverage, regardless of sexual orientation, gender identity, or whether or not any employee or individual has a

preexisting condition. A health benefit plan may restrict enrollment in coverage described in this paragraph to open or special enrollment periods.

(b) The commissioner shall establish a statewide open enrollment period of no shorter than 30 days for every individual health benefit plan to allow individuals, including individuals who do not have coverage, to enroll in coverage.

(3) PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS. (a) An individual health benefit plan or a self–insured health plan may not establish rules for the eligibility of any individual to enroll, or for the continued eligibility of any individual to remain enrolled, under the plan based on any of the following health status–related factors in relation to the individual or a dependent of the individual:

1. Health status.

2. Medical condition, including both physical and mental illnesses.

3. Claims experience.

4. Receipt of health care.

5. Medical history.

6. Genetic information.

7. Evidence of insurability, including conditions arising out of acts of domestic violence.

8. Disability.

(b) An insurer offering an individual health benefit plan or a self–insured health plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status–related factor under par. (a) with respect to the individual or a dependent of the individual, a premium or contribution or a deductible, copayment, or coinsurance amount that is

greater than the premium or contribution or deductible, copayment, or coinsurance amount respectively for a similarly situated individual enrolled under the plan.

(c) Nothing in this subsection prevents an insurer offering an individual health benefit plan or a self–insured health plan from establishing premium discounts or rebates or modifying otherwise applicable cost sharing in return for adherence to programs of health promotion and disease prevention.

(4) PREMIUM RATE VARIATION. A health benefit plan offered on the individual or small employer market or a self–insured health plan may vary premium rates for a specific plan based only on the following considerations:

(a) Whether the policy or plan covers an individual or a family.

(b) Rating area in the state, as established by the commissioner.

(c) Age, except that the rate may not vary by more than 3 to 1 for adults over the age groups and the age bands shall be consistent with recommendations of the National Association of Insurance Commissioners.

(d) Tobacco use, except that the rate may not vary by more than 1.5 to 1.

(5) ANNUAL AND LIFETIME LIMITS. An individual or group health benefit plan or a self–insured health plan may not establish any of the following:

(a) Lifetime limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan.

(b) Annual limits on the dollar value of benefits for an enrollee or a dependent of an enrollee under the plan.

(6) SHORT-TERM PLANS. This section and s. 632.76 apply to every short–term, limited–duration health insurance policy. In this subsection, "short–term, limited–duration health insurance policy" means health coverage that is provided under a contract with an insurer, has an expiration date specified in the contract that

is less than 12 months after the original effective date of the contract, and, taking into account renewals or extensions, has a duration of no longer than 36 months in total. "Short–term, limited–duration health insurance policy" includes any short–term policy subject to s. 632.7495 (4).

SECTION 2080i. 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and amended to read:

632.746 **(1)** ~~Subject to subs. (2) and (3), an~~ An insurer that offers a group health benefit plan may~~, with respect to a participant or beneficiary under the plan,~~ not impose a preexisting condition exclusion ~~only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6–month period ending on the participant's or beneficiary's enrollment date under the plan~~ on a participant or beneficiary under the plan.

SECTION 2081i. 632.746 (1) (b) of the statutes is repealed.

SECTION 2082i. 632.746 (2) (a) of the statutes is amended to read:

632.746 **(2)** (a) An insurer offering a group health benefit plan may not ~~treat~~ impose a preexisting condition exclusion based on genetic information ~~as a preexisting condition under sub. (1) without a diagnosis of a condition related to the information~~.

SECTION 2083i. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 2084i. 632.746 (3) (a) of the statutes is repealed.

SECTION 2085i. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 2086i. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 2087i. 632.746 (5) of the statutes is repealed.

SECTION 2088i. 632.746 (8) (a) (intro.) of the statutes is amended to read:

632.746 **(8)** (a) (intro.) A health maintenance organization that offers a group health benefit plan ~~and that does not impose any preexisting condition exclusion under sub. (1)~~ with respect to a particular coverage option may impose an affiliation period for that coverage option, but only if all of the following apply:

SECTION 2089i. 632.748 (2) of the statutes is amended to read:

632.748 **(2)** An insurer offering a group health benefit plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay, on the basis of any health status–related factor with respect to the individual or a dependent of the individual, a premium or contribution or a deductible, copayment, or coinsurance amount that is greater than the premium or contribution or deductible, copayment, or coinsurance amount respectively for a similarly situated individual enrolled under the plan.

SECTION 2090i. 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self–insured health plan, as defined in s. 632.85 (1) (c).

(ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability commencing ~~after 12 months from the date of issue of~~ under an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the

ground that a disease or physical condition existed prior to the effective date of coverage~~, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss~~.

2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy, as defined in s. 632.895 (1) (a), ~~other than a short–term policy subject to s. 632.7495 (4) and (5),~~ may not define a preexisting condition more restrictively than a condition that was present before the date of enrollment for the coverage, whether physical or mental, regardless of the cause of the condition, ~~for which~~ and regardless of whether medical advice, diagnosis, care, or treatment was recommended or received ~~within 12 months before the effective date of coverage~~.

SECTION 2091i. 632.76 (2) (ac) 3. of the statutes is repealed.

SECTION 2092i. 632.795 (4) (a) of the statutes is amended to read:

632.795 **(4)** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

SECTION 2093k. 632.796 of the statutes is created to read:

632.796 Drug cost report. (1) DEFINITION. In this section, "disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(2) REPORT REQUIRED. Annually, at the time the insurer files its rate request with the commissioner, each insurer that offers a disability insurance policy that covers prescription drugs shall submit to the commissioner a report that identifies the 25 prescription drugs that are the highest cost to the insurer and the 25 prescription drugs that have the highest cost increases over the 12 months before the submission of the report.

SECTION 2094k. 632.865 (3) of the statutes is created to read:

632.865 **(3)** REGISTRATION REQUIRED. (a) No person may perform any activities of a pharmacy benefit manager in this state without first registering with the commissioner under this subsection.

(b) The commissioner shall establish a registration procedure for pharmacy benefit managers. The commissioner may promulgate any rules necessary to implement the registration procedure under this paragraph.

SECTION 2095k. 632.866 of the statutes is created to read:

632.866 Prescription drug cost reporting. (1) DEFINITIONS. In this section:

(a) "Brand–name drug" means a prescription drug approved under 21 USC 355 (b) or 42 USC 262.

(b) "Covered hospital" means an entity described in 42 USC 256b (a) (4) (L) to (N) that participates in the federal drug–pricing program under 42 USC 256b.

(c) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(d) "Generic drug" means a prescription drug approved under 21 USC 355 (j).

(e) "Manufacturer" has the meaning given in s. 450.01 (12). "Manufacturer" does not include an entity that is engaged only in the dispensing, as defined in s. 450.01 (7), of a brand–name drug or a generic drug.

(f) "Manufacturer–sponsored assistance program" means a program offered by a manufacturer or an intermediary under contract with a manufacturer through which a brand–name drug or a generic drug is provided to a patient at no charge or at a discount.

(g) "Margin" means, for a covered hospital, the difference between the net cost of a brand–name drug or generic drug covered under the federal drug–pricing program under 42 USC 256b and the net payment by the covered hospital for that brand–name drug or generic drug.

(h) "Net payment" means the amount paid for a brand–name drug or generic drug after all discounts and rebates have been applied.

(i) "Pharmacy benefit manager" has the meaning given in s. 632.865 (1) (c).

(j) "Wholesale acquisition cost" means the most recently reported manufacturer list or catalog price for a brand–name drug or a generic drug available to wholesalers or direct purchasers in the United States, before application of discounts, rebates, or reductions in price.

(2) PRICE INCREASE OR INTRODUCTION NOTICE; JUSTIFICATION REPORT. (a) A manufacturer shall notify the commissioner if it is increasing the wholesale acquisition cost of a brand–name drug on the market in this state by more than 10 percent or by more than $10,000 during any 12–month period or if it intends to introduce to market in this state a brand–name drug that has an annual wholesale acquisition cost of $30,000 or more.

(b) A manufacturer shall notify the commissioner if it is increasing the wholesale acquisition cost of a generic drug by more than 25 percent or by more than $300 during any 12–month period or if it intends to introduce to market a generic drug that has an annual wholesale acquisition cost of $3,000 or more.

(c) The manufacturer shall provide the notice under par. (a) or (b) in writing at least 30 days before the planned effective date of the cost increase or drug introduction with a justification that includes all documents and research related to the manufacturer's selection of the cost increase or introduction price and a description of life cycle management, market competition and context, and estimated value or cost–effectiveness of the product.

(3) NET PRICES PAID BY PHARMACY BENEFIT MANAGERS. By March 1 annually, the manufacturer shall report to the commissioner the value of price concessions, expressed as a percentage of the wholesale acquisition cost, provided to each pharmacy benefit manager for each drug sold in this state.

(4) REBATES AND PRICE CONCESSIONS. By March 1 annually, each pharmacy benefit manager shall report to the commissioner the amount received from manufacturers as drug rebates and the value of price concessions, expressed as a percentage of the wholesale acquisition cost, provided by manufacturers for each drug.

