HEALTH SERVICES

Budget Summary						FTE Position Summary				
				2021-23 Change Over Base Year Doubled					2022-23 Over 2020-21	
	2020-21	Governor					Governor			
Fund	Adjusted Base	2021-22	2022-23	Amount	%	2020-21	2021-22	2022-23	Number	%
GPR	$4,407,796,700	$4,413,593,800	$4,864,641,200	$462,641,600	5.2%	2,657.23	2,721.05	2,721.34	64.11	2.4%
FED	6,754,343,400	8,806,178,600	8,572,931,300	3,870,423,100	28.7	1,270.77	1,275.55	1,273.55	2.78	0.2
PR	1,576,572,600	1,798,180,400	1,845,182,600	490,217,800	15.5	2,434.19	2,436.09	2,436.80	2.61	0.1
SEG	576,631,600	634,794,600	591,554,700	73,086,100	6.3	2.00	2.00	2.00	0.00	0.0
TOTAL	$13,315,344,300	$15,652,747,400	$15,874,309,800	$4,896,368,600	18.4%	6,364.19	6,434.69	6,433.69	69.50	1.1%

Budget Change Items

Medical Assistance

1. OVERVIEW OF MEDICAL ASSISTANCE FUNDING AND ENROLLMENT

This item presents several summary tables relating to the funding that would be provided for medical assistance (MA) benefits under the bill.

The MA program is supported by general purpose revenue (GPR), federal Medicaid matching funds (FED), three segregated funds (the MA trust fund, the hospital assessment trust fund, and the critical access hospital assessment trust fund), and various program revenue (PR) sources, such as drug manufacturer rebates.

Table 1 shows, by year and fund source, the total amounts that would be budgeted for MA benefits for each year of the 2021-23 biennium, compared to the base level funding for the program. The cost-to-continue item reflects the administration's estimates of MA costs in the 2021-23 biennium with no programmatic changes to benefits or eligibility. The remaining items show changes to the MA benefits appropriations to reflect program changes. These items are grouped as eligibility changes (full Medicaid expansion and post-partum coverage), provider payment changes (generally reimbursement rate increases or provider supplements), and program benefit changes.

TABLE 1

Summary of MA Benefits Funding
2021-22

	GPR	FED	PR	SEG	Total
2021-22					
Base Funding	$3,456,720,900	$5,959,530,100	$1,119,547,800	$576,283,900	$11,112,082,700
Cost-to-Continue					
MA Benefits	$163,182,700	$1,062,244,500	$203,958,100	$58,166,600	$1,487,551,900
Other Adjustments*	0	-8,000,000	2,615,600	0	-5,384,400
Eligibility Changes					
Medicaid Expansion	-$328,788,000	$674,963,500	$0	$0	$346,175,500
Post-Partum Coverage	0	0	0	0	0
Provider Payment Changes					
Nursing Home Rates	$29,084,000	$49,204,100	$0	$0	$78,288,100
Family Care, Direct Care	15,000,000	25,376,900	0	0	40,376,900
Personal Care, Direct Care	15,000,000	25,376,900	0	0	40,376,900
Hospital Access Payments	760,900	99,239,100	0	0	100,000,000
Disp. Share Hospital Payments	20,000,000	33,835,800	0	0	$53,835,800
Pediatric Hospital Supplement	1,950,200	5,549,800	0	0	7,500,000
Critical Access Hospital Payments	28,300	1,474,900	0	0	1,503,200
Mental Health/Day Treatment	4,069,200	6,103,900	0	0	10,173,100
Dental Access Incentives	4,779,900	7,169,800	0	0	11,949,700
Autism Treatment	3,015,800	4,523,600	0	0	7,539,400
Emergency Physician	1,983,000	3,235,500	0	0	5,218,500
Medication-Assisted Treatment	1,453,100	2,179,700	0	0	3,632,800
Speech-Language Pathology	383,500	575,300	0	0	958,800
Audiology	187,400	281,100	0	0	468,500
Tribal Shared Savings	0	0	0	0	0
Benefit Changes					
Community Health Benefit	$0	$0	$0	$0	$0
Community Health Worker	0	0	0	0	0
Residential Room & Board	3,274,600	0	0	0	3,274,600
Prescription Drug Copayment	2,228,300	3,769,800	0	0	5,998,100
Acupuncture	0	0	0	0	0
Psychosocial Rehabilitation	0	0	0	0	0
Doula Services	0	0	0	0	0
Total Change to Base	-$62,407,100	$1,997,104,200	$206,573,700	$58,166,600	$2,199,437,400
2021-22 Total	$3,394,313,800	$7,956,634,300	$1,326,121,500	$634,450,500	$13,311,520,100

* Includes program revenue reestimates and standard budget adjustments.

TABLE 1 (Continued)

Summary of MA Benefits Funding
2022-23

	GPR	FED	PR	SEG	Total
2022-23					
Base Funding	$3,456,720,900	$5,959,530,100	$1,119,547,800	$576,283,900	$11,112,082,700
Cost-to-Continue					
MA Benefits	$483,193,800	$702,068,300	$242,732,300	-$5,073,300	$1,422,921,100
Other Adjustments*	0	-8,000,000	2,615,600	0	-5,384,400
Program Eligibility Changes					
Medicaid Expansion	-$305,925,400	$716,084,600	$0	$0	$410,159,200
Post-Partum Coverage	11,077,300	9,871,300	0	0	20,948,600
Provider Reimbursement Changes					
Nursing Home Rates	$65,574,200	$98,115,700	$0	$0	$163,689,900
Family Care, Direct Care	15,000,000	22,443,800	0	0	37,443,800
Personal Care, Direct Care	15,000,000	22,443,800	0	0	37,443,800
Hospital Access Payments	-289,300	100,289,300	0	0	100,000,000
Disp. Share Hospital Payments	20,000,000	29,925,100	0	0	49,925,100
Pediatric Hospital Supplement	2,103,100	5,396,900	0	0	7,500,000
Critical Access Hospital Payments	15,100	1,488,100	0	0	1,503,200
Mental Health/Day Treatment	12,207,700	18,311,500	0	0	30,519,200
Dental Access Incentives	9,559,700	14,339,600	0	0	23,899,300
Autism Treatment	6,031,500	9,047,200	0	0	15,078,700
Emergency Physician	1,983,000	3,235,500	0	0	5,218,500
Medication-Assisted Treatment	2,906,200	4,359,300	0	0	7,265,500
Speech-Language Pathology	767,000	1,150,600	0	0	1,917,600
Audiology	374,800	562,100	0	0	936,900
Tribal Shared Savings	0	5,537,900	0	0	5,537,900
Benefit Changes					
Community Health Benefit	$9,014,000	$13,486,000	$0	$0	$22,500,000
Community Health Worker	5,701,600	8,530,400	0	0	14,232,000
Residential Room & Board	3,274,600	0	0	0	3,274,600
Prescription Drug Copayment	2,402,800	3,595,300	0	0	5,998,100
Acupuncture	1,281,900	1,918,100	0	0	3,200,000
Psychosocial Rehabilitation	803,200	1,201,800	0	0	2,005,000
Doula Services	406,700	608,500	0	0	1,015,200
Total Change to Base	$362,463,500	$1,786,010,700	$245,347,900	-$5,073,300	$2,388,748,800
2022-23 Total	$3,819,184,400	$7,745,540,800	$1,364,895,700	$571,210,600	$13,500,831,500

* Includes program revenue reestimates and standard budget adjustments.

Table 2 shows the biennial changes to the program under the bill, shown in relationship to the 2020-21 appropriation base, doubled for the purposes of comparison.

TABLE 2

Biennial Summary of MA Benefits Funding

	GPR	FED	PR	SEG	Total
Base Doubled	$6,913,441,800	$11,919,060,200	$2,239,095,600	$1,152,567,800	$22,224,165,400
Cost-to-Continue	$646,376,500	$1,764,312,800	$446,690,400	$53,093,300	$2,910,473,000
Full Medicaid Expansion	-634,713,400	1,391,048,100	0	0	756,334,700
All Other Changes	288,393,300	627,754,000	5,231,200	0	921,378,500
Total Change to Base	$300,056,400	$3,783,114,900	$451,921,600	$53,093,300	$4,588,186,200
Total 2021-23 Funding	$7,213,498,200	$15,702,175,100	$2,691,017,200	$1,205,661,100	$26,812,351,600

Table 3 shows actual and projected average monthly enrollment by major eligibility group under the bill. For BadgerCare Plus, the administration's baseline projection, used for the MA cost-to-continue reestimate, is shown separately from the impact of the bill's proposed eligibility changes--full Medicaid expansion and post-partum eligibility extension. During 2020-21 and 2021-22, enrollment in most categories is expected to be affected by a continuous enrollment policy enacted as a condition of receiving enhanced federal matching under the federal Families First Coronavirus Relief Act, as well as the economic impact of the COVID-19 pandemic. The administration anticipates that baseline enrollment will continue to increase throughout calendar year 2021, then begin to decline in 2022 before leveling off in 2023.

TABLE 3

Actual and Projected Monthly Average Enrollment by Group

	Actual	Projected	Estimates	
	2019-20	2020-21	2021-22	2022-23
Elderly, Blind, Disabled MA				
Elderly	73,054	79,842	83,306	82,503
Disabled, Non-Elderly Adults	141,496	147,859	151,329	148,371
Disabled Children	31,842	31,925	32,271	31,164
EBD Total	246,392	259,626	266,906	262,038
BadgerCare Plus				
Baseline				
Parents	163,888	200,905	216,314	194,540
Children	458,248	517,172	547,593	519,986
Childless Adults	158,164	222,421	256,692	223,178
Pregnant Women	19,796	26,184	28,713	21,973
Proposed Eligibility Changes				
MA Expansion Parents	0	0	46,119	52,989
MA Expansion Childless Adults	0	0	32,768	37,930
Post-Partum Coverage	0	0	0	5,089
BadgerCare Plus Total	800,096	966,682	1,128,199	1,055,685
Other Full Benefit MA				
Foster Care/Subsidized Adoption	20,907	23,215	25,146	24,885
Well Woman	499	491	497	507
Total Full Benefit Enrollment	1,067,895	1,250,013	1,420,749	1,343,115
Limited Benefit Groups				
Family Planning Only	37,081	39,540	43,557	44,667
Medicare Cost Sharing Assistance	19,548	17,217	17,232	17,404
Total Enrollment	1,124,524	1,306,770	1,481,538	1,405,186

Table 4 shows actual and projected SEG revenues to the MA trust fund (MATF) under the bill, as well as anticipated MATF expenditures. MATF revenues are used for the nonfederal share of MA benefits, offsetting an equal amount of GPR. Transfers to the MATF from the hospital assessment and critical access hospital assessment funds were higher than anticipated in 2019-20 and are projected to be higher in 2020-21 and 2021-22 due to the impact of enhanced federal matching received under the Families First Coronavirus Response Act. A higher matching rate reduces the amount of assessment revenue needed to pay hospital access payments, which, in turn, allows more assessment revenue to be transferred to the MATF. Because MATF expenditures are limited to the amount in the MATF SEG appropriation, the fund has carried over an unspent balance, projected at $48.8 million at the start of the $2021-22 biennium. Under the bill, the SEG appropriation is adjusted to spend down this balance in 2021-22.

TABLE 4

Actual and Projected Medical Assistance Trust Fund Revenues
Fiscal Years 2019-20 through 2022-23

	Actual	Projection	Bill	
	2019-20	2020-21	2021-22	2022-23
Beginning Balance	$0	$10,034,600	$48,800,000	$0
Provider Assessments				
Hospital Assessment*	$183,752,700	$194,388,300	$173,208,500	$155,566,200
Nursing Home/ICF-ID Bed Assessment	62,102,200	59,978,900	56,149,200	54,109,300
Critical Access Hospital Assessment*	1,210,100	1,602,100	1,343,300	981,900
Federal Funds Deposited to MA Trust Fund				
County Nursing Home Cert. Pub. Expenditures	$38,203,300	$37,057,200	$35,945,500	$34,867,100
UW Intergovernmental Transfer	15,474,900	15,726,900	15,726,900	15,726,900
UW Certified Public Expenditures	1,834,500	1,900,000	1,900,000	1,900,000
Other				
Transfer from Permanent Endowment Fund	$50,000,000	$50,000,000	$50,000,000	$50,000,000
Interest Earnings**	-1,315,100	-401,700	-450,000	-450,000
Total Available	$351,262,600	$370,286,300	$382,623,400	$312,701,400
Expenditure Authority	$334,215,300	$313,788,400	$382,623,400	$312,701,500
Gross Balance	$17,047,200	$56,497,900	$0	$0
Year-End Adjustments				
County Nursing Home Supplement***	-$7,936,000	-$7,697,900	$0	$0
Other Revenue Adjustment	923,400	0	0	0
Net, Year-End Balance	$10,034,600	$48,800,000	$0	$0

* Assessment revenue is first deposited in separate trust funds and a portion is used to make supplemental hospital payments. The amounts shown are the transfers to the MA trust fund after these supplemental payments are made.

** Negative interest earnings reflect negative cash balances that occur at times during the year.

*** Any amount of county nursing home certified public expenditure revenue collected in excess of budget projections is paid as a supplement to counties. This amount is shown as a negative adjustment to the available balance.

Table 5 shows the annual income levels, by household size, at various percentages of the 2021 federal poverty level (FPL). The current income eligibility threshold for BadgerCare Plus adults is 100%, whereas the standard for full Medicaid expansion is 138%. The other percentages shown, 160%, 200%, and 240%, are used for the different eligibility tiers in the SeniorCare program.

Annual Household Income at Various Percentages of the 2021 Federal Poverty Level, By Household Size

Household Size	Percentage of FPL 100%	138%	160%	200%	240%
One	$12,880	$17,774	$20,608	$25,760	$30,912
Two	17,420	24,040	27,872	34,840	41,808
Three	21,960	30,305	35,136	43,920	52,704
Four	26,500	36,570	42,400	53,000	63,600
Five	31,040	42,835	49,664	62,080	74,496

2. MEDICAL ASSISTANCE COST-TO-CONTINUE ESTIMATE

GPR	$646,376,500
FED	1,764,312,800
PR	446,729,200
SEG	53,093,300
Total	$2,910,511,800

Governor: Provide $1,487,571,300 ($163,182,700 GPR, $1,062,244,500 FED, $203,977,500 PR, and $58,166,600 SEG) in 2021-22 and $1,422,940,500 ($483,193,800 GPR, $702,068,300 FED, $242,751,700 PR, and -$5,073,300 SEG) in 2023-23 to fund projected MA benefits under a cost-to-continue scenario.

Background. The cost-to-continue estimate adjusts the appropriations for MA benefits to reflected anticipated costs during the biennium, under a scenario that generally assumes no changes to program eligibility or provider reimbursement rates. Thus, the funding increases are based on the administration's projections of caseload growth, changes in the use and cost of providing medical and long-term care services, and changes to the state's federal medical assistance percentage (FMAP). Although the cost-to-continue estimate generally assumes no changes to provider reimbursement rates, there are exceptions. For certain MA services, the Department's practice is to make cost-based adjustments to rates, or the rate methodology is itself based, in whole or in part, on provider costs. Examples include hospital base rates, and rates paid to federally qualified health centers, nursing homes, and state centers for individuals with intellectual disabilities. In keeping with past practice, the cost-to-continue estimates incorporate adjustments to account for these reimbursement policies.

MA Enrollment Assumptions used for the Cost-to-Continue Estimate. The total funding increases under the cost-to-continue estimate, $1,487.6 million in 2021-22 and $1,422.9 million in 2022-23, are considerably higher than in recent biennia. This is due, in large part, to the fact that the appropriation base for the program reflects enrollment projections developed prior to the COVID -19 pandemic. Enrollment in full benefit MA eligibility categories is now expected to be approximately 27% higher at the end of the 2019-21 biennium than the projections used to set the Act 9 appropriations. Thus, a significant portion of the 2021-23 cost-to-continue estimate are adjustments to the appropriation base to reflect a higher enrollment baseline.

As with previous economic recessions, increases in MA enrollment is partially due to job and income losses associated with the COVID-19 pandemic. In addition, policies adopted under the federal Families First Coronavirus Response Act (FFCRA), which was passed in March of 2020, affect both program enrollment and the state's share of total program costs. FFCRA provides a temporary 6.2 percentage point increase to the state's federal matching rate, applicable for any

quarter that the federal public health emergency associated with the COVID-19 pandemic is in effect. In order to qualify for the FMAP increase, the state must adopt a "continuous enrollment" policy, meaning that no individual enrolled in the program may be disenrolled for the duration of the federal public health emergency, even if that individual would otherwise no longer qualify due to an increase in household income or other reasons. As a consequence of the continuous enrollment policy, as well as economic recession, total MA benefits expenditures are higher in the 2019-21 biennium than budgeted levels. However, the increase in the state's FMAP has meant that GPR expenditures are lower than budgeted levels. On an all-funds basis, MA benefit expenditures in 2020-21 are projected to exceed the amount budgeted by $575.4 million, but GPR expenditures are projected to be less than the amount budgeted by $321.3 million. Thus, additional federal matching funding has allowed the program to maintain benefits and, at the same time, has reduced state spending commitments.

The administration anticipates that the federal public health emergency, and thus the continuous enrollment policy, will continue until the end of calendar year 2021. MA enrollment is projected to continue to grow in all eligibility categories throughout 2021, before declining through 2022 and then leveling off in 2023. Total enrollment in full benefit eligibility categories at the end of the biennium (June of 2023) is expected to be approximately 7% lower than at the start of the biennium and total MA benefit expenditures in 2022-23 are expected to be lower than in 2021-22. See Table 3 in the previous item for projected monthly average enrollment by category.

Federal Matching Rates. As noted, the 6.2 percentage point increase under provisions of FFCRA is expected to be in effect for the first six months of the 2021-23 biennium. The following table shows the FMAP projections, along with the corresponding state share percentage, the administration used for the cost-to-continue estimate. Most MA services are subject to the FMAP shown in the first column, although services provided to certain children eligible under the Children's Health Insurance Plan (CHIP) are subject to a higher FMAP. Due to the FFCRA increase, both the standard and CHIP FMAPs are higher in 2020-21 and 2021-22 than would otherwise be the case.

Federal Medical Assistance Percentage (FMAP) Rates
By State Fiscal Year

State Fiscal Year	Title 19 (Most MA Services)	Title 21 (Children's Health Insurance Plan)
2020-21		
State	34.44%	21.23%
Federal	65.56	78.77
2021-22		
State	37.15%	26.00%
Federal	62.85	74.00
2022-23		
State	40.06%	28.04%
Federal	59.94	71.96

Managed Care Capitation Rates. The administration assumes that monthly managed care capitation rates will increase by 2% annually. This includes payments to health maintenance organizations for acute care services under BadgerCare Plus and SSI Medicaid, as well as managed care capitation rates for long-term care services provided under Family Care. Capitation payments account for approximately 50% of total program costs.

Cost of Services and Provider Reimbursement. The administration bases the estimate of the per-beneficiary cost and utilization of services on trends in actual paid claims, using the latest data available for these estimates. For the most part, average costs assume no changes in provider reimbursement rates. However, the estimates for some services, such as inpatient and outpatient hospital services, reflect some inflationary factors in the reimbursement rates. Similarly, payments for prescription drugs reflect assumptions on increasing drug costs.

Family Care. The administration anticipates increases in Family Care enrollment, with average monthly enrollment in the program expected to be 51,900 in 2020-21, increasing to 53,200 in 2021-22 and 54,600 in 2022-23. Total costs, on an all fund basis, are estimated to be $2,241 million in 2021-22 and $2,307.6 million in 2022-23, up from $2,160.3 million in 2020-21.

IRIS Caseload and Costs. The administration assumes that enrollment in IRIS (Include, Respect, I Self-Direct), an alternative to Family Care for long-term care supports, will increase by 9.3% in 2021-22 and 8.3% in 2022-23. Average monthly IRIS enrollment is expected to be 24,300 in 2021-22 and 26,300 in 2022-23, up from 22,200 in 2020-21. Average, per-beneficiary costs are expected to increase by approximately 1.5% annually, with total costs, on an all funds basis, estimated at $927.0 million in 2021-22 and $1,020.7 million in 2022-23, up from $836.2 million in 2020-21.

Nursing Home Reimbursement. The administration projects that fee-for-service nursing home bed days will decrease by just over 8% per year, consistent with the trend of recent years. Payments to nursing homes reflect acuity adjustments to the reimbursement rate (2.3% in 2021-22 and an additional 2.3% in 2022-23). On an all funds basis, total nursing home payments, including to the state veterans homes and state centers for individuals with intellectual disabilities, are estimated at $696.4 million in 2021-22 and $672.7 million in 2022-23, compared to an estimated $729.8 million in 2020-21.

Children's Long-term Support (CLTS) Waiver. The administration anticipates increases in enrollment in the CLTS waiver program as counties continue to make progress enrolling children on the program waiting list. Total CLTS enrollment is expected to be 12,600 by the end of 2020-21, increasing to a monthly average of 13,300 in 2021-22 and 14,200 in 2022-23. Annual per beneficiary costs are anticipated to be $12,763 in both years of the biennium (including administrative costs), a 2.5% increase from average costs in 2020-21. CLTS costs, on an all funds basis, are estimated at $163.1 million in 2021-22 and $176.0 million in 2022-23, up from $138.9 million in 2020-21.

Medicare Premiums for Dual Eligibles and Medicare Part D Clawback Payments. Estimates of premium payments for Medicare dual eligibles are based on out-year projections developed by the federal Medicare Board of Trustees. Medicare Part B premiums are anticipated to increase by 6.2% in 2022 and by 5.7% in 2023. The program pays monthly Part B premiums

for approximately 135,000 dual eligible members. Medicare premium payments, on an all funds basis, are estimated at $287.9 million in 2021-22 and $308.7 million in 2022-23. The Medicare Part D clawback is a GPR payment made to the federal government to offset a portion of federal prescription drug coverage under Medicare Part D, in lieu of prescription drug coverage that, prior to Part D, was provided through MA for dual eligible members. The per-beneficiary payment is indexed to the price of drugs. The administration used the Medicare Trustee's projection of this index, a 2.7% annual increase, to estimate clawback payments. Clawback payments are estimated at $277.4 million GPR in 2021-22 and $321.4 million GPR in 2022-23. Because the clawback formula is based, in part, on the state's FMAP, the 2021-22 payment is lower than it would otherwise be due to the impact of the temporary FMAP increase under FFCRA.

Summary of Total MA Benefits Funding under the Cost-to-Continue Scenario. The following table shows, by fund source, the total MA funding under just the cost-to-continue estimate in comparison to the appropriation base. That is, the table shows the funding level that would be provided if all other items affecting MA benefits funding were excluded.

Total MA Benefits Funding Under Cost-to-Continue Estimate, by Fund Source, In Comparison to Appropriation Base

	GPR	FED	PR	SEG	Total
Appropriation Base	$3,456,720,900	$5,959,530,100	$1,119,547,800	$576,283,900	$11,112,082,700
Total Funding under Cost-to-Continue Estimate					
2021-22	$3,619,903,600	$7,021,774,600	$1,323,505,900	$634,450,500	$12,599,634,600
2022-23	3,939,914,700	6,661,598,400	1,362,280,100	571,210,600	12,535,003,800

Of the total funding under the cost-to-continue estimate item, $19,400 PR annually is provided in an appropriation for the administration of the MA-supported long-term care programs. Although this adjustment reflects a cost-to-continue estimate for MA-supported services, the appropriation supports administrative costs, rather than benefits costs. For this reason the PR and all funds totals in this cost-to-continue reestimate item are slightly different than the totals shown in Table 1, which only reflects funding in MA benefits appropriations.

3. FULL MEDICAID EXPANSION

GPR	- $634,100,000
FED	1,392,888,100
Total	$758,788,100

Governor: Increase funding for MA benefits and administration to reflect the fiscal effect of adopting the full Medicaid expansion, effective on July 1, 2021. The following table shows the funding changes by fund source and funding purpose under the bill.

Full Medicaid Expansion
Governor's Recommendations

	2021-22	2022-23	Biennial Total
MA Benefits Funding			
GPR	-$328,788,000	-$305,925,400	-$634,713,400
FED	674,963,500	716,084,600	1,391,048,100
Subtotal	$346,175,500	$410,159,200	$756,334,700
MA Administration			
GPR	$306,700	$306,700	$613,400
FED	920,000	920,000	1,840,000
Subtotal	$1,126,700	$1,126,700	$2,253,400
Total Funding Change			
GPR Total	-$328,481,300	-$305,618,700	-$634,100,000
FED Total	675,883,500	717,004,600	1,392,888,100
Total	$347, 4 02,200	$411,385,900	$758,788,100

Statutory Changes to Implement Full Medicaid Expansion. Increase the income eligibility threshold under MA for parents and caretakers from 100% of the federal poverty level (FPL) to 133% of the FPL. Include "childless adults" in the list of eligibility categories for BadgerCare Plus. Define a childless adult, for the purposes of MA eligibility, as an individual who: (a) is an adult under the age of 65; (b) has family income that does not exceed 133% of the FPL; and (c) is not otherwise eligible for MA or Medicare.

Require DHS to comply with all federal requirements to qualify for the highest available enhanced federal medical assistance percentage and to 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 do so. Repeal current law provisions related to childless adult eligibility through federal waiver authority. Require DHS to submit any necessary request to the federal Department of Health and Human Services to modify or withdraw from the childless adult demonstration project to reflect the incorporation of childless adults into BadgerCare Plus. Repeal a current law provision that prevents DHS from expanding MA program eligibility to qualify for enhanced federal matching funds under the Affordable Care Act (ACA). Specify that these provisions take effect on July 1, 2021.

Background. The ACA provides an enhanced FMAP to states for coverage of "newly-eligible" adults with income up to 133% of the federal poverty level. The enhanced FMAP for newly eligible groups is 90%, meaning that the state is responsible for 10% of the cost. The standard FMAP for Wisconsin is currently approximately 60%, meaning that the state is responsible for 40% of the cost. Because federal Medicaid law uses a standard 5% income disregard for the purposes of determining income eligibility, the 133% of FPL income threshold as specified in statute is effectively 138% of FPL as measured using gross income.

Under the ACA, an eligibility group is determined to be "newly-eligible" if members of the group were not eligible to receive full Medicaid benefits as of December 1, 2009. For Wisconsin,

parents would not be considered to be "newly eligible" since the state covered parents up to 200% of the FPL on that date. However, childless adults would meet the "newly-eligible" definition since they were not eligible for full coverage on that date. Furthermore, although the state has provided full benefits coverage to childless adults up to 100% of the FPL since 2014, all childless adults would be considered "newly-eligible" with the adoption of full Medicaid expansion, and so their costs would be eligible for the enhanced FMAP if the state adopts the full Medicaid expansion eligibility standards. The state currently funds coverage for childless adults at the state's standard FMAP.

Fiscal Effect. The funding adjustments for MA benefits under the full Medicaid expansion reflect the net impact of two changes: (a) funding increases both GPR and FED, associated with extending coverage to parents and childless adults with household income between 100% of FPL and 138% of FPL; and (b) an increase in FED and corresponding decrease in GPR to reflect the shift from standard FMAP to enhanced FMAP for the coverage of childless adults who are currently eligible, those under 100% of the FPL. Since the GPR reductions under the second change exceed the GPR increases under the first change, adopting full Medicaid expansion would result in net GPR savings, estimated at $634.7 million over the biennium. The following table shows the fiscal effect for each of these changes, as well as the net effect, by fund source.

Full Medicaid Expansion Benefits Funding Changes by Component
($ in Millions)

	2021-22	2022-23	2021-23 Biennium
Expansion Population Coverage			
GPR	$79.8	$99.9	$179.7
FED	266.4	310.3	576.6
Total	$346.2	$410.2	$756.3
Enhanced FMAP			
GPR	-$408.6	-$405.8	-$814.4
FED	408.6	405.8	814.4
Total	$0.0	$0.0	$0.0
Net MA Benefits Funding			
GPR	-$328.8	-$305.9	-$634.7
FED	675.0	716.1	1,391.0
Total	$346.2	$410.2	$756.3

Subsequent to the introduction of the bill, the U.S. Congress passed, and the President signed, legislation that provides an incentive to non-expansion states to adopt full Medicaid expansion. Under the American Rescue Plan Act of 2021, states that adopt expansion (if they have not already done so) receive a 5.0 percentage point increase in the standard FMAP for the two years following adoption of full expansion income eligibility standards. The increase to the FMAP would apply to most MA services that are subject to the standard FMAP. It would not affect the FMAP for the newly-eligible groups, which would remain at 90%. If the state becomes eligible for the incentive FMAP, the additional federal funds would offset GPR in the program. The GPR reductions associated with this new federal incentive are not reflected in the bill and would be in

addition to the GPR savings included under this item.

To estimate the enrollment growth associated with increasing the eligibility threshold to 138% of the FPL, the administration assumes that the number of parents and childless adults would increase by an amount approximately equal to the share of the current enrollment who have a household income in the range between 60% of the FPL and 100% of the FPL. The administration also assumes that enrollment in the expansion population would phase in over the course of the first six months, which lowers the average monthly enrollment in 2021-22, relative the expected enrollment when fully phased in. The following table shows the administration's estimates of additional average monthly enrollment that would occur as the result of full Medicaid expansion.

Estimated Average Monthly Expansion Enrollment

Enrollment Category	2021-22	2022-23
Parents	46,119	52,989
Childless Adults	32,768	37,930
Total Enrollment Increase	78,887	90,919

Funding for Administrative Costs. In addition to funding changes for MA benefits, this item provides funding for an anticipated increase in enrollment services conducted by county income maintenance consortia. The amount in the bill is based on a calculation of an average per person cost for enrollment, multiplied by the estimated expansion caseload. No additional funding would be provided for the Department's Milwaukee Enrollment Services (MilES) Bureau, which conducts enrollment services in Milwaukee County. The Department indicates that it would absorb the cost of the additional anticipated enrollment workload in Milwaukee County.

[Bill Sections: 390, 529, 1007, 1021, 1022, 1044 thru 1047, 1052, 3469, 9119(1), and 9419(1)]

4. NURSING HOME REIMBURSEMENT RATES

GPR	$94,658,200
FED	147,319,800
Total	$241,978,000

Governor: Provide $78,288,100 ($29,084,000 GPR and $49,204,100 FED) in 2021-22 and $163,689,900 ($65,574,200 GPR and $98,115,700 FED) in 2022-23 to increase MA reimbursement rates paid to skilled nursing facilities and intermediate care facilities for individuals with an intellectual disability (ICFs-IID).