(5) HOSPITAL MARGIN SPENDING. By March 1 annually, each covered hospital operating in this state shall report to the commissioner the per unit margin for each drug covered under the federal drug pricing program under 42 USC 256b dispensed in the previous year multiplied by the number of units dispensed at that margin and how the margin revenue was used.

(6) MANUFACTURER-SPONSORED ASSISTANCE PROGRAMS. By March 1 annually, each manufacturer shall provide the commissioner with a description of each manufacturer–sponsored patient assistance program in effect during the previous year that includes all of the following:

(a) The terms of the programs.

(b) The number of prescriptions provided to state residents under the program.

(c) The total market value of assistance provided to residents of this state under the program.

(7) CERTIFICATION AND PENALTIES FOR NONCOMPLIANCE. Each manufacturer and covered hospital that is required to report under this section shall certify each report as accurate under the penalty of perjury. A manufacturer or covered hospital that fails to submit a report required under this section is subject to a forfeiture of no more than $10,000 each day the report is overdue.

(8) HEARING AND PUBLIC REPORTING. (a) The commissioner shall publicly post manufacturer price justification documents and covered hospital documentation of how each hospital spends the margin revenue. The commissioner shall keep any trade secret or proprietary information confidential.

(b) The commissioner shall analyze data collected under this section and publish annually a report on emerging trends in prescription prices and price increases, and shall annually conduct a public hearing based on the analysis under this paragraph. The report under this paragraph shall include analysis of manufacturer prices and price increases, analysis of hospital–specific margins and how that revenue is spent or allocated on a hospital–specific basis, and analysis of how pharmacy benefit manager discounts and net costs compare to retail prices paid by patients.

(9) ALLOWING COST DISCLOSURE TO INSURED. The commissioner shall ensure that every disability insurance policy that covers prescription drugs or biological products does not restrict a pharmacy or pharmacist that dispenses a prescription drug or biological product from informing and does not penalize a pharmacy or pharmacist for informing an insured under a policy of a difference between the negotiated price of, or copayment or coinsurance for, the drug or biological product under the policy and the price the insured would pay for the drug or biological product if the insured obtained the drug or biological product without using any health insurance coverage.

SECTION 2097i. 632.895 (8) (d) of the statutes is amended to read:

632.895 **(8)** (d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c), and (e), coverage under this subsection may only be subject to exclusions and limitations, including ~~deductibles, copayments and~~ restrictions on excessive charges, that are applied to other radiological examinations covered under the disability insurance policy. Coverage under this subsection may not be subject to any deductibles, copayments, or coinsurance.

SECTION 2098i. 632.895 (13m) of the statutes is created to read:

632.895 **(13m)** PREVENTIVE SERVICES. (a) In this section, "self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(b) Every disability insurance policy, except any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12., and every self–insured health plan shall provide coverage for all of the following preventive services:

1. Mammography in accordance with sub. (8).

2. Genetic breast cancer screening and counseling and preventive medication for adult women at high risk for breast cancer.

3. Papanicolaou test for cancer screening for women 21 years of age or older with an intact cervix.

4. Human papillomavirus testing for women who have attained the age of 30 years but have not attained the age of 66 years.

5. Colorectal cancer screening in accordance with sub. (16m).

6. Annual tomography for lung cancer screening for adults who have attained the age of 55 years but have not attained the age of 80 years and who have health histories demonstrating a risk for lung cancer.

7. Skin cancer screening for individuals who have attained the age of 10 years but have not attained the age of 22 years.

8. Counseling for skin cancer prevention for adults who have attained the age of 18 years but have not attained the age of 25 years.

9. Abdominal aortic aneurysm screening for men who have attained the age of 65 years but have not attained the age of 75 years and who have ever smoked.

10. Hypertension screening for adults and blood pressure testing for adults, for children under the age of 3 years who are at high risk for hypertension, and for children 3 years of age or older.

11. Lipid disorder screening for minors 2 years of age or older, adults 20 years of age or older at high risk for lipid disorders, and all men 35 years of age or older.

12. Aspirin therapy for cardiovascular health for adults who have attained the age of 55 years but have not attained the age of 80 years and for men who have attained the age of 45 years but have not attained the age of 55 years.

13. Behavioral counseling for cardiovascular health for adults who are overweight or obese and who have risk factors for cardiovascular disease.

14. Type II diabetes screening for adults with elevated blood pressure.

15. Depression screening for minors 11 years of age or older and for adults when follow–up supports are available.

16. Hepatitis B screening for minors at high risk for infection and adults at high risk for infection.

17. Hepatitis C screening for adults at high risk for infection and one–time hepatitis C screening for adults born in any year from 1945 to 1965.