Of this amount, require DHS to increase MA rates paid to nursing facilities and ICFs-IID by a budgeted sum of $15,000,000, as the state share of payments, and the matching federal share of payments, in 2021-22, and by a budgeted sum of $15,000,000, as the state share of payments, and the matching federal share of payments, in 2022-23, to support staff in those facilities who perform direct care. The administration estimates that funding targeted at staff who perform direct care would be $40,376,900 ($15,000,000 GPR and $25,376,900 FED) in 2021-22 and $37,443,800 ($15,000,000 GPR and $22,443,800 FED) in 2022-23.

[Bill Section: 9119(11)]

5. NURSING HOME AND COMMUNITY-BASED RESIDENTIAL FACILITY RATE SETTING METHODOLOGY

Governor: Modify the methodology used by the Department in setting Medicaid payment rates to nursing homes and licensed community-based residential facilities (CBRFs).

Setting Medicaid Rates. Repeal the requirement that DHS establish nursing home and CBRF rates using the Resource Utilization Groupings methodology in determining a facility's case-mix index. Instead, require that a facility's case-mix index be determined using acuity based measures. Repeal the definition of "Resource Utilization Groupings," which currently means a comparative resource utilization grouping that classifies each facility resident based on information obtained from performing, for the resident, a minimum data set assessment developed by the federal Centers for Medicare and Medicaid Services (CMS).

Specify that the Department's payment system may incorporate payment adjustments for dementia, behavioral needs, or other complex medical conditions. Under current law, such payment adjustments are required.

These changes would align the state's rate-setting methodology with the updated patient driven payment model established by CMS.

Use of Cost Report Data for Rate Setting. Authorize the Department, for purposes of determining Medicaid payments to nursing homes and CBRFs, to use data other than data from calendar year 2020 or 2021, if the Department determines that calendar year 2020 or 2021 are not appropriate bases for prospective rate setting due to fluctuations in costs caused by the COVID-19 pandemic.

[Bill Sections: 1014, 1015, and 9119(3)]

6. FAMILY CARE DIRECT CARE REIMBURSEMENT

GPR	$30,000,000
FED	47,820,700
Total	$77,820,700

Governor: Provide $40,376,900 ($15,000,000 GPR and $25,376,900 FED) in 2021-22 and $37,443,800 ($15,000,000 GPR and $22,443,800 FED) in 2022-23 to increase the direct care and services portion of the capitation rates the Department provides to managed care organizations (MCOs) to fund long-term care services for individuals enrolled in Family Care. This funding would be provided in addition to funding in the bill that the administration estimates would be needed to fund actuarially sound capitation rates in the 2021-23 biennium, which is included as part of the Medicaid cost-to-continue item.

Funding was provided for this purpose in 2017 Act 59 (the 2017-19 budget act) and 2019 Act 9 (the 2019-21 budget act). In the 2017-19 and 2019-21 biennia, the Department distributed the additional funding through the Direct Care Workforce Funding Initiative, which required MCOs to pass additional funding on to providers. Subsequently, providers chose how to pass the funding on to their staff, for example, in the form of wage increases, bonuses, or additional paid time off for certain direct care workers, or to fund employer payroll tax increases that result from increasing workers' wages.

7. PERSONAL CARE REIMBURSEMENT RATE

GPR	$30,000,000
FED	47,820,700
Total	$77,820,700

Governor: Provide $40,376,900 ($15,000,000 GPR and $25,376,900 FED) in 2021-22 and $37,443,800 ($15,000,000 GPR and $22,443,800 FED) in 2022-23 to increase MA personal care reimbursement rates.

Require DHS to increase MA rates paid for direct care to agencies that provide personal care by a budgeted sum of $15,000,000, as the state share of payments, and the matching federal share of payments, in 2021-22, and by a budgeted sum of $15,000,000, as the state share of payments, and the matching federal share of payments, in 2022-23, to support staff in those agencies who perform direct care.

[Bill Section: 9119(6)]

8. ACUTE CARE HOSPITAL ACCESS PAYMENTS

GPR	$471,600
FED	199,528,400
Total	$200,000,000

Governor: Specify that if income eligibility thresholds are expanded for BadgerCare Plus adults to comply with standards for full Medicaid expansion under the Affordable Care Act, the total amount of hospital supplement payments under MA would be equal to the amount collected under the hospital assessment divided by 53.69%, instead of the amount of the assessment divided by 61.68%, as under current law. This change would have the effect of increasing the annual total by $100.0 million, from $672,028,700 to $772,028,700.

Provide $100,000,000 ($760,900 GPR and $99,239,100 FED) in 2021-22 and $100,000,000 (-$289,300 GPR and $100,289,300 FED) in 2022-23 to reflect a $100.0 million annual increase in the total hospital access payments under MA, as well as a higher average federal matching rate for payments, associated with the adoption of full Medicaid expansion. Modify SEG appropriation funding to reflect shifts in the use of SEG revenues for access payments and the availability of MA trust fund revenue for MA benefits under this item, as follows: (a) an increase of $760,900 SEG in 2021-22 in the appropriation for hospital access payments and a corresponding decrease in the SEG appropriation for MA benefits from the MA trust fund; and (b) a decrease of $289,300 SEG in 2022-23 in the appropriation for hospital access payments and a corresponding increase in the SEG appropriation for MA benefits from the MA trust fund.

Background. Under current law, DHS collects an assessment on hospitals (excluding psychiatric hospitals) based on a percentage of patient revenues. There are two separate assessments -- one collected on large acute care and rehabilitation hospitals (hereafter "acute care hospital" or ACH assessment), and another collected on critical access hospitals (generally rural hospitals with 25 or fewer beds). For the ACH assessment, the rate, which is 0.78% of gross patient revenues in 2020-21, is set each year so that the total amount collected equals $414,507,300. ACH hospital assessment revenue is deposited in the hospital assessment fund and a portion is used, along with federal matching funds, to make hospital access payments and other hospital supplements provided in addition to the base rate reimbursement for hospital services. Under the statutory formula, DHS is required to make payments totaling $672,028,700. Of this amount, $654,228,700 is used for hospital access payments, while the remaining $17,800,000 is used for

other hospital supplemental payments. Hospital access payments are flat rate payments made in addition to the base reimbursement for inpatient and outpatient services. In 2020-21, the hospital access payment is set at $3,862 for inpatient services (paid upon discharge) and $267 for outpatient services (paid per visit), amounts that are recalculated each year to distribute the total amount of funding allocated for access payments.

Any assessment revenue remaining in the hospital assessment fund after making the access payments is transferred to the medical assistance trust fund (MATF), where it is used for the state share of general MA benefits, offsetting what would otherwise be GPR expenditures.

For the purposes of determining the amount of the access payment, DHS divides the total access payment pool by the total number of number of MA hospital visits, except that visits by childless adults are excluded from the calculation, so no access payments are made on behalf of childless adults.

Currently, childless adults are covered under the terms of a federal demonstration waiver. DHS does not make access payments for childless adult hospital services, a policy that effectively reduces the cost of childless adult coverage, in order to comply with federal "budget neutrality" rules applicable to such waivers. Under the bill, childless adults would be covered under standard federal eligibility rules (under full Medicaid expansion), rather than under the federal waiver, meaning that federal budget neutrality rules would no longer apply and the Department could begin making access payments for childless adults.

Change to Effective Matching Rate Due to Full Medicaid Expansion. Although this item would increase annual hospital access payments by $100,000,000, this increase requires only small changes in state GPR funding (a slight increase in 2021-21 and a slight decrease in 2022-23) due to the effect of full Medicaid expansion and the proposal to make access payments for hospital visits by childless adults.

As with other MA benefits costs, access payments and other hospital supplements are eligible for federal matching funds. The applicable federal matching rate depends upon the eligibility category of the MA beneficiary who receives the hospital services. In most cases, the standard FMAP, which is approximately 60%, applies. If, however, the hospital services are provided to a child eligible under the children's health insurance program (CHIP), then the higher CHIP FMAP applies, approximately 72%. Both of these rates are increased on a temporary basis under federal legislation passed in response to the COVID-19 epidemic. Based on the mix of MA patients currently receiving hospital services, as well as the temporary increase to the standard FMAP, DHS estimates that the blended average FMAP for all hospital access payments would be 63.3% in 2021-22 and 60.4% in 2022-23, in the absence of any other changes. If, however, DHS includes childless adults in the access payment distribution and they were to become eligible for an enhanced FMAP with full Medicaid expansion (90%), the effective blended FMAP would be projected to increase to 68.3% in 2021-22 and 65.9% in 2022-23. This reduction in the state share of access payments would allow the state to increase access payments by $100.0 million annually with only a small change to GPR costs.

Without the enhanced FMAP associated with full Medicaid expansion, a $100,000,000 annual increase to access payments would require GPR increases of approximately $36.7 million

in 2021-22 and $39.6 million in 2022-23.

[Bill Section: 1009]

9. CRITICAL ACCESS HOSPITAL ACCESS PAYMENTS

GPR	$43,400
FED	2,963,000
Total	$3,006,400

Governor: Specify that if income eligibility thresholds are expanded for BadgerCare Plus adults to comply with standards for full Medicaid expansion under the Affordable Care Act, the total amount of critical access hospital (CAH) access payments under MA would be equal to the amount collected under the CAH assessment divided by 53.69%, instead of the amount of the assessment divided by 61.68%, as under current law. This change would have the effect of increasing CAH access payments by an estimated $1,503,200 annually.

Provide $1,503,200 ($28,300 GPR and $1,474,900 FED) in 2021-22 and $1,503,200 ($15,100 GPR and $1,488,100 FED) in 2022-23 to increase the total amount of CAH access payments under MA. Modify SEG appropriation funding to reflect shifts in the use of SEG revenues for CAH access payments and the availability of MA trust fund revenue for MA benefits under this item, as follows: (a) increases of $23,800 SEG in 2021-22 and $15,100 SEG in 2022-23 in the appropriation for CAH access payments; and (b) corresponding decreases in the SEG appropriation for MA benefits from the MA trust fund.

Unlike the ACH hospital access payments (described in the previous summary item), the total amount of the CAH access payments changes each year since the amount collected from the CAH assessment changes. DHS projects that the CAH access payments (SEG and FED total) will be $9,976,300 in 2020-21. Under the current law formula, total CAH access payments are projected to decline (due to a decline of CAH assessment revenues) to $9,477,500 in 2021-22 and $9,003,600 in 2022-23. The annual net funding increase of $1,503,200 to CAH access payments under this item reflects the administration's estimate of the effect of the change to the formula used to determine the amount of the total payments. The actual change in CAH access payments would depend upon the actual amount of CAH assessment revenue collected.

Similar to the proposed change to ACH access payments, the federal share of the CAH access payments would increase as the result of the full Medicaid expansion item. Thus, although the bill would increase total access payments by an estimated $1.5 million, the state share of this increase is just $28,300 in 2021-22 and $15,100 in 2022-23. Without full Medicaid expansion, a $1.5 million annual increase to CAH access payments would require GPR increases of approximately $547,500 in 2021-22 and $590,700 in 2022-23.

[Bill Section: 1010]

10. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

GPR	$40,000,000
FED	63,760,900
Total	$103,760,900

Governor: Specify that if income eligibility thresholds are expanded for BadgerCare Plus adults to comply with standards for full Medicaid

expansion under the Affordable Care Act (as summarized in an item above), the payment parameters for the disproportionate share hospital (DSH) program would be modified as follows: (a) an increase from $27,500,000 to $47,500,000 per year in the amount of state that DHS is required to allocate for payments, in addition to the associated federal matching funds; and (b) an increase from $4,600,000 to $7,950,000 to the maximum amount any single hospital can receive in each fiscal year.

Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $49,925,100 ($20,000,000 GPR and $29,925,100 FED) in 2022-23 to increase DSH payments, to reflect the increase to the base level payments that would be made under the bill.

DSH payments are provided to hospitals for which more than 6% of inpatient days are attributable to MA patients. The 2019-21 biennial budget act, as modified by partial veto, temporarily increased the state share of payments and the maximum individual payment for 2019-21 only. Under the corresponding state plan approved by the federal Medicaid authority, the state share of DSH payments was set at $47,500,000 per year and the individual payment cap was $7,950,000, an increase from a total state share of $27,500,000 per year and a maximum payment cap of $4,600,000. In addition to the increase in the state share of payments, the total amount distributed was also affected by a temporary 6.2 percentage point increase to the state's FMAP under provisions of federal COVID relief legislation. This increase, which first applied in January of 2020 and will remain in effect through at least the end of the 2019-21 biennium, has the effect of increasing total payments since the state share of the payment is fixed in statute. With the combination of the temporary increase to the amount of state funds allocated for payments and the increase to the FMAP, total DSH payments (state and federal funds) increased from $67.7 million in 2018-19 to $127.5 million in 2019-20 and $132.8 million in 2020-21.

Since the increase to the state allocation for DSH payments was only in effect for the 2019-21 biennium, the funding for providing the increase is not part of the appropriation base for the 2021-23 biennial budget. Under the Governor's proposal, the state share of payments would be established at the same level as in the 2019-21 biennium, but on a permanent basis, provided that the state enacts full Medicaid expansion (as proposed by the Governor). Total DSH payments would be approximately $127.9 million in 2021-22 and $118.6 million in 2022-23. Payments are expected to decrease from the amount distributed in 2020-21 due to the expectation that the temporary 6.2 percentage point increase to the state's FMAP will expire at the end of calendar year 2021.

[Bill Sections: 1011 and 1012]

11. PEDIATRIC HOSPITAL SUPPLEMENTAL PAYMENTS

GPR	$4,053,300
FED	10,946,700
Total	$15,000,000

Governor: Specify that if income eligibility thresholds are expanded for BadgerCare Plus adults to comply with standards for full Medicaid expansion under the Affordable Care Act, the Department may, using a method determined by the Department, distribute $7,500,000 to free-standing pediatric teaching hospitals located in Wisconsin for which 45% or more of their total inpatient days are for MA recipients. Currently, Children's Hospital of Wisconsin is the only hospital in the state that would be eligible for this

payment.

Provide $7,500,000 ($1,950,200 GPR and $5,549,800 FED) in 2021-22 and $7,500,000 ($2,103,100 GPR and $5,396,900 FED) in 2022-23 for making this payment.

Require DHS to distribute $2,000,000 from existing appropriations to acute care hospitals located in Wisconsin that have inpatient days in the hospital's acute care and intensive care pediatric units (excluding neonatal intensive care units) that exceed 12,000 days in the second calendar year prior to the hospital's current fiscal year. DHS already makes such payments under terms in the state's Medicaid plan, but the terms are not established in state statute. Since these payments are currently made from the MA program budget, no additional funds are provided by the bill. Currently, UW Hospital and Clinics and Children's Hospital of Wisconsin receive these supplemental payments.

[Bill Section: 1016]

12. POST-PARTUM ELIGIBILITY EXTENSION

GPR	$11,077,300
FED	9,871,300
Total	$20,948,600

Governor: Provide $20,948,600 ($11,077,300 GPR and $9,871,300 FED) in 2022-23 to reflect the estimated cost of extending benefits for MA-eligible pregnant women until the last day of the month in which the 365th day after the last day of the pregnancy falls, instead of the last day of the month in which the 60th day after the last day of the pregnancy falls, as under current law. Require the Department to request federal approval of a state Medicaid plan amendment or federal waiver to extend post-partum eligibility for pregnant women, but require the Department to extend post-partum coverage as described above, regardless of whether federal approval is granted. In the event that a state plan amendment or waiver is not approved, the state would be responsible for the full cost of such coverage.

Under current law, the income eligibility threshold for pregnant women is 300% of the federal poverty level (FPL), and eligibility for coverage expires at the end of the month in which the 60th day following the pregnancy falls. Women whose household income is below 100% of the FPL may retain eligibility following pregnancy, as either a parent or (if she is not a parent of a child in the household) as a childless adult. Women above that level (unless eligible under other MA provisions) are no longer eligible for coverage. This item would extend the post-partum coverage period from 60 days following delivery to 365 days following delivery, which in effect provides an additional 10 months of coverage for women whose household income is above 100% of the FPL. The administration projects that this provision would increase enrollment (monthly average) by approximately 8,100 women once fully phased in. However, because this policy would phase in over a period of 10 months (as, with each month following implementation, women retain coverage who would otherwise lose it), the impact on average monthly enrollment would be an increase of approximately 5,000 in 2022-23.

In addition to standard BadgerCare Plus eligibility, federal law provides coverage for pregnant women under the Children's Health Insurance Plan (CHIP) who would otherwise be ineligible. This CHIP coverage applies to pregnant women who are incarcerated and pregnant women who are lawfully admitted immigrants but who are not eligible for Medicaid coverage

since they are within five years of the time of establishing residency in the United States. The funding estimates for this item are based on the assumption that the state would receive federal approval for extended post-partum coverage of pregnant women eligible under standard BadgerCare Plus, but that the state would cover the full cost of providing extended coverage of women eligible under CHIP. Of the total funding estimate for 2022-23, $16,469,200 ($6,597,800 GPR and $9,871,300) would be for women eligible for standard BadgerCare Plus coverage (eligible for federal match) and $4,479,400 GPR would be for coverage extension for inmates and qualifying immigrants.

[Bill Sections: 1033, 1034, 1042, and 1048 thru 1050]

13. OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AND CHILD-ADOLESCENT DAY TREATMENT REIMBURSEMENT

GPR	$16,276,900
FED	24,415,400
Total	$40,692,300

Governor: Provide $10,173,100 ($4,069,200 GPR and $6,103,900 FED) in 2021-22 and $30,519,200 ($12,207,700 GPR and $18,311,500 FED) in 2022-23 to increase reimbursement rates paid for outpatient services for mental health and substance abuse and for day treatment services for children and adolescents. The funding provided by the bill is based on an estimate of the cost to increase rates for these services by 40% on January 1, 2023, with half of the increase (a 20% increase) phased in beginning on January 1, 2022. The administration estimates that, when fully phased in, the new reimbursement rates will increase MA expenditures for these services by approximately $40.7 million on an annualized basis.

14. MEDICATION-ASSISTED TREATMENT REIMBURSEMENT

GPR	$4,359,300
FED	6,539,000
Total	$10,898,300

Governor: Provide $3,632,800 ($1,453,100 GPR and $2,179,700 FED) in 2021-22 and $7,265,500 ($2,906,200 GPR and $4,359,300 FED) in 2022-23 to increase reimbursement rates for medication-assisted treatment (MAT) services for individuals with substance use disorder. The funding provided in the bill is based on an estimate of the cost to provide a 20% rate increase for services provided by opioid treatment providers and to provide a $15 increase to evaluation and management billing codes claimed by primary care physicians for MAT services. Medication-assisted treatment services include patient evaluation, laboratory analysis of samples, and administration of methadone and other opioid abuse treatment medications. These services are primarily provided by specialized opioid treatment providers (OTPs), but similar services can be provided by primary care physicians, especially when less-intensive treatment in required. The administration estimates that the rate increase for medication-assisted treatment services would lead to a 3% increase in utilization of OTP services, and that the rate increase for primary care physicians would lead to a 25% increase in utilization of their services for medication-assisted treatment.

15. COVERAGE OF ROOM AND BOARD DURING RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT

GPR	$6,549,200

Governor: Provide $3,274,600 annually to provide coverage for room and board costs of MA enrollees receiving residential treatment for substance use disorders.

Since 2017, coverage for residential substance use disorder (RSUD) treatment at certain facilities with fewer than 16 beds has been available through the county-option comprehensive community services benefit. Federal Medicaid regulations prohibit using federal matching funds for room and board costs other than in an inpatient hospital; currently, some counties use their own funds to provide assistance with these costs, but they are otherwise the responsibility of the individual seeking treatment. Beginning in February, 2021, under the terms of a federal waiver, DHS is expanding MA coverage of RSUD treatment to include larger facilities, classified as institutes of mental disease (IMDs), and to make the benefit available in all counties.

This provision would provide coverage, using 100% GPR, of room and board costs under the newly-expanded RSUD benefit. The administration estimates reimbursement of $50 per day, and forecasts an average of approximately 240 members receiving treatment at a time.

[Bill Section: 1035]

16. PSYCHOSOCIAL SERVICES

GPR	$803,200
FED	1,201,800
Total	$2,005,000

Governor: Provide $2,005,000 ($803,200 GPR and $1,201,800 FED) in 2022-23 to expand access to medical assistance psychosocial services through the use of non-county providers. Specify that DHS may certify psychosocial service providers that are not county-based and require DHS to reimburse non-county providers of psychosocial services for both the federal and nonfederal share of a service fee schedule that is determined by the Department. Require the Department to reimburse counties and multi-county partnership providers for both the federal and non-federal share of allowable charges for services in all cases. (Under current law, the program pays both the nonfederal and federal share of the reimbursement only to counties that provide services on a regional basis, as determined by the Department.) Specify that DHS may promulgate or amend rules, update medical assistance policies, and request any state plan amendment or waiver of federal Medicaid law from the federal government necessary to provide reimbursement to non-county-based providers for medical assistance psychosocial services.

Under current law, most psychosocial services, including peer support, employment services, and health monitoring and management, are provided only through the county-based comprehensive community services (CCS) benefit. Under CCS, these services are only available to medical assistance enrollees who reside in counties that have elected to provide these services and demonstrate behavioral health needs meeting their county's eligibility requirements. Currently all but two counties (Douglas and Florence) offer the CCS benefit. This item seeks to increase access to these services for enrollees in all counties and with broader behavioral health needs by offering services through non-county-based providers in addition to the existing county-based and multi-county partnership providers.

Based on related current benefits, the administration estimates that non-county-based providers could eventually serve 15,000 to 25,000 medical assistance enrollees per year, with an average annual cost of $600 to $1,000 each, for a total annual cost of $12 million to $20 million. However, they forecast that uptake will grow to this level over several years, and so expect the first full year of benefits to cost $3 million to $5 million. The funding provided under this item reflects the administration's assumption that non-county providers would begin providing services on January 1, 2023, meaning that services would be provided for half of fiscal year 2022-23, for an all-funds cost of approximately $2,005,000.

[Bill Sections: 1027 thru 1031, and 9119(5)]

17. COMMUNITY HEALTH BENEFIT

GPR	$10,514,000
FED	14,986,000
Total	$25,500,000

Governor: Provide $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $24,500,000 ($10,014,000 GPR and $14,486,000 FED) in 2022-23 to fund a new MA benefit, subject to federal approval, for nonmedical services that contribute to determinants of health. Direct the Department to determine which specific nonmedical services that contribute to determinants of health would be included as an MA benefit, and require the Department to seek any necessary plan amendment or request any waiver of federal Medicaid law to implement this benefit. Specify that DHS is not required to provide these services as a benefit if the federal Department of Health and Human Services does not provide federal matching funds for these services.

The administration indicates that the eligible services under the proposed benefit may include housing referrals, nutritional mentoring, stress management, and other services that would positively impact an individual's economic and social condition. The administration's funding estimate assumes that approximately 12,500 individuals would be served on a monthly basis, at an average cost of $300 per person per month, for an annual total of $45.0 million. Assuming the benefit would begin in January of 2023, the bill provides $22,500,000 ($9,014,000 GPR and $13,486,000 FED) in fiscal year 2022-23 in the MA benefits appropriations. In addition to MA benefits, this item also includes $1,000,000 ($500,000 GPR and $500,000 FED) in 2021-22 and $2,000,000 ($1,000,000 GPR and $1,000,000 FED) in 2022-23 for costs to implement and administer the benefit.

[Bill Sections: 1039 and 1040]

18. COMMUNITY HEALTH WORKER SERVICES

GPR	$5,701,600
FED	8,530,400
Total	$14,232,000

Governor: Provide $14,232,000 ($5,701,600 GPR and $8,530,400 FED) in 2022-23 to fund coverage of community health worker services under MA. Requite DHS to submit to the federal Medicaid authority any necessary state plan amendments or requests for waiver to cover community health worker services under MA, but limit coverage under this benefit to those services receiving federal approval.

Define a community health worker as a frontline public health worker who is a trusted

member of or has a close understanding of the community served, enabling the worker to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery, and who builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

[Bill Sections: 1026 and 1036]

19. COVERAGE OF DOULA SERVICES

GPR	$406,700
FED	608,500
Total	$1,015,200

Governor: Provide $1,015,200 ($406,700 GPR and $608,500 FED) in 2022-23 to fund MA coverage of doula services. Require DHS to apply for any necessary waivers of federal Medicaid law and submit any necessary state plan amendments to provide coverage of doula services under MA. Require DHS to reimburse certified doulas for childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, if federal approval is granted. Define a certified doula as an individual who has received certification from a doula certifying organization recognized by DHS.

DHS estimates that coverage of doula services would begin July 1, 2022, and that approximately 1,300 women would access the benefit per year, at a cost of $770 each.

[Bill Sections: 1032 and 1038]

20. ELIMINATE COPAYMENTS FOR PRESCRIPTION DRUGS

GPR	$4,631,100
FED	7,365,100
Total	$11,996,200

Governor: Provide $5,998,100 ($2,228,300 GPR and $3,769,800 FED) in 2021-22 and $5,998,100 ($2,402,800 GPR and $3,595,300 FED) in 2022-23 to reflect the elimination of prescription drug copayments under MA. Exempt prescription drugs covered under MA from current recipient copayment requirements.

Under current law, MA requires providers to collect small copayments from MA recipients for many services, including prescription drugs. The copayment for generic drugs is $1, the copayment for brand-name drugs is $3, and the total copay charged for drugs is capped at $12 per month. Several groups of recipients, including nursing home residents and children under 19, are already exempted from copayment requirements, and no provider may deny services because the recipient is unable to pay. Provider reimbursement payments are reduced by the amount of the copayment, regardless of whether the provider collects it. This item provides funding to reflect an increase in payments to pharmacies, equal to the amount of the copayment reduction that would otherwise occur.

[Bill Sections: 1017 thru 1020]

21. MA DENTAL ACCESS INCENTIVE PAYMENTS

GPR	$14,339,600
FED	21,509,400
Total	$35,849,000

Governor: Provide $11,949,700 ($4,779,900 GPR and $7,169,800 FED) in 2021-22 and $23,899,300 ($9,559,700 GPR and $14,339,600 FED) in 2022-23 to increase reimbursement rates for dental providers that meet quality of care standards, as established by the Department, and that meet one of the following qualifications: (a) for a non-profit or public provider, 50 percent or more of the individuals served by the provider lack dental insurance or are enrolled in MA; or (b) for a for-profit provider, five percent or more of the individuals served by the provider are enrolled in MA.

Require the Department to increase reimbursement in the following manner, for dental services rendered on or after January 1, 2022, by a provider meeting the above criteria: (a) for a qualified non-profit or public provider, a 50 percent increase above the rate that would otherwise be paid to that provider; (b) for a qualified for-profit provider, a 30 percent increase above the rate that would otherwise be paid to that provider; and (c) for providers rendering services to individuals enrolled in managed care under the MA program, an increase to reimbursement on the basis of the rate that would have been paid to the provider had the individual not been enrolled in managed care. Specify that if a provider has more than one service location, the eligibility thresholds described above apply to each location, and payment for each service location would be determined separately.

Specify that any provider receiving reimbursement through the enhanced dental reimbursement pilot program created by 2015 Act 55 is not eligible for increased reimbursement under this new program. The pilot program, which would be retained under the bill, increases MA reimbursement rates for pediatric dental care and adult emergency dental services provided in Brown, Marathon, Polk, and Racine counties.

The administration estimates that the proposed dental access incentives will increase total payments for dental services by approximately 23%.

[Bill Section: 1023]

22. AUTISM SERVICES

GPR	$9,047,300
FED	13,570,800
Total	$22,618,100

Governor: Provide $7,539,400 ($3,015,800 GPR and $4,523,600 FED) in 2021-22 and $15,078,700 ($6,031,500 GPR and $9,047,200 FED) in 2022-23 to increase reimbursement rates for behavioral health assessments and adaptive treatments provided to enrollees with autism or other diagnoses or conditions associated with similar behaviors. The funding provided by the bill is based on an estimate of the cost to increase reimbursement rates for autism treatment services by 25%, beginning on January 1, 2022.

23. EMERGENCY PHYSICIAN REIMBURSEMENT

GPR	$3,966,000
FED	6,471,000
Total	$10,437,000

Governor: Provide $5,218,500 ($1,983,000 GPR and $3,235,500 FED) in 2021-22 and the same in 2022-23 in one-time funding to

temporarily increase reimbursement rates for hospital emergency room physician services in calendar year 2022. The funding provided by the bill is based on an estimate of the cost to establish the rates for these services at 50% of the rate paid by Medicare, which would increase payments for physician services for emergency room visits by approximately 36% in aggregate, during calendar year 2022 only.

24. COVERAGE OF ACUPUNCTURE SERVICES

GPR	$1,281,900
FED	1,918,100
Total	$3,200,000

Governor: Provide $3,200,000 ($1,281,900 GPR and $1,918,100 FED) in 2022-23 to fund a new MA benefit, subject to federal approval, for acupuncture services provided by a certified acupuncturist. Require DHS to submit any necessary plan amendment or request any necessary waiver of federal Medicaid law to implement this benefit. Specify that DHS shall provide this benefit only if the federal government approves the request or if no approval is necessary.

[Bill Sections: 1037 and 1041]

25. SPEECH-LANGUAGE PATHOLOGIST REIMBURSEMENT

GPR	$1,150,500
FED	1,725,900
Total	$2,876,400

Governor: Provide $958,800 ($383,500 GPR and $575,300 FED) in 2021-22 and $1,917,600 ($767,000 GPR and $1,150,600 FED) in 2022-23 to increase reimbursement rates paid for speech and language pathology services. The funding provided in the bill is based on an estimate of the cost to establish rates for speech-language pathology billing codes, beginning on January 1, 2022, at 75% of the amount paid by Medicare. Payment enhancers for services provided under the Birth to 3 program would be retained. The administration estimates that total payments for speech and language pathology services would increase by approximately 34% in aggregate.

26. AUDIOLOGY REIMBURSEMENT

GPR	$562,200
FED	843,200
Total	$1,405,400

Governor: Provide $468,500 ($187,400 GPR and $281,100 FED) in 2021-22 and $936,900 ($374,800 GPR and $562,100 FED) in 2022-23 to increase reimbursement rates for hearing aid and audiology services. The funding provided by the bill is based on an estimate of the cost to establish rates for hearing aid and audiology billing codes, beginning on January 1, 2022, at 75% of the amount paid by Medicare, or, in the case of MA services for which there is not a comparable Medicare rate, to provide a 19% increase to the current rate. The administration estimates that total payments for hearing aid and audiology services would increase by approximately 35% in aggregate.

27. TRIBAL CARE COORDINATION AGREEMENTS

FED	$5,537,900

Governor: Provide $5,537,900 FED in 2022-23 to eligible governing bodies of federally-recognized Native American tribes or bands or tribal health care providers, for health-related

purposes. A 2016 change in federal Medicaid policy allows tribal healthcare providers to enter into written care coordination agreements with non-tribal providers for certain healthcare services provided to tribal members who are enrolled in MA. These agreements make services provided by non-tribal providers eligible for the same 100% federal payment that applies to tribal providers, as opposed to the typical non-tribal 60% FED, 40% GPR matching agreement.