18. Obesity screening and management for all minors and adults with a body mass index indicating obesity, counseling and behavioral interventions for obese minors who are 6 years of age or older, and referral for intervention for obesity for adults with a body mass index of 30 kilograms per square meter or higher.

19. Osteoporosis screening for all women 65 years of age or older and for women at high risk for osteoporosis under the age of 65 years.

20. Immunizations in accordance with sub. (14).

21. Anemia screening for individuals 6 months of age or older and iron supplements for individuals at high risk for anemia and who have attained the age of 6 months but have not attained the age of 12 months.

22. Fluoride varnish for prevention of tooth decay for minors at the age of eruption of their primary teeth.

23. Fluoride supplements for prevention of tooth decay for minors 6 months of age or older who do not have fluoride in their water source.

24. Gonorrhea prophylaxis treatment for newborns.

25. Health history and physical exams for prenatal visits and for minors.

26. Length and weight measurements for newborns and height and weight measurements for minors.

27. Head circumference and weight–for–length measurements for newborns and minors who have not attained the age of 3 years.

28. Body mass index for minors 2 years of age or older.

29. Blood pressure measurements for minors 3 years of age or older and a blood pressure risk assessment at birth.

30. Risk assessment and referral for oral health issues for minors who have attained the age of 6 months but have not attained the age of 7 years.

31. Blood screening for newborns and minors who have not attained the age of 2 months.

32. Screening for critical congenital health defects for newborns.

33. Lead screenings in accordance with sub. (10).

34. Metabolic and hemoglobin screening and screening for phenylketonuria, sickle cell anemia, and congenital hypothyroidism for minors including newborns.

35. Tuberculin skin test based on risk assessment for minors one month of age or older.

36. Tobacco counseling and cessation interventions for individuals who are 5 years of age or older.

37. Vision and hearing screening and assessment for minors including newborns.

38. Sexually transmitted infection and human immunodeficiency virus counseling for sexually active minors.

39. Risk assessment for sexually transmitted infection for minors who are 10 years of age or older and screening for sexually transmitted infection for minors who are 16 years of age or older.

40. Alcohol misuse screening and counseling for minors 11 years of age or older.

41. Autism screening for minors who have attained the age of 18 months but have not attained the age of 25 months.

42. Developmental screening and surveillance for minors including newborns.

43. Psychosocial and behavioral assessment for minors including newborns.

44. Alcohol misuse screening and counseling for pregnant adults and a risk assessment for all adults.

45. Fall prevention and counseling and preventive medication for fall prevention for community–dwelling adults 65 years of age or older.

46. Screening and counseling for intimate partner violence for adult women.

47. Well–woman visits for women who have attained the age of 18 years but have not attained the age of 65 years and well–woman visits for recommended preventive services, preconception care, and prenatal care.

48. Counseling on, consultations with a trained provider on, and equipment rental for breastfeeding for pregnant and lactating women.

49. Folic acid supplement for adult women with reproductive capacity.

50. Iron deficiency anemia screening for pregnant and lactating women.

51. Preeclampsia preventive medicine for pregnant adult women at high risk for preeclampsia.

52. Low–dose aspirin after 12 weeks of gestation for pregnant women at high risk for miscarriage, preeclampsia, or clotting disorders.

53. Screenings for hepatitis B and bacteriuria for pregnant women.

54. Screening for gonorrhea for pregnant and sexually active females 24 years of age or younger and females older than 24 years of age who are at risk for infection.

55. Screening for chlamydia for pregnant and sexually active females 24 years of age and younger and females older than 24 years of age who are at risk for infection.

56. Screening for syphilis for pregnant women and adults who are at high risk for infection.

57. Human immunodeficiency virus screening for adults who have attained the age of 15 years but have not attained the age of 66 years and individuals at high risk of infection who are younger than 15 years of age or older than 65 years of age.

58. All contraceptives and services in accordance with sub. (17).

59. Any services not already specified under this paragraph having an A or B rating in current recommendations from the U.S. preventive services task force.

60. Any preventive services not already specified under this paragraph that are recommended by the federal health resources and services administration's Bright Futures project.

61. Any immunizations, not already specified under sub. (14), that are recommended and determined to be for routine use by the federal advisory committee on immunization practices.

(c) Subject to par. (d), no disability insurance policy and no self–insured health plan may subject the coverage of any of the preventive services under par. (b) to any deductibles, copayments, or coinsurance under the policy or plan.

(d) 1. If an office visit and a preventive service specified under par. (b) are billed separately by the health care provider, the disability insurance policy or self–insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit but not on the preventive service.