Authorize Wisconsin tribes to use these care coordination agreements, shifting the current GPR share of certain care costs to FED. Provide corresponding GPR payments to tribes or tribal healthcare providers based on the amount of GPR savings achieved by the care coordination agreements. Withhold from the payments the state share of administrative costs associated with carrying out this program, not to exceed 10 percent of the payment amounts.

[Bill Sections: 386 and 1013]

28. SENIORCARE REESTIMATE

GPR	- $6,589,500
FED	- 1,202,800
PR	9,992,200
Total	$2,199,900

Governor: Decrease funding by $2,609,000 (-$3,956,200 GPR, -$905,800 FED, and $2,253,000 PR) in 2021-22 and provide an increase of $4,808,900 (-$2,633,300 GPR, -$297,000 FED, and $7,739,200 PR) in 2022-23 to fully fund the estimated cost of benefits under the SeniorCare program. SeniorCare provides drug benefits for Wisconsin residents over the age of 65 who are not eligible for full Medicaid benefits.

The program is supported with a combination of state funds (GPR), federal funds the state receives under a Medicaid demonstration waiver (FED), and program revenue (PR) from rebate payments DHS collects from drug manufacturers. The program has four income eligibility categories: (a) less than 160% of the federal poverty level (FPL); (b) 160% of FPL to 200% of FPL; (c) 200% of FPL to 240% of FPL; and (d) greater than 240% of FPL. Each of these eligibility tiers has different requirements for deductibles. Persons in the last category, known as "spend-down" eligibility, do not receive benefits until they have out-of-pocket drug expenses in an annual period that exceed the difference between their annual income and 240% of the FPL, plus the deductible. The federal Medicaid matching funds apply only to participants with incomes under 200% of the federal poverty level. Over the past several years, manufacturer rebates have covered approximately 71% of costs for this group, while federal funds have covered 16% and the GPR portion has been 13%. Variation in agreements with manufacturers and drug utilization means that the percentage of costs covered by rebates is typically higher for participants with incomes above 200% of the poverty line; for this group rebates (PR) generally cover about 83% of benefit costs, while the remainder is GPR.

Although the administration estimates that each fund source's share of costs for each income group will remain constant over the biennium, the populations in each group are expected to change, as are the per-member average costs. The administration assumes that the number of participants with incomes under 200% of the FPL will increase by one percent annually in the 2021-23 biennium due to projected increases in Wisconsin's total elderly population. Based on increases over the past three years, the Department estimates per-member costs will increase about five to six percent annually for this group, depending on year and specific income level. Overall,

this gives an annual increase in expenditures of approximately six to seven percent for the Medicaid group (income under 200% of the FPL), relative to projected expenditures in 2020-21. For participants with higher income, the Department projects enrollment increasing faster, at two percent annually for enrollees in the tier between 200% of the FPL and 240% of the FPL, and by nine percent each year in the tier above 240% of the FPL. Per-enrollee costs for this group are projected to increase at two to three percent per year, for total expenditure increases of five to six percent annually.

The base funding for SeniorCare is $123,311,100 ($20,090,100 GPR, $17,333,500 FED, and $85,887,500 PR). Actual expenditures in 2020-21 are expected to be below the base level. Consequently, despite the estimated expenditure increases discussed above, the total estimated expenditures in 2021-22 are still below the base, with a modest increase above the base in 2022-23. These amounts are shown in the tables below, along with estimated enrollment in each income group for the current year and both years of the upcoming biennium.

SeniorCare Funding by Fund Source

	GPR	FED	PR	Total
2020-21 Appropriation Base	$20,090,100	$17,333,500	$85,887,500	$123,311,100
2021-22 Change to Base	-3,956,200	-905,800	2,253,000	-2,609,100
2021-22 Total Funding	16,133,900	16,427,700	88,140,500	120,702,000
2022-23 Change to Base	-2,633,300	-297,000	7,739,200	4,808,900
2022-23 Total Funding	17,456,800	17,036,500	93,626,700	128,120,000

SeniorCare Enrollment Estimates

Income Category	2020-21	2021-22	2022-23
Less than 160% of FPL	26,000	26,200	26,500
160% of FPL to 200% of FPL	15,500	15,700	15,800
200% of FPL to 240% of FPL	10,500	10,700	10,900
Greater than 240% of FPL	47,600	52,000	56,800
Total Enrollment	99,600	104,600	110,000

29. CHILDREN'S LONG-TERM SUPPORT WAIVER PROGRAM

Governor: Require DHS to ensure that any child who is eligible, and applies, for the children's long-term support (CLTS) waiver program receives services under the CLTS waiver program. As of November 30, 2020, 11,572 children were enrolled in the program, and 1,336 children were on a statewide waiting list for services.

The bill would provide additional funding to support CLTS waiver services as part of the MA cost-to-continue item. The following table shows the amount DHS has budgeted for CLTS

program services in 2020-21, the funding increases that would be provided for children currently enrolled and estimated to be enrolled in the program under the cost-to-continue item, and the administration's enrollment estimates.

Children's Long-Term Support Services
Governor's Bill

	2021-22			2022-23		
	GPR	FED	Total	GPR	FED	Total
2019 Act 9 SFY21 Budget	$52,861,200	$83,071,700	$135,932,900	$52,861,200	$83,071,700	$135,932,900
Cost-to-Continue Increase in Bill	10,084,000	17,060,900	27,144,900	16,032,100	23,987,500	40,019,600
Total Funding in Bill for CLTS Services	$62,945,200	$100,132,600	$163,077,800	$68,893,300	$107,059,200	$175,952,500
Estimated Enrollment as of June 30			13,407			14,106

[Bill Section: 795]

30. COVERAGE OF GROUP PHYSICAL THERAPY

Governor: Require DHS to submit proposed rules to include group physical therapy as a covered service under MA and specify that the rules must be submitted to the Legislative Council staff by July 1, 2022. Grant the Department emergency rule-making authority, notwithstanding current law prerequisites for emergency rules. Current law includes physical therapy as an MA benefit, and current rules define it to include application of casts, patient evaluations, use of modalities, and therapeutic procedures, but not group treatment.

[Bill Section: 9119(2)]

31. JOINT COMMITTEE ON FINANCE REVIEW AND APPROVAL OF CERTAIN MA PROGRAM CHANGES

Governor: Repeal provisions enacted as part of 2017 Wisconsin Act 370 that require DHS to submit all MA state plan amendments, rate changes, and supplemental payments to the Joint Committee on Finance for review and approval under a 14-day passive review process if the amendment, rate change, or payment has an expected fiscal effect of $7,500,000 or more from all revenue sources over a 12-month period following the implementation date of the amendment, rate change, or payment.

Under the Act 370 provisions, proposed changes to a reimbursement rate for, or supplemental payment to, a provider under MA are exempt from the Committee's review and approval if explicit expenditure authority or funding for the specific change or supplemental payment has been included in enacted legislation.

[Bill Section: 1008]

32. JOINT COMMITTEE ON FINANCE REVIEW PROCESS FOR FEDERAL WAIVERS, PILOT PROGRAMS, AND DEMONSTRATION PROJECTS

Governor: Repeal provisions enacted as part of 2017 Act 370 that require DHS to follow various procedures related to requests to a federal agency for a waiver, or a renewal, modification, withdrawal, suspension, or termination of a waiver of federal law or rules, or for federal authorization to implement a pilot program or demonstration project (collectively referred to as "waiver requests" hereafter).

The Act 370 provision that would be repealed does the following: (a) prohibits DHS from submitting a waiver request unless legislation has been enacted specifically directing the submission of the request; (b) requires DHS to submit implementation plans to the Joint Committee on Finance for waiver requests that the Department is required to submit but which have not yet been submitted; (c) requires DHS to submit any waiver request to the Committee for approval prior to submittal to a federal agency; (d) requires DHS to provide monthly progress reports and provide quarterly testimony upon request to the Committee on waiver requests that have been submitted but not yet acted upon by a federal agency; (e) requires DHS to submit any waiver request approved by a federal agency to the Committee for approval before the Department agrees to the final proposal; (f) requires DHS to submit an implementation plan to the Committee for approval of any waiver request that has been approved by a federal agency but not yet fully implemented; (g) requires DHS to provide monthly progress reports and provide quarterly testimony upon request to the Committee on waiver requests that have been approved but not yet fully implemented; (h) requires DHS to submit an application for a renewal of a waiver request to the Committee for approval and authorizes the Co-Chairs to determine whether the renewal request contains substantial modifications, in which case the renewal request must comply with the procedures and requirements outlined above for initial requests; and (i) authorizes the Committee to reduce DHS appropriations or authorized positions if the Committee determines that the Department is not making sufficient progress in complying with these provisions.

Repeal an Act 370 provision that requires the Office of the Commissioner of Insurance to comply with the waiver request oversight provisions described above as it relates to any renewal or modification of a waiver request for the Wisconsin healthcare stability program. The bill would not otherwise modify the provisions of that program.

[Bill Sections: 529, 1022, and 2918]

Medical Assistance and FoodShare Administration

1. MA AND FOODSHARE ADMINISTRATION -- CONTRACTS

GPR	$11,008,300
FED	22,781,200
Total	$33,789,500

Governor: Provide $29,827,600 ($5,025,300 GPR and $24,802,300) FED) in 2021-22 and $3,961,900 ($5,983,000 GPR and -$2,021,100 FED)

in 2022-23 to increase funding for contractual services and systems costs for the administration of the medical assistance (MA) and FoodShare programs.

This item includes funding adjustments to numerous contracts DHS has with private vendors, including increased funding for: (a) projected cost increases for DXC Technology, the MA program's fiscal agent and contract vendor for the Medicaid management information system (MMIS); (b) contracts to continue to "modularize" MMIS, as required by federal Centers for Medicare and Medicaid Services policy, which will enable MMIS functions to be modified in the future without disrupting the system's operations; (c) rates, beginning in calendar year 2023, paid to Deloitte for programming services for the client assistance for reemployment and economic support (CARES) system, which state and county staff use in making eligibility determinations and maintaining case information for MA and several other public assistance programs; (d) a new contract to evaluate the FoodShare employment and training program (FSET); and (e) the creation of a new five-person unit in the DHS Office of the Inspector General, consisting of DXC staff, that would conduct prepayment reviews of claims from MA providers that are at high risk of submitting fraudulent claims.

The following table summarizes the administration's proposed 2021-23 spending plan for the GPR and FED appropriations that fund contracted services and systems costs for the MA and FoodShare programs and the basis for the additional funding that would be provided under this item.

Summary of Medicaid and FoodShare Administrative Contracts GPR and FED Funding Governor's Recommendations

	2021-22			2022-23		
	GPR	FED	Total	GPR	FED	Total
FoodShare Electronic Benefit Contract	$1,221,600	$1,221,600	$2,443,200	$1,221,600	$1,221,600	$2,443,200
FoodShare Employment and Training Program Evaluation	225,000	225,000	450,000	225,000	225,000	450,000
Fiscal Agent Main Contract	32,280,100	90,695,000	122,975,100	33,223,900	76,165,000	109,388,900
MMIS Modules and Related Contracts	3,721,400	23,602,600	27,324,000	2,573,600	9,877,500	12,451,100
CARES Maintenance and Programming	29,802,400	55,025,900	84,828,300	30,933,000	57,610,300	88,543,300
Other Major and Minor Contracts	14,450,100	26,766,600	41,216,700	14,450,100	26,766,600	41,216,700
General Services	2,075,000	2,052,500	4,127,500	2,106,100	2,087,100	4,193,200
Subtotal -- Expenditures	$83,775,600	$199,589,200	$283,364,800	$84,733,300	$173,953,100	$258,686,400
Adjustments						
Costs Allocated to Other Appropriations	-$3,500,000	$0	-$3,500,000	-$3,500,000	$0	-$3,500,000
Other Items in DHS Request	145,800	1,187,300	1,333,100	145,800	0	145,800
Net Expenditures	$80,421,400	$200,776,500	$281,197,900	$81,379,100	$173,953,100	$255,332,200
2020-21 Base Funding	$75,396,100	$175,974,200	$251,370,300	$75,396,100	$175,974,200	$251,370,300
Difference (Funding Change in Bill)	$5,025,300	$24,802,300	$29,827,600	$5,983,000	-$2,021,100	$3,961,900

2. INCOME MAINTENANCE WORKLOAD

GPR	$3,562,300
FED	5,343,300
Total	$8,905,600

Governor: Provide $3,613,200 ($1,445,300 GPR and $2,167,900

FED) in 2021-22 and $5,292,400 ($2,117,000 GPR and $3,175,400 FED) in 2022-23 to fund projected workload increases for income maintenance (IM) consortia and tribal IM agencies in the 2021-23 biennium. IM agencies process applications and renewals for individuals enrolled in Medicaid, FoodShare, and other public assistance programs.

The funding increase reflects the administration's estimates that Medicaid caseloads managed by IM consortia will increase from approximately 412,800 cases in July, 2020, to 471,200 cases in June, 2023, and that FoodShare caseloads will increase from approximately 361,700 cases in July, 2020, to 471,200 cases in June, 2023. This funding increase is intended to maintain the same level of state support per case in the 2021-23 biennium as DHS estimates the state will provide in calendar year 2020 ($75.72 per case). The request includes funding increases for tribal IM agencies that are proportional to the funding increases that would be provided to support the county IM consortia. Base funding for these IM county and tribal costs is $75,499,500 ($15,132,500 GPR and $60,367,000 FED).

The caseload and cost estimates under this item do not reflect costs associated with the Governor's proposal to increase, from 100% to 138% of the federal poverty level, the maximum income standard for adults to be eligible for coverage under BadgerCare Plus (Medicaid expansion). Funding to support IM costs for that proposal is included in the Medicaid expansion item.

3. FUNERAL AND CEMETERY AIDS

GPR	- $530,200

Governor: Reduce funding by $506,900 in 2021-22 and by $23,300 in 2022-23 to reflect estimates of the amount of funding necessary to support payments under the Wisconsin funeral and cemetery aids program (WFCAP). Under the program, DHS reimburses costs incurred by funeral homes, cemeteries, and crematories for services they provide to certain deceased individuals who were eligible for medical assistance or Wisconsin Works benefits at the time of their death. DHS is required to pay up to $1,000 for cemetery expenses and up to $1,500 for funeral and burial expenses not covered by the decedent's estate or other persons. The program does not provide any reimbursement if the total cemetery expenses exceed $3,500 or total funeral expenses exceed $4,500.

Base funding for the program is $8,500,000. Reimbursement payments totaled $7,169,900 in 2019-20. The administration estimates that payments will total $7,537,100 in 2020-21, $7,993,100 in 2021-22, and $8,476,700 in 2022-23.

4. MEDICAL ASSISTANCE RECOVERIES -- QUI TAM CLAIMS

Governor: Create procedures under which a private individual could bring a *qui tam* claim against a person who knowingly: (a) presents a false or fraudulent claim to a state agency, including a false or fraudulent claim for MA; (b) makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim to a state agency, including a false or fraudulent claim for MA; (c) makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the MA program, or conceals and

improperly avoids or decreases an obligation to pay or transmit money or property to the MA program; (d) makes, uses, or causes to be made or used a false record or statement to an obligation to pay or transmit money or property to a state agency, or conceals and improperly avoids or decreases an obligation to pay or transmit money or property to a state agency; or (e) conspires to commit any violation listed previously.