2. If the primary reason for an office visit is not to obtain a preventive service, the disability insurance policy or self–insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit.

3. Except as otherwise provided in this subdivision, if a preventive service specified under par. (b) is provided by a health care provider that is outside the disability insurance policy's or self–insured health plan's network of providers, the policy or plan may apply deductibles to and impose copayments or coinsurance on the office visit and the preventive service. If a preventive service specified under par. (b) is provided by a health care provider that is outside the disability insurance policy's or self–insured health plan's network of providers because there is no available health care provider in the policy's or plan's network of providers that provides the preventive service, the policy or plan may not apply deductibles to or impose copayments or coinsurance on the preventive service.

4. If multiple well–woman visits described under par. (b) 47. are required to fulfill all necessary preventive services and are in accordance with clinical recommendations, the disability insurance policy or self–insured health plan may not apply a deductible to or impose a copayment or coinsurance on any of those well–woman visits.

SECTION 2099i. 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

632.895 **(14)** (a) 1. i. Hepatitis A and B.

j. Varicella and herpes zoster.

SECTION 2100i. 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

632.895 **(14)** (a) 1. k. Human papillomavirus.

L. Meningococcal meningitis.

m. Pneumococcal pneumonia.

n. Influenza.

o. Rotavirus.

SECTION 2101i. 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, ~~that provides coverage for a dependent of the insured~~ shall provide coverage of appropriate and necessary immunizations~~, from birth to the age of 6 years,~~ for an insured or plan participant, including a dependent ~~who is a child~~ of the insured or plan participant.

SECTION 2102i. 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. ~~This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.~~

SECTION 2103i. 632.895 (14) (d) 3. of the statutes is amended to read:

632.895 **(14)** (d) 3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3)~~, or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b)~~.

SECTION 2104i. 632.895 (14m) of the statutes is created to read:

632.895 **(14m)** ESSENTIAL HEALTH BENEFITS. (a) In this subsection, "self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(b) On a date specified by the commissioner, by rule, every disability insurance policy, except as provided in par. (g), and every self–insured health plan shall provide

coverage for essential health benefits as determined by the commissioner, by rule, subject to par. (c).

(c) In determining the essential health benefits for which coverage is required under par. (b), the commissioner shall do all of the following:

1. Include benefits, items, and services in, at least, all of the following categories:

a. Ambulatory patient services.

b. Emergency services.

c. Hospitalization.

d. Maternity and newborn care.

e. Mental health and substance use disorder services, including behavioral health treatment.

f. Prescription drugs.

g. Rehabilitative and habilitative services and devices.

h. Laboratory services.

i. Preventive and wellness services and chronic disease management.

j. Pediatric services, including oral and vision care.

2. Conduct a survey of employer–sponsored coverage to determine benefits typically covered by employers and ensure that the scope of essential health benefits for which coverage is required under this subsection is equal to the scope of benefits covered under a typical disability insurance policy offered by an employer to its employees.

3. Ensure that essential health benefits reflect a balance among the categories described in subd. 1. such that benefits are not unduly weighted toward one category.

4. Ensure that essential health benefit coverage is provided with no or limited cost–sharing requirements.

5. Require that disability insurance policies and self–insured health plans do not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.

6. Establish essential health benefits in a way that takes into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

7. Ensure that essential health benefits established under this subsection are not subject to a coverage denial based on an insured's or plan participant's age, expected length of life, present or predicted disability, degree of dependency on medical care, or quality of life.

8. Require that disability insurance policies and self–insured health plans cover emergency department services that are essential health benefits without imposing any requirement to obtain prior authorization for those services and without limiting coverage for services provided by an emergency services provider that is not in the provider network of a policy or plan in a way that is more restrictive than requirements or limitations that apply to emergency services provided by a provider that is in the provider network of the policy or plan.

9. Require a disability insurance policy or self–insured health plan to apply to emergency department services that are essential health benefits provided by an emergency department provider that is not in the provider network of the policy or plan the same copayment amount or coinsurance rate that applies if those services are provided by a provider that is in the provider network of the policy or plan.

(d) The commissioner shall periodically update, by rule, the essential health benefits under this subsection to address any gaps in access to coverage.

(e) If an essential health benefit is also subject to mandated coverage elsewhere under this section and the coverage requirements are not identical, the disability insurance policy or self–insured health plan shall provide coverage under whichever subsection provides the insured or plan participant with more comprehensive coverage of the medical condition, item, or service.

(f) Nothing in this subsection or rules promulgated under this subsection prohibits a disability insurance policy or a self–insured health plan from providing benefits in excess of the essential health benefit coverage required under this subsection.