Under the bill, a private individual bringing a *qui tam* claim may be awarded at least 15% but not more than 25% of the proceeds of the action or settlement of the claim, depending upon the extent to which the person contributed to the prosecution of the action or claim. For a complete summary of these provisions, see "Justice."

[Bill Section: 528]

5. FOODSHARE HEALTHY EATING INCENTIVE PILOT

GPR	$850,000

Governor: Provide $425,000 annually to fund a healthy eating incentive pilot for 2,000 FoodShare participants and authorize DHS to expend up to this amount annually for the pilot program. Repeal a provision that prohibits DHS from expending funds from an appropriation that was created to fund the pilot program after December 31, 2019, other than amounts it had encumbered on or before that date.

2017 Act 266 provided $425,000 in 2017-18 on a one-time basis to fund a pilot program to provide discounts on fresh produce and other healthy foods to FoodShare recipients. Act 266 created an appropriation to fund the program, but specified that no funding could be expended from the appropriation after December 31, 2019, except for moneys encumbered on or before that date. This funding was never expended or encumbered.

[Bill Sections: 389 and 1054]

6. EBT PROCESSING EQUIPMENT FOR FARMERS MARKETS AND DIRECT-MARKETING FARMERS

GPR	$375,000

Governor: Provide $187,500 annually to supply electronic benefit transfer (EBT) processing equipment to farmers markets and direct-marketing farmers to participate in the FoodShare program.

The federal Agricultural Act of 2014 requires that supplemental nutrition assistance program (SNAP or FoodShare in Wisconsin) retailers purchase their own EBT processing equipment. However, states are required to provide no-cost, EBT-only point of sale processing equipment to certain farmers markets and direct-marketing farmers that are exempt from the federal requirement.

In federal fiscal year 2019, the U.S. Department of Agriculture, Food and Nutrition Service provided states an opportunity to obtain funding to provide farmers markets and direct-marketing farmers with equipment that can be used to process SNAP transactions. Twenty-nine states, including Wisconsin, applied for and received funding. Wisconsin received $187,500 on a one-

time basis. The administration indicates that this funding must be spent before the end of federal fiscal year 2021 (September 30, 2021) and anticipates having expended the full amount by that date. The administration indicates that funding included in the Governor's budget is intended to continue the program after federal funding is no longer available.

[Bill Section: 389]

7. FOODSHARE EMPLOYMENT AND TRAINING PROGRAM REESTIMATE

GPR	$186,500
FED	186,500
Total	$373,000

Governor: Provide $373,000 ($186,500 GPR and $186,500 FED) in 2022-23 to reflect estimated increases to FoodShare enrollment and subsequent FoodShare employment and training (FSET) program participation, due to the recession caused by the SARS-CoV-2 pandemic.

Temporary Suspension of the ABAWD Work Requirement. During the SARS-CoV-2 pandemic, the federal work requirement applicable to able-bodied adults without dependents (ABAWDs) was largely suspended, pursuant to provisions in the federal Families First Coronavirus Response Act (FFCRA), and will remain suspended until the month after the national health emergency expires.

However, some "pledge" states, including Wisconsin, that agree to provide services to all ABAWDs who wish to participate in supplemental nutrition assistance program (SNAP) employment and training programs, qualify for 100% federal funding for eligible FSET costs. In order to maintain its eligibility for "pledge state" funding, Wisconsin was not able to suspend the ABAWD work requirement under FFCRA. Instead, DHS received federal approval to apply more broadly the ABAWD work requirement "good cause" exemption between March and July, 2020. Subsequently, the Department suspended the ABAWD work requirement by using administrative exemptions that expired on September 30, 2020. The Department notified the U.S. Department of Agriculture, Food and Nutrition Services of Wisconsin’s intent to temporarily suspend the ABAWD work requirement under provisions in federal law pertaining to high unemployment, effective October 1, 2020, through September 31, 2021. The temporary suspension of the ABAWD work requirement has resulted in decreased enrollment in FSET in the 2019-21 biennium.

Enrollment. The administration indicates that prior to the suspension of the ABAWD policy, 1.35% of FoodShare participants were enrolled in FSET. Since the suspension of the ABAWD policy, 0.95% of FoodShare participants have been enrolled in the FSET program. In estimating future FoodShare participation, the administration assumes that unemployment relating to the SARS-CoV-2 pandemic peaked in April, 2020, and that the economic recovery will largely mirror the recovery following peak unemployment during the Great Recession. For the 2021-23 biennium, the administration assumes that FSET enrollments will remain at 0.95% of FoodShare participants through September, 2021, returning to 1.35% of FoodShare participants by December, 2021. As such, the administration estimates that average monthly FSET enrollment will be 9,470 in 2021-22 and 10,764 in 2022-23.

Enrollee Expenditures. The administration estimates that total per enrollee per month

expenses will be $330.04 in 2020-21 and decrease to $327.41 in 2021-22 and $326.59 in 2022-23. These total expenses are primarily based on payments to the FSET program's vendors, but also include $777,500 annually, which funds administrative expenses relating to the FSET program. Excluding the amounts for administrative expenses, the administration estimates average per enrollee per month payments to the FSET vendors of $320.57 in both years of the 2021-23 biennium.

2020-21 Carry Over Funding. The administration estimates that FSET funding for 2021-23 will be offset by unspent carry over funding from 2020-21 resulting from an estimated 12.5% decrease in average monthly FSET enrollment between 2019-20 and 2020-21 (7,821 and 6,872, respectively), in part due to the temporary suspension of the ABAWD work requirement. The following table summarizes the administration's caseload, cost, and funding estimates for the FSET program in for the 2021-23 biennium.

Summary of 2021-23 FSET Expenses and Funding

	2021-22	2022-23
Estimated Program Costs		
Vendor Contracts		
Estimated Average Monthly Enrollment	9,470	10,764
Average Cost per Enrollee per Month	$320.57	$320.57
Annual Vendor Costs	$36,429,600	$41,407,400
DHS Program Administration	777,500	777,500
Total Program Costs	$37,207,100	$42,184,900
100% Federal Funding Offset (including "Pledge State" Funds)	$2,590,900	$2,902,600
Funding Needs		
Remaining Costs after 100% FED Offset	$34,616,200	$39,282,300
50% GPR Expenses	17,308,100	19,641,000
50% FED Expenses	17,308,100	19,641,300
Available GPR Funding		
GPR Base Funding	$14,623,800	$14,623,800
Projected GPR Carry Over from Previous Year	7,515,000	4,830,700
Subtotal	$22,138,800	$19,454,500
GPR Surplus/Deficit (Available GPR minus 50% GPR Expenses)	$4,830,700	-$186,500

8. REPEAL FSET DRUG SCREENING, TESTING, AND TREATMENT REQUIREMENTS

Governor: Repeal the requirement that eligibility for an able-bodied adult without dependents (ABAWDs) to participate in the FoodShare employment and training (FSET) program is subject to compliance with the statutory screening, testing, and treatment policy for illegal use of a controlled substance without a valid prescription for the controlled substance.

Repeal provisions, enacted as part of 2017 Act 370, that require DHS to implement a drug screening, testing, and treatment policy for ABAWDs participating in FSET. In addition, repeal nonstatutory provisions contained in 2017 Act 370 as they pertain to implementing the drug screening, testing, and treatment provisions by October 1, 2019, and requiring compliance with the waiver provisions contained in 2017 Act 370, as though the drug screening, testing, and treatment provisions were a waiver request approved on December 16, 2018.

Repeal a biennial GPR appropriation that was created to fund substance abuse treatment costs under the FSET drug screening, testing, and treatment requirements. No funding has been budgeted for this purpose.

[Bill Sections: 388, 1056, 1058, and 3470]

9. REPEAL FOODSHARE WORK REQUIREMENT FOR ABLE-BODIED ADULTS WITH DEPENDENTS

Governor: Repeal provisions enacted in 2017 Act 264 relating to required participation in the FoodShare employment and training (FSET) program, subject to certain exceptions. With the repeal, DHS must require, to the extent allowed by the federal government, that able-bodied adults without dependents (ABAWDs) participate in FSET, except for ABAWDs who are employed, as determined by DHS. The bill would retain the Department's current authority to require able individuals who are 18 to 60 years of age, or a subset of those individuals to the extent allowed by the federal government, who are not in a Wisconsin Works employment position, to participate in FSET.

Current law, requires that by October 1, 2019, not only all ABAWDs, but also all other able-bodied adults between the ages of 18 and 50, who are not pregnant and not determined by DHS to be medically certified as physically or mentally unfit for employment or exempt from the work requirement as specified in federal law, must participate in FSET. Current law prohibits DHS from requiring participation in FSET for an individual who is: (a) enrolled at least half time in a school, a training program, or an institution of higher education; or (b) the caretaker of a child under the age of six or the caretaker of a dependent who is disabled.

[Bill Section: 1055]

10. REPEAL PAY-FOR-PERFORMANCE PAYMENT SYSTEM FOR FSET VENDORS

Governor: Repeal provisions enacted in 2017 Act 266 that require DHS to create and implement a payment system based on performance for FoodShare Employment and Training (FSET) program vendors.

Current law requires DHS to establish performance outcomes for the payment system based on: (a) the placement of participants into unsubsidized employment; (b) whether the placement is full or part-time; (c) the job retention rate; (d) wages and benefits earned; (e) appropriate

implementation of FSET; and (f) customer satisfaction. Implementation of the payment system is contingent on federal approval and must not affect the funding available for supportive services for participants in FSET. These provisions first applied to contracts DHS enters into or renews on the Act's effective date (April 12, 2018). However the Department's current contracts with the FSET vendors, effective for federal fiscal year 2020-21 (October 1, 2020 through September 30, 2021), do not include performance outcomes as the basis for payments.

[Bill Section: 1057]

Public Health

1. HEALTH EQUITY GRANTS

GPR	$10,000,000
SEG	20,000,000
Total	$30,000,000

Governor: Provide $10,000,000 GPR in 2021-22 and $20,000,000 SEG from the community reinvestment fund in 2022-23 to award grants to promote health equity. Create annual GPR and SEG appropriations in the Division of Public Health for this purpose. Require DHS to award grants to community organizations to implement community health worker care models and to community organizations and local or tribal health departments to hire health equity strategists and implement health equity action plans.

The bill would create the community reinvestment fund as part of the Governor's proposal to permit recreational use of marijuana. It would comprise segregated revenue from a portion of the excise tax levied on cannabis producers and retailers.

[Bill Sections: 383, 384, and 2573]

2. COMMUNICABLE DISEASES -- GRANTS TO LPHDS

GPR	$10,000,000

Governor: Provide $5,000,000 annually to increase, from $500,000 to $5,500,000, GPR funding DHS provides annually to local public health departments (LPHDs) to prevent and control communicable diseases.

DHS proposes to allocate the funding increase by providing a base amount of $2,500 to each of the 96 LPHDs in the state and distributing the remaining funding to the LPHDs based on the population within each LPHD's jurisdiction, which may include a county, city, multi-county region, or tribe.

LPHDs are charged with providing communicable disease surveillance, prevention and control; services to prevent other diseases and hazards; and other services to promote public health. State (GPR) support for LPHDs is limited to several targeted programs, including the Wisconsin well woman program, the reproductive health program, the lead poisoning prevention and control program, and the communicable disease control and prevention program. LPHDs are also

supported with federal funds (primarily from grants administered by the Centers for Disease Control and Prevention), and local tax levy.

3. BLACK WOMEN AND INFANTS' HEALTH

GPR	$8,000,000

Governor: Provide $3,500,000 annually to fund grants to address Black women's health and infant and maternal mortality. Require DHS to award: (a) $1,750,000 annually to community-serving organizations that are led by Black women that improve Black women's health in Dane, Milwaukee, Rock, and Kenosha Counties; and (b) $1,750,000 annually to organizations that work to reduce racial disparities related to infant and maternal mortality. Modify the current appropriation from which DHS funds minority health grants to contain references to these new ongoing allocations.

In addition, provide one-time funding of $500,000 annually in the 2021-23 biennium for DHS to provide a grant to an entity to connect and convene efforts between state agencies, public and private sector organizations, and community organizations to support a statewide public health strategy to advance Black women's health.

Under current law, DHS awards $383,600 annually in minority health grants, including up to $50,000 for a public information campaign on minority health and the remainder for activities to improve the health status of economically disadvantaged minority group members. This provision would increase ongoing funding for minority health grants to $3,883,600 per year.

[Bill Sections: 382, 2571, 2572, and 9119(17)]

4. COMMUNITY HEALTH CENTER GRANTS

GPR	$4,000,000

Governor: Provide $2,000,000 annually to increase, from $5,490,000 to $7,490,000, annual funding for grants DHS distributes to community health centers.

Under current law, except for two specific allocations of $50,000 per year each, this funding is distributed to federally qualified health centers (FQHCs) in amounts proportional to grants they receive from the federal Department of Health and Human Services, Health Resources and Services Administration. FQHCs provide comprehensive primary health care services to underserved areas and populations, including migrant agricultural workers and people experiencing homelessness. They serve individuals regardless of ability to pay, and charge patients based on sliding fee scales.

5. GRANTS TO FREE AND CHARITABLE CLINICS

GPR	$4,000,000

Governor: Provide $2,000,000 annually to increase, from $500,000 to $2,500,000, annual funding for grants DHS distributes to free and charitable clinics and specify this annual allocation amount in statute.

For this purpose, define "free and charitable clinics" as health care organizations that: (a) are nonprofit and tax exempt or are a part of a larger nonprofit, tax-exempt organization; (b) are

located in Wisconsin or serve Wisconsin residents; (c) serve only people who are uninsured, underinsured, or have limited or no access to primary, specialty, or prescription care; (d) provide one or more of medical care, mental health care, dental care, or prescription medications; (e) use volunteer health care professionals, nonclinical volunteers, and partnerships with other health care providers to provide these services; and (f) are not federally qualified health centers (FQHCs) or reimbursed by Medicare or medical assistance as FQHCs.

2019 Act 9 provided $500,000 annually, beginning in 2019-20, for DHS to distribute as grants to free and charitable clinics, but did not define the term for purposes of the grant program.

[Bill Sections: 2568 thru 2570]

6. BUREAU OF COMMUNICABLE DISEASES STAFF -- EPIDEMIOLOGY

	Funding	Positions
GPR	$3,608,400	23.00

Governor: Provide $1,564,300 in 2021-22 and $2,044,100 in 2022-23, and 23.0 positions (17.0 permanent positions and 6.0 four-year project positions), beginning in 2021-22, for the Bureau of Communicable Diseases (BCD) to prevent and respond to future outbreaks of communicable diseases.

The additional positions include: (a) 4.0 permanent epidemiologists ($259,500 in 2021-22 and $338,400 in 2022-23); (b) 6.0 four-year project epidemiologists ($389,200 in 2021-22 and $507,500 in 2022-23), 3.0 public health educators ($194,600 in 2021-22 and $253,800 in 2022-23), 5.0 infection preventionists ($360,500 in 2021-22 and $472,200 in 2022-23), and 5.0 disease intervention specialists ($360,500 in 2021-22 and $472,200 in 2022-23).

The epidemiologists and public health educators would work in the epidemiology section to support the response to, and surveillance of, COVID-19 and build capacity for routine communicable disease management and outreach. The infection preventionists would work on the healthcare-associated infections prevention program, maintaining efforts currently performed by five contractors funded by a COVID-19–related supplemental grant from the Centers for Disease Control and Prevention (CDC), which expires in May, 2022. The disease intervention specialists would work in the harm reduction section, performing sexually-transmitted disease testing and contact tracing, tasks currently performed by five CDC employees assigned to Wisconsin who will not be replaced as they retire or otherwise depart.