(g) This subsection does not apply to any disability insurance policy that is described in s. 632.745 (11) (b) 1. to 12.

SECTION 2105i. 632.895 (16m) (b) of the statutes is amended to read:

632.895 **(16m)** (b) The coverage required under this subsection may be subject to any limitations~~,~~ or exclusions~~, or cost–sharing provisions~~ that apply generally under the disability insurance policy or self–insured health plan. The coverage required under this subsection may not be subject to any deductibles, copayments, or coinsurance.

SECTION 2106i. 632.895 (17) (b) 2. of the statutes is amended to read:

632.895 **(17)** (b) 2. Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, ~~if covered for any other drug benefits under the policy or plan~~ sterilization procedures, and patient education and counseling for all females with reproductive capacity.

SECTION 2107i. 632.895 (17) (c) of the statutes is amended to read:

632.895 **(17)** (c) Coverage under par. (b) may be subject only to the exclusions~~,~~ and limitations~~, or cost–sharing provisions~~ that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the policy or self–insured health plan. A disability insurance policy or self–insured health plan may not apply a deductible or impose a copayment or coinsurance to at least one of each type of contraceptive method approved by the federal food and drug administration for which coverage is required under this subsection. The disability insurance policy or self–insured health plan may apply reasonable medical management to a method of contraception to limit coverage under this subsection that is provided without being subject to a deductible, copayment, or coinsurance to prescription drugs without a brand name. The disability insurance policy or self–insured health plan may apply a deductible or impose a copayment or coinsurance for coverage of a contraceptive that is prescribed for a medical need if the services for the medical need would otherwise be subject to a deductible, copayment, or coinsurance.

SECTION 2108i. 632.897 (11) (a) of the statutes is amended to read:

632.897 **(11)** (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, ~~application of~~

~~preexisting condition exclusions,~~ election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t), 2011 stats.".

105. Page 455, line 18: after that line insert:

"**SECTION 2118m.** 767.805 (4) (d) of the statutes is repealed.

SECTION 2119m. 767.89 (3) (e) of the statutes is repealed.".

106. Page 460, line 2: after that line insert:

"**SECTION 2264g.** 2017 Wisconsin Act 370, Section 44 (2) and (3) are repealed.".

107. Page 488, line 8: after that line insert:

"(1) PRESCRIPTION DRUG POOLING STUDY. The department of employee trust funds, in consultation with the department of corrections, the department of health services, and the department of veterans affairs, shall study the options and opportunities for cost savings to state agencies through prescription drug pooling. No later than January 1, 2020, the department of employee trust funds shall submit a report of the study to the governor and the appropriate standing committees of the legislature, as determined by the speaker of the assembly and the president of the senate, in the manner provided under s. 13.172 (3).".

108. Page 488, line 16: after that line insert:

"(1s) FORENSIC UNIT EXPANSION AT SAND RIDGE SECURE TREATMENT CENTER. From the appropriation under s. 20.435 (2) (bm), the department of health services shall allocate $3,430,900 in fiscal year 2020–21 and create 36.50 FTE GPR positions to operate a 20–bed unit for forensic patients at the Sand Ridge Secure Treatment Center.

(1t) YOUTH CRISIS STABILIZATION FACILITIES AND PEER-RUN RESPITE CENTERS FOR VETERANS. The department of health services shall award in each fiscal year $996,400

in grants to youth crisis stabilization facilities and $450,000 in grants to a peer–run respite center for veterans.".

109. Page 488, line 17: delete the material beginning with that line and ending with page 489, line 3, and substitute:

"(2b) MEDICAL ASSISTANCE REIMBURSEMENT FOR SERVICES PROVIDED THROUGH TELEHEALTH. The department of health services shall develop, by rule, a method of reimbursing providers under the Medical Assistance program for a service that is covered by the Medical Assistance program under subch. IV of ch. 49 and that satisfies any of the following:

(a) The service is a consultation between a provider at an originating site and a provider at a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment.

(b) The service is an asynchronous transmission of digital clinical information through a secure electronic system from a Medical Assistance recipient or provider to a provider.".

110. Page 489, line 3: after that line insert:

"(2g) CHILDLESS ADULTS DEMONSTRATION PROJECT REFORM WAIVER. The department of health services may submit a request to the federal department of health and human services to modify or withdraw the waiver granted under s. 49.45 (23) (g), 2017 stats.

(3g) ACADEMIC DETAILING TRAINING PROGRAM.

(a) In this subsection, "academic detailing" means a teaching model under which health care experts are taught techniques for engaging in interactional educational outreach to other health care providers and clinical staff to provide

information on evidence–based practices and successful therapeutic interventions with the goal of improving patient care.

(b) The department of health services shall establish and implement a 2–year academic detailing primary care clinic dementia training program in 10 primary care clinics in the state through a contract with the Wisconsin Alzheimer's Institute.

(c) The department shall, as part of the training program, provide primary care providers with clinical training and access to educational resources on best practices for diagnosis and management of common cognitive disorders, and referral strategies to dementia specialists for complicated or rare cognitive or behavioral disorders.

(d) The department shall ensure that the training program under this subsection includes at least the following three components:

1. The most current research on effective clinical treatments and practices is systematically evaluated by the academic detailing team.

2. Information gathered and evaluated under subd. 1. is packaged into an easily accessible format that is clinically relevant, rigorously sourced, and compellingly formatted.

3. Training is provided for clinicians to serve as academic detailers that equips them with clinical expertise and proficiency in conducting an interactive educational exchange to facilitate individualized learning among participating primary care practitioners in the target clinics.".

111. Page 489, line 14: after that line insert:

"(4c) CHILDLESS ADULTS DEMONSTRATION PROJECT. The department of health services shall submit any necessary request to the federal department of health and

human services for a state plan amendment or waiver of federal Medicaid law or to modify or withdraw from any waiver of federal Medicaid law relating to the childless adults demonstration project under s. 49.45 (23), 2017 stats., to reflect the incorporation of recipients of Medical Assistance under the demonstration project into the BadgerCare Plus program under s. 49.471 and the termination of the demonstration project.".

112. Page 489, line 15: delete lines 15 to 20 and substitute:

"(6b) EVIDENCE-BASED ORAL HEALTH GRANTS AND SEAL-A-SMILE PROGRAM. Notwithstanding s. 250.10 (1m) (b), in fiscal year 2019–20, the department of health services shall, from the appropriation under s. 20.435 (1) (de), award to qualified applicants grants totaling $50,000 for fluoride varnish and other evidence–based oral health activities, $525,000 for school–based preventive dental services, and $100,000 for school–based restorative dental services.".

113. Page 489, line 20: after that line insert:

"(6d) PRESCRIPTION DRUG IMPORTATION PROGRAM. The department of health services shall submit the first report required under s. 250.048 (5) by the next January 1 or July 1, whichever is earliest, that is at least 180 days after the date the prescription drug importation program is fully operational under s. 250.048 (4). The department of health services shall include in the first 3 reports submitted under s. 250.048 (5) information on the implementation of the audit functions under s. 250.048 (1) (n).".

114. Page 490, line 5: after that line insert:

"(8m) COMMUNITY-BASED DOULAS. From the appropriation under s. 20.435 (4) (bm), the department of health services shall in fiscal year 2019–20 allocate $192,000

to public or private entities, American Indian tribes or tribal organizations, or community–based organizations for grants for community–based doulas. The recipients of the grants shall use the moneys to identify and train local community workers to mentor pregnant women.".

115. Page 490, line 6: delete lines 6 to 11 and substitute:

"(9b) DENTAL SERVICES UNDER MEDICAL ASSISTANCE. During the 2019–21 fiscal biennium, the department of health services shall allocate a total of $2,000,000 in the 2019–20 fiscal year and $3,000,000 in the 2020–21 fiscal year from all funding sources to increase reimbursement rates for dental services that are covered under the Medical Assistance program under subch. IV of ch. 49 and that are provided to recipients of Medical Assistance who have disabilities.".

116. Page 490, line 11: after that line insert:

"(9r) WISCONSIN CHRONIC DISEASE PROGRAM. In fiscal year 2019–20, the department of health services shall allocate $3,782,200 from the appropriation under s. 20.435 (4) (e) and $983,500 from the appropriation under s. 20.435 (4) (je) to fund the Wisconsin Chronic Disease Program as provided under ss. 49.68, 49.683, and 49.685. In fiscal year 2020–21, the department of health services shall allocate $3,939,300 from the appropriation under s. 20.435 (4) (e) and $1,027,300 from the appropriation under s. 20.435 (4) (je) to fund the Wisconsin Chronic Disease Program as provided under ss. 49.68, 49.683, and 49.685.".

117. Page 490, line 12: delete lines 12 to 16 and substitute:

"(10c) INFANT MORTALITY PREVENTION PROGRAM. The department of health services shall allocate 5.0 FTE positions that are authorized for the department of health services to staff an infant mortality prevention program. The department of

health services shall report in its 2021–23 budget request any necessary budget adjustments to reflect this allocation of positions.".