Currently, BCD is staffed by 69.0 FTE positions. These positions are supported primarily with federal funds, largely from CDC grants and cooperative agreements (93%), as well as GPR (5%) and program revenues (2%).

7. SPINAL CORD INJURY RESEARCH GRANTS

GPR	$3,000,000

Governor: Create a sum sufficient GPR appropriation in the Division of Public Health to fund a grant program and symposia related to spinal cord injury research, but limit total expenditures from the appropriation to $3,000,000, which could occur over a multi-year period. Estimate that $1,500,000 would be expended from the appropriation in 2021-22 and in 2022-23.

An amendment is needed to clarify the administration's intent that $3,000,000 be provided in each fiscal biennium, rather than on a one-time basis.

Require DHS to establish a program to award grants supporting research into new and innovative treatments and rehabilitative efforts for the functional improvement of people with spinal cord injuries, including pharmaceutical, medical device, brain stimulus, and rehabilitative approaches and techniques. Authorize DHS to hold symposia once every two years, and require grant recipients to agree to present their research findings. Require DHS to submit, by January 15 of each year, annual reports to the Legislature identifying the recipients of grants under the grant program and the purposes for which the grants were used.

Create a Spinal Cord Injury Council in DHS. Require the Council to develop criteria for DHS to evaluate and award grants under the grant program, review and make recommendations to the Department on applications submitted under the grant program, and perform other duties specified by the DHS. Require DHS to appoint to the Council the following members serving two-year terms ending on July 1 of even-numbered years:

- One member representing the University of Wisconsin School of Medicine and Public Health;
- One member who has a spinal cord injury;
- One member who is a veteran who has a spinal cord injury; and
- One member who is a researcher in the field of neurosurgery.

Specify that DHS must appoint to the Council the following members serving two-year terms ending on July 1 of odd-numbered years:

- One member representing the Medical College of Wisconsin;
- One member who is a family member of a person with a spinal cord injury;
- One member who is a physician specializing in the treatment of spinal cord injuries; and
- One member who is a researcher employed by the Veterans Health Administration of the U.S. Department of Veterans Affairs.

Specify that, if DHS is unable to appoint a member meeting one of the above conditions, the agency may appoint a member representing the general public instead. Specify that the initial appointees would serve until July 1 of 2024 or 2025, respectively, and that all appointees must disclose in a written statement to be included in the annual report to the Legislature any financial interest in any organization that the Council recommends to receive a grant under the grant program.

[Bill Sections: 79, 381, 2598, and 9119(16)]

8. WINDOWS PLUS LEAD EXPOSURE PREVENTION PROGRAM

	Funding	Positions
GPR	$2,016,600	1.00

Governor: Provide $961,800 in 2021-22 and $1,054,800 in 2022-23 and 1.0 position, beginning in 2021-22, to resume the Windows Plus lead exposure prevention program that DHS initiated in 2019-20 with one-time funding that was provided for lead abatement projects in 2019 Act 9. The program provided lead-safe renovation in homes built before 1950 that were inhabited or frequently visited by low-income families with children and focused on high-risk components, such as windows, porches, floors, and siding. DHS estimates that the funding amount in the bill would provide lead-safe renovations to approximately 47 homes in 2021-22 and 53 homes in 2022-23. The cost estimate includes indirect costs such as administration and relocation of resident families.

Currently, DHS provides related lead abatement services through the lead safe homes project (LSHP), funded in part by federal funds from a children's health insurance program (CHIP) health services initiative. However, participation in the LSHP is limited to housing units that meet certain requirements that do not apply under the Windows Plus lead exposure prevention program. For example, under the LSHP program, the unit must be inhabited by children enrolled in medical assistance, a formal lead risk assessment must be conducted by a certified assessor, and all workers on the site must be certified as lead abatement workers or supervisors. The Windows Plus lead exposure prevention program would fund renovation projects that are ineligible for funding under the LSHP program.

9. TOBACCO AND VAPING PREVENTION

GPR	$2,000,000

Governor: Increase funding for the tobacco use control program by $2,000,000 in 2021-22 to fund a new public health campaign aimed at preventing initiation of tobacco and vapor product use. Authorize DHS to include in the new public health campaign grants for local and regional organizations working on youth vaping and providing cessation services. Require DHS to include the new public health campaign in a required annual report to the Legislature detailing and evaluating the tobacco use control grants, beginning April 15, 2022.

Base funding for the tobacco use control program is $5,315,000 annually, which DHS uses to support grants for a variety of tobacco use cessation and prevention activities.

[Bill Sections: 2596 and 2597]

10. HEALTH INFORMATION EXCHANGE GRANTS

GPR	$1,310,000

Governor: Provide $655,000 annually in one-time funding for DHS to provide as grants to support health information exchange activities. Require DHS to make one such grant of $655,000 each year of the biennium, but permit DHS to transfer funding budgeted for the grants from fiscal year 2021-22 to 2022-23.

[Bill Section: 9119(15)]

11. WISCONSIN CHRONIC DISEASE PROGRAM

GPR	- $725,000
PR	- 266,200
Total	- $991,200

Governor: Reduce funding by $650,600 (-$486,500 GPR and -$164,100 PR) in 2021-2022 and by $340,600 (-$238,500 GPR and -$102,100 PR) in 2022-2023 to reflect reestimates of the amounts needed to fully fund the Wisconsin chronic disease program (WCDP) in the 2021-23 biennium.

The WCDP funds services for individuals with chronic renal disease, hemophilia, and adult cystic fibrosis that are not covered by other public or private health insurance plans. Enrollees in WCDP are responsible for deductibles and coinsurance based on their household income and size, and copayments on prescription medications. The Department receives rebate revenue from drug manufactures for medications dispensed through WCDP, which is budgeted as program revenue.

Base funding for the program is $4,966,600 ($3,939,300 GPR and $1,027,300 PR). The administration estimates that total program costs will be $4,316,000 ($3,452,800 GPR and $863,200 PR) in 2021-22 and $4,626,000 ($3,700,800 GPR and $925,200 PR) in 2022-23. The estimate includes an additional $250,000 GPR in both years as a contingency that would be available if costs exceed estimates.

12. EMS FUNDING ASSISTANCE PROGRAM

GPR	$479,600

Governor: Provide $239,800 annually to increase annual funding for the emergency medical services funding assistance program from $1,960,200 to $2,200,000 beginning in 2021-22. The funding assistance program provides annual grants to all public ambulance service providers, including volunteer fire departments, nonprofits, and counties or municipalities that operate their own ambulance service or contract with a private provider. Grants consist of a uniform base allocation to each provider, an additional amount based on population served, and funding for providers who apply for assistance with training, examinations, and licensure.

13. BUREAU OF COMMUNICABLE DISEASES STAFF -- HARM REDUCTION

	Funding	Positions
GPR	$435,300	3.00

Governor: Provide $189,300 in 2021-22 and $246,000 in 2022-23, and 3.0 positions, beginning in 2021-22, to create a field team dedicated to harm reduction in the Bureau of Communicable Diseases.

This item includes funding to support: (a) 1.0 public health nurse ($72,000 in 2021-22 and $94,100 in 2022-23); (b) 1.0 behavioral health specialist ($66,400 in 2021-22 and $86,500 in 2022-23); and (c) 1.0 benefits navigator and income determination specialist ($50,900 in 2021-22 and $65,400 in 2022-23).

The team would be based in Madison and provide several field services, including: (a) opioid-related services, including overdose rescue using naloxone, training in naloxone use, and referrals to medication-assisted treatment providers; (b) communicable disease prevention and harm reduction services, including COVID-19 testing and vaccination, HIV/Hepatitis C

counseling and testing, harm reduction materials distribution, Hepatitis A and B vaccination, and mobile syringe exchange; and (c) other services such as wound care, insurance enrollment, and assistance with housing instability, utility needs, interpersonal violence, and transportation needs.

14. FAMILY PLANNING AND WOMEN'S HEALTH BLOCK GRANT

GPR	$387,200

Governor: Provide $193,600 annually to increase, from $1,742,000 to $1,935,600, annual GPR funding for the women's health block grant program.

In addition, modify provisions relating to the state's family planning and women's health block grant programs as follows.

Title X (Family Planning and Related Preventive Health Services) Grant Funding. Repeal all provisions created in 2015 Wisconsin Act 151. These provisions:

- Require DHS to apply for federal funding under Title X of the Public Health Service Act, beginning with the 2018 application and before each subsequent application thereafter.

- Require DHS to distribute these federal funds to public entities, including state, county and local health departments and health clinics, and the well-woman program.

- Specify the types of family planning services that may be funded by the Department's grantees to include: (1) screening for cervical cancer and breast cancer; (2) screening for high blood pressure, anemia and diabetes; (3) screening for sexually transmitted diseases and HIV and AIDS; (4) infertility services; (5) health education; (6) pregnancy testing; (7) contraceptive services; (8) pelvic examinations; and (9) referrals for other health and social services.

- Permit a public entity that receives funds to provide some or all of the funds to other public or private entities, as long as the recipient of the funds does not provide abortion services or have an affiliate that provides abortion services. However, specify that providing abortion services or having an affiliate that provides abortion services under certain specified circumstances, such as to save the life of a woman, or in a case of sexual assault or incest reported to law enforcement, does not disqualify an entity from receiving these funds.

- Specify that a person's acceptance or refusal to receive family planning services does not affect the person's right to receive public assistance or services, that these provisions do not abridge the right of the individual to make decisions concerning family planning, and that a person is not required to state his or her reason for refusing any offer of family planning services.

- Specify that any employee of the agencies engaged in the administration of these provisions may refuse to accept the duty of offering family planning services to the extent that the duty is contrary to his or her personal beliefs, that such a refusal may not be grounds for dismissal, suspension, demotion, or any other discrimination in employment, and that the directors or supervisors of the agencies must reassign the duties of employees in order to carry out the provisions of the program.

• Require DHS to promulgate rules necessary to implement and administer the program.

Women's Health Block Grant. Modify the definition of "family planning" and "family planning services" under the women's health block grant program to include the provision of nondirective information explaining pregnancy termination. In addition, repeal a provision that prohibits a public grantee from providing some or all of the grant funds to another public or private entity if the other public or private entity: (a) provides abortion services; (b) makes referrals for abortion services; or (c) has an affiliate that provides abortion services or makes referrals for abortion services.

Under current law, DHS allocates GPR and a portion of the funding the state receives under the federal maternal and child health block grant (Title V of the Social Security Act) to support the state's women's health block grant program, which is intended to develop and maintain an integrated system of community health services and maximize coordination of family planning services. Current law excludes from the definition of "family planning" performance, promotion, encouragement, or counseling in favor of, or referral either directly or through an intermediary for, voluntary termination of pregnancy, but includes in the definition of "family planning" the provision of nondirective information explaining prenatal care and delivery or infant care, foster care, or adoption. DHS may distribute women's health funds only to public entities. Under current law, those public entities may provide some or all of the funds to other public entities or private entities as long as the recipients of the funds do not provide abortion services, make referrals for abortion services, or have an affiliate that provides abortion services or makes referrals for abortion services.

[Bill Sections: 2576 thru 2581]

15. HEALTH DATA ANALYSIS AND PREDICTIVE MODELING TEAM

	Funding	Positions
GPR	$375,900	2.00

Governor: Provide $162,400 in 2021-22 and $213,500 in 2022-23, and 2.0 positions, beginning in 2021-22, to create a data analysis team within the Office of Health Informatics dedicated to analyzing health metrics and creating predictive models to inform public health responses. The team, which would consist of a senior statistician and a modeler, would develop statistical, visualization, and communication tools to analyze spatial, temporal, and demographic trends for a wide variety of health conditions.

16. SURGICAL QUALITY IMPROVEMENT GRANT

GPR	$335,000

Governor: Provide $335,000 in 2021-22 for DHS to make a one-time grant to support surgical quality improvement activities. Permit DHS to transfer this funding from fiscal year 2021-22 to 2022-23. The administration indicates that the funding would be used to fund a coordinating center, outreach activities, online tools, and related materials.

[Bill Section: 9119(14)]

17. HEARING AID ASSISTANCE

GPR	$643,600

Governor: Provide $321,800 annually to increase, from $25,000 to $346,800, funding for the hearing aid assistance program. The program provides up to $250 per applicant towards the cost of a telecoil, Bluetooth-enabled hearing aid, or cochlear implant external processor to Wisconsin residents who; (a) have income under 200% of the federal poverty line; (b) are not enrolled in the MA program; and (c) complete a hearing loss certification form.

Base funding for the Department's program that supports interpreter services and telecommunications aids for individuals who are hearing impaired is $178,200 annually. DHS uses this funding to reimburse hearing interpreters and, subject to availability of funds, operate several financial assistance programs for telecommunication equipment for low-income people with hearing impairments, including the hearing aid assistance program.

18. TRAUMA PROGRAM STAFFING

	Funding	Positions
GPR	$269,700	2.00
FED	- 269,700	- 2.00
Total	$0	0.00

Governor: Convert 2.0 FED positions to 2.0 GPR positions, beginning in 2021-22, and provide $116,600 GPR in 2021-22 and $153,100 in 2022-23 and reduce FED funding by corresponding amounts, to support 1.0 state trauma coordinator and 1.0 trauma program associate with state funds, rather than federal funding the state receives under the federal hospital preparedness program.

The Office of Preparedness and Emergency Health Care is charged with supporting and enhancing the capacity of the state, local public health departments, tribes, and the health care system to prepare for public health threats and emergencies through planning, exercising, responding and training. Within the Office, the state trauma program is responsible for ensuring that trauma patients receive comprehensive trauma care. DHS indicates that 2.0 FED positions that oversee the trauma program are funded by a federal hospital preparedness program grant. The terms of this grant limit the amount of funding DHS may use to support staff costs. Consequently, DHS must regularly seek federal approval to exceed this limit to maintain its current staffing. By converting these positions to GPR funding, DHS would no longer need to seek federal approval to maintain these positions.

19. TRANSLATE DHS WEB PAGES

GPR	$200,000

Governor: Provide $100,000 annually to contract for the services of one full-time web developer in the Division of Public Health to translate DHS web pages into multiple languages. The position would assist in the Department's efforts to meet the National Standards for Culturally and Linguistically Appropriate Services (CLAS) established by the U.S. Department of Health and Human Services.

20. HEALTH IN ALL POLICIES STAFF

	Funding	Positions
GPR	$154,400	1.00

Governor: Provide $66,200 in 2021-22 and $88,200 in 2022-23 and 1.0 position, beginning in 2021-22, to create an inter-departmental team to promote health in all policies.

DHS indicates that the position would convene and facilitate team and subgroup meetings, engage with stakeholders, research, analyze and write a collective action plan, and help lead the group in execution of that plan. The team would consist of representatives from all executive branch agencies and create a plan to promote health addressing the following topics: (a) systemic and institutional racism; (b) access to safe and affordable housing; (c) educational attainment; (d) opportunities for employment; (e) economic stability; (f) inclusion, diversity, and equity in the work place; (g) barriers to career success and promotion in the work place; (h) access to transportation and mobility; (i) social justice; (j) environmental factors; and (k) public safety including impacts of crime, citizen unrest, and incarceration.

21. LEAD SCREENING AND OUTREACH GRANTS

GPR	$100,000

Governor: Provide $50,000 annually to increase a grant for lead screening and outreach activities provided by a community-based human service agency that provides primary health care, health education, and social services to low-income individuals in the City of Milwaukee, from $125,000 to $175,000. This grant has most recently been awarded to Sixteenth Street Community Health Centers, a federally qualified health center.