118. Page 490, line 16: after that line insert:

"(10d) DISPATCHER ASSISTED CARDIOPULMONARY RESUSCITATION. Beginning in fiscal year 2019–20, the department of health services shall allocate $105,900 each fiscal year to assist public safety answering points in complying with dispatcher training requirements on telephonic assistance on administering cardiopulmonary resuscitation enacted in 2017 Wisconsin Act 296, including $75,900 under 20.435 (1) (cj) for the department of health services to distribute, either as grants to public safety answering points or by contracting with an entity to provide training to public safety answering points, and $30,000 to fund supplies and services for the program under the department of health services general program operations appropriation under s. 20.435 (1) (a).".

119. Page 491, line 3: delete lines 3 to 15.

120. Page 491, line 15: after that line insert:

"(10s) ONE-TIME FUNDING FOR INFORMATION TECHNOLOGY INFRASTRUCTURE IMPROVEMENTS. In fiscal year 2019–20, the department of health services shall allocate $500,000 on a one–time basis to fund information technology infrastructure improvements as part of an automated licensing project and to enable assisted living providers to enter reports online.".

121. Page 491, line 20: delete the material beginning with "facilities;" and ending with "2020–21" on line 23 and substitute "facilities and an additional $15,000,000, as the state share of payments, and the matching federal share of payments in each of fiscal years 2019–20 and 2020–21".

122. Page 492, line 1: delete lines 1 to 7 and substitute:

"(12b) MEDICAL ASSISTANCE REIMBURSEMENT RATE INCREASE FOR DIRECT CARE IN PERSONAL CARE AGENCIES. The department of health services shall increase the Medical Assistance rates paid for direct care to agencies that provide personal care services by $15,300,000, as the state share of payments and the matching federal share of payments in fiscal year 2019–20 and $21,600,000, as the state share of payments and the matching federal share of payments in fiscal year 2020–21 to support staff in those agencies who perform direct care.".

123. Page 492, line 7: after that line insert:

"(13) LEAD EXPOSURE AND POISONING PREVENTION STAFF. The authorized FTE positions for the department of health services are increased by 1.0 GPR project position for the period ending June 30, 2021, and 1.14 GPR positions beginning on July 1, 2019, to be funded from the appropriation under s. 20.435 (1) (a), for the purpose of administering the department's lead public health outreach initiative and for enhancing the department's lead poisoning prevention programs.".

124. Page 492, line 18: after that line insert:

"(1k) PRESCRIPTION DRUG COST SURVEY. The commissioner of insurance shall conduct a statistically valid survey of pharmacies in this state regarding whether the pharmacy agreed to not disclose that customer drug benefit cost sharing exceeds the cost of the dispensed drug.

(2k) PRESCRIPTION DRUG COST REPORTING POSITIONS. The authorized FTE positions for the office of the commissioner of insurance are increased by 2.0 PR positions, to be funded from the appropriation under s. 20.145 (1) (g), for the purpose

of administering prescription drug cost reporting and registration of pharmacy benefit managers under ss. 632.796, 632.865 (3), and 632.866.".

125. Page 501, line 11: delete lines 11 to 20.

126. Page 505, line 11: after that line insert:

"(2m) ELIMINATION OF BIRTH COST RECOVERY. The treatment of ss. 49.45 (19) (a) and (c), 49.855 (3) (with respect to the elimination of statutory reference to court authority to issue new orders for birth expenses) and (4m) (b), 767.805 (4) (d), and 767.89 (3) (e) first applies to an order or judgment relating to paternity issued on the effective date of this subsection.".

127. Page 505, line 16: after that line insert:

"(1i) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES.

(a) For policies and plans containing provisions inconsistent with these sections, the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in par. (b).

(b) For policies and plans that are affected by a collective bargaining agreement containing provisions inconsistent with these sections, the treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1)

(a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is entered into, extended, modified, or renewed, whichever is later.".

128. Page 509, line 1: after that line insert:

"(1c) MEDICAID EXPANSION. The treatment of ss. 20.435 (4) (jw) and 49.45 (23) takes effect on January 1, 2020.".

129. Page 509, line 6: after that line insert:

"(1i) COVERAGE OF INDIVIDUALS WITH PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS, AND PREVENTIVE SERVICES. The treatment of ss. 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.713, 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2., and 3., (5), and (8) (a) (intro.), 632.748 (2), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c) and (d) 3., (14m), (16m) (b), and (17) (b) 2. and (c), and 632.897 (11) (a) and SECTION 9323 (1i) of this act take effect on the first day of the 4th month beginning after publication.".

(END)

This proposal may contain a health insurance mandate requiring a social and financial impact report under s. 601.423, stats.