[Bill Section: 2582]

22. AMBULANCE INSPECTION PROGRAM

	Funding	Positions
GPR	$87,600	1.00

Governor: Provide $87,600 in 2022-23 and 1.0 position, beginning in 2022-23, to oversee a self-reported compliance program, for ambulance medical equipment and operational requirements, and conduct inspections as necessary. Currently, the Department of Transportation (DOT) conducts vehicle safety inspections of ambulances, as well as certain inspections of medical equipment. However, under recent modifications to DOT administrative rules related to the inspection program, DOT expects to transfer responsibility for the medical equipment portion of the ambulance inspection program to DHS on January 1, 2023.

23. DRUG REPOSITORY PROGRAM

Governor: Authorize the Wisconsin drug repository program to partner with out-of-state drug repository programs, including allowing participating pharmacies or medical facilities in Wisconsin to receive drugs or supplies from other states and allowing out-of-state pharmacies or medical facilities that participate in a partner drug repository to receive drugs or supplies from Wisconsin. Require DHS to study and implement a centralized physical drug repository program.

Under current law, the drug repository program allows patients to donate unused drugs or medical supplies, and provides them to individuals with cancer or chronic disease that do not have insurance or are underinsured.

[Bill Sections: 2595 and 9119(4)]

Elder and Disability Services

1. BIRTH TO 3 PROGRAM -- EXPAND ELIGIBILITY

GPR	$9,900,000

Governor: Expand eligibility for services provided under the Birth to 3 program by requiring DHS to ensure that any child with a level of lead in his or her blood that is five or more micrograms per 100 milliliters (5 µg/dL), as confirmed by one venous blood test, is eligible for services under the Birth to 3 program. Provide $3,300,000 in 2021-22 and $6,600,000 in 2022-23 to fund the administration's estimates of costs of providing Birth to 3 services to additional children.

Wisconsin's current eligibility standard for the program, as it pertains to lead exposure, is 10 µg/dL. In 2012, the Centers for Disease Control and Prevention (CDC) established a 5 µg/dL threshold for identifying children with elevated lead levels. The administration estimates that expanding eligibility would result in an additional 2,000 children becoming eligible for Birth to 3 services annually. In 2019, approximately 12,700 children received services under the program.

The Birth to 3 program offers early intervention services to children, from birth to age three, who are identified with, or determined to be at risk for, developmental delays. Currently, a child is eligible for services if the child has a developmental delay of at least 25% in one area of development or is diagnosed by a physician as having a high probability of developmental delay. The program is funded from several sources, including federal funds that the state receives under the Individuals with Disabilities Education Act, county funds, community aids, medical assistance, private insurance, and parental cost sharing.

[Bill Section: 1064]

2. BIRTH TO 3 PROGRAM -- MAINTENANCE OF EFFORT

GPR	$2,250,000

Governor: Provide $1,125,000 annually in order for the Department to meet its federal Individuals with Disabilities Education Act (IDEA) maintenance of effort (MOE) requirement for the Birth to 3 program in the 2021-23 biennium.

Wisconsin's Birth to 3 program, which provides early intervention services to eligible Wisconsin children from birth to age three, is partially funded with federal funds through IDEA. In the 2019-21 budget, one time funding was used to increase funding by $1,125,000 annually for the Birth to 3 program.

In order to continue to receive federal IDEA funding, federal law requires that the total amount of state and local funds budgeted for expenditures in the current fiscal year for early intervention services must be at least equal to the total amount of state and local funds actually expended for early intervention services for eligible children and their families in the most recent preceding fiscal year for which the information is available.

The administration indicates that in the 2021-23 biennium, Wisconsin's MOE funding obligation is expected to increase by $1,125,000 annually, assuming the full annual amount allocated in the current biennium is expended on Birth to 3 program services.

3. AGING AND DISABILITY RESOURCE CENTERS -- EXPANDED SERVICES

GPR	$6,968,000
FED	92,300
Total	$7,060,300

Governor: Provide $2,425,800 ($2,395,000 GPR and $30,800 FED) in 2021-22 and $4,634,500 ($4,573,000 GPR and $61,500 FED) in 2022-23 to fund expanded services at the aging and disability resource centers (ADRCs).

While not specified in the bill, the Executive Budget Book indicates that the funding would be used to: (a) expand caregiver support services to address the needs of caregivers of adults with disabilities who are age 19 to 59; (b) require ADRCs to designate a caregiver coordinator and create a marketing plan to increase knowledge of available programs; (c) expand the tribal aging and disability resources specialist program, which provides liaison services between the tribes and ADRCs to ensure that tribal members receive culturally appropriate information and access long-term care programs and services; and (d) expand the tribal disability benefit specialist program, which is a contractual partnership between DHS and the Great Lakes Inter-Tribal Council to provide assistance and advocacy services to adult tribal members with disabilities.

4. DEMENTIA CARE SPECIALISTS

GPR	$3,000,000
FED	525,000
Total	$3,525,000

Governor: Provide $1,175,000 ($1,000,000 GPR and $175,000 FED) in 2021-22 and $2,350,000 ($2,000,000 GPR and $350,000 FED) in 2022-23 to expand the dementia care specialist program to all tribes and aging and disability resource centers (ADRCs) in the state. The administration indicates that funding in the bill is intended to fund 18 dementia care specialist positions at ADRCs and seven tribal dementia care specialist positions.

Dementia care specialists are employed by county ADRCs and tribal agencies. Currently, there are 29 dementia care specialists working in ADRCs, as well as four tribal dementia care specialists employed by tribal agencies. Dementia care specialists provide: cognitive screenings, programs that engage individuals with dementia in regular exercise and social activities, and promote independence for individuals with dementia; support for family caregivers, including assistance with care planning and connections to support groups; and community support, assisting in the development of dementia friendly communities through outreach events and professional consultations.

5. ALZHEIMER'S FAMILY AND CAREGIVER SUPPORT PROGRAM

GPR	$1,000,000

Governor: Provide $500,000 annually to increase the maximum amount of funding the Department may provide under the Alzheimer's family and caregiver support program from $2,558,900 to $3,058,900 annually. Modify the financial eligibility limit for the program to specify that a person is eligible for assistance under the program if the joint income of the person with Alzheimer's and that person's spouse, if any, is $55,000 per year or less, unless the Department sets a higher limitation on income eligibility by rule. Under current law, the income limit is $48,000 per year.

Under the program, DHS allocates funding to counties, tribes, and area agencies on aging to assist individuals to purchase services and goods related to the care of someone with Alzheimer's disease. Up to $4,000 per person may be available, depending on the county's priorities and the person's need for services. In some instances, the funds are used within the county to expand or develop new services related to Alzheimer's disease, such as respite care, adult day care, or support groups.

[Bill Sections: 779 and 788]

6. OFFICE OF CAREGIVER QUALITY

	Funding	Positions
FED	$102,200	0.78
PR	159,700	1.22
Total	$261,900	2.00

Governor: Provide $118,300 ($46,200 FED and $72,100 PR) in 2021-22 and $143,600 ($56,000 FED and $87,600 PR) in 2022-23 to fund 2.0 (0.78 FED and 1.22 PR) four-year project positions, beginning in 2021-22, in the Office of Caregiver Quality to conduct background checks, screen misconduct reports, and conduct field investigations into misconduct allegations in regulated healthcare settings and programs. Generally, PR funding to support the Office of Caregiver Quality staff comes from fees for the costs of inspecting, licensing or certifying, and approving facilities, issuing permits, and providing technical assistance.

Currently, the Office of Caregiver Quality is authorized 11.0 FTE positions, of which 2.0 positions are consumer protection investigators-senior and 4.0 positions are consumer protection investigators-advanced. The Governor recommends providing 1.0 additional consumer protection investigator position and 1.0 consumer protection investigator-advanced position.

7. GUARDIANSHIP TRAINING REQUIREMENTS

GPR	$250,000

Governor: Create new training requirements for persons nominated for or seeking appointment as a guardian for an individual found to be incompetent under Chapter 54 of the statutes (Guardianships and Conservatorships), and provide $125,000 annually for the Department to award as a grant to an organization to train and assist guardians for individuals found to be incompetent under Chapter 54 of the statutes.

Training Requirements

Training for Guardians of the Person. Specify that, unless exempt, before the final hearing for a permanent guardianship, any person nominated for, or seeking appointment as a guardian of the person must complete training on all of the following: (a) the duties and responsibilities of a guardian of the person under the law and limits of the guardian's decision-making authority; (b) alternatives to guardianship, including supported decision-making agreements and powers of attorney; (c) rights retained by the ward; (d) best practices for a guardian to solicit and understand the wishes and preferences of a ward, to involve a ward in decision making, and to take a ward's wishes and preferences into account in decisions made by the guardian; (e) restoration of a ward's rights and the process of removal of guardianship; (f) future planning and identification of a potential standby or successor guardian; and (g) resources and technical support for guardians.

Training for Guardians of the Estate. Specify that before the final hearing for a permanent guardianship, any person nominated for, or seeking appointment as a guardian of the estate must, at minimum, complete training on: (a) the duties and responsibilities of a guardian of the estate under the law and the limits of the guardian's decision-making authority; and (b) inventory and accounting requirements.

Exemptions from Training Requirements. Exempt the following from the initial training requirements: (a) court-appointed guardians of a person, guardians of an estate, or both that are private nonprofit corporations or other entities regulated by the Department; and (b) court-appointed guardians of the person and guardians of the estate for a minor from these training requirements. Additionally, specify that volunteer guardians who have completed these training requirements are exempt with regard to subsequent wards.

Statement of Acts by the Proposed Guardian. Require a proposed guardian to submit to the court, within 96 hours before a hearing on a petition for guardianship, a sworn and notarized statement that the proposed guardian has completed the training requirements previously described, unless the proposed guardian is exempt from the requirements.

Initial Applicability. Specify that the requirement that a proposed guardian must submit to the court a sworn and notarized statement regarding completion of the training requirements first applies to guardianships filed on the first day of the 13th month beginning after the general effective date of the bill.

Training Grants

Grant to Develop Training. Require DHS to award a grant to develop, administer, and conduct the training program. Specify that DHS must require the grantee to have expertise in state guardianship law, experience with technical assistance and support to guardians and wards, and knowledge of common challenges and questions encountered by guardians and wards.

Require that the grantee selected to develop training develop plain-language, web-based training modules using adult-learning design principles that can be accessed for free by training topic and in formats that maximize accessibility, with printed versions available for free upon request.

Specify that in reviewing applications for grants to develop such a training, the Department must consider the extent to which the proposed program will effectively train and assist guardians for individuals found incompetent under Chapter 54.

Finally, require that the grantee selected to administer and conduct training must, no later than one year after the effective date of this provision, and in coordination with DHS, develop the content for the initial training to be provided to guardians and implement the program.

Current Funding. The Department is currently budgeted $100,000 GPR annually for grants to private, nonprofit agencies or county departments for the purpose of training and assisting guardians for individuals found incompetent under Chapter 54. Under current law, no grant may be paid unless the awardee provides matching funds equal to 10 percent of the amount of the award. This requirement would continue to apply to awardees.

[Bill Sections: 789 thru 794, 1066 thru 1070, 9119(13), and 9319(1)]

8. NURSING HOME GRANT PROGRAM

	Funding	Positions
PR	$151,800	1.00

Governor: Provide $68,100 in 2021-22 and $83,700 in 2022-23 to fund 1.0 grant specialist position, beginning in 2021-22, to administer the nursing home grant program. The position would review applications, develop and manage grant agreements, and conduct outreach and marketing for the program. Currently, the program is administered by several staff in the Division of Quality Assurance (DQA).

The federal Centers for Medicare and Medicaid Services (CMS) collects civil money penalties (CMP) from nursing facilities that have not maintained compliance with federal nursing home requirements and distributes a portion of this revenue to states to support projects to protect the health or property of residents of nursing facilities. Under the nursing home grant program, DHS typically approves 15 to 20 applications per year. In 2019, DQA managed 14 ongoing projects, with total awards ranging from less than $5,000 to more than $1,500,000.

9. TAILORED CAREGIVER ASSESSMENT AND REFERRAL PILOT PROGRAM

GPR	$60,000

Governor: Provide $60,000 in 2021-22 and require that the Department conduct a one-year tailored caregiver assessment and referral (TCARE) pilot program as described in the September, 2020, report of the Governor's Task Force on Caregiving.

According to the Governor's Task Force on Caregiving, TCARE is a caregiver survey designed to support family members who are providing care to adults with chronic or acute health conditions. TCARE includes a pre-screening tool and a full assessment that seeks information from the family or informal caregiver in order to assess their health and well-being, stress levels, challenges, skills needed to perform care, their informal support system, and strengths that enable them to provide care. The assessment is conducted by staff who would be trained and licensed to conduct a TCARE assessment to identify areas where the caregiver may need additional supports

to keep them healthy and allow them to continue to provide care.

Funding is based on a $10,000 initial implementation cost and the purchase of 25 licenses at $2,000 per license. Examples of staff who may be trained and receive one of these licenses include aging and disability resource center staff, IRIS consultants, tribal and county aging unit staff, and health care staff.

[Bill Section: 9119(8)]

10. SSI SUPPLEMENTS REESTIMATE

GPR	- $2,684,000
PR	- 13,316,800
Total	- $16,000,800

Governor: Reduce funding by $7,790,500 (-$1,342,000 GPR and -$6,448,500 PR) in 2021-22 and by $8,210,300 (-$1,342,000 GPR and -$6,868,300 PR) in 2022-23 to: (a) reflect reestimates of funding that will be needed to support supplemental security income (SSI) state supplement and caretaker supplement payments in the 2021-23 biennium; and (b) partially fund caretaker supplement payments with GPR, in addition to PR (temporary assistance for needy families (TANF) funds), so that the state can continue to meet a federal SSI maintenance of effort requirement (MOE). DHS anticipates that, due to one-time retroactive payments DHS made to approximately 5,200 recipients in calendar year 2020, the state will be required to expend $158,405,424 GPR annually, on a calendar year basis, for SSI related benefits to comply with the MOE requirement.

The SSI program provides federal and GPR-funded benefits to low-income residents who are elderly, blind, or disabled. In August, 2020, approximately 119,900 Wisconsinites received state supplemental SSI benefits payments (currently $83.78 per month for single individuals, $132.05 for couples). Some SSI beneficiaries who require 40 hours of supportive home care or other care per month or live in small community-based residential facilities or other assisted living settings also qualify for an exceptional expense benefit ($95.99 per month for single individuals, $345.36 for couples). Recipients with dependent children may also receive a caretaker supplement payment supported by TANF funds transferred as program revenue from the Department of Children and Families (DCF). Eligible caretakers receive $250 per month for a first child and $150 per month for each additional child.

The following table summarizes the funding that would be provided for SSI supplemental payments under the Governor's bill.

SSI Supplemental Payments
Governor's Budget

	Base	Governor 2021-22	Governor 2022-23	Change to Base 2021-22	Change to Base 2022-23	Change to Base 2021-23
SSI State Supplements						
GPR	$159,747,400	$155,288,500	$155,288,500	-$4,458,868	-$4,458,900	-$8,917,800
Caretaker Supplement						
GPR	$0	$3,116,900	$3,116,892	$3,116,900	$3,116,900	$6,233,800
PR	24,321,200	17,872,700	17,452,937	-6,448,500	-6,868,300	-13,316,800
All Funds	$24,321,200	$20,989,600	$20,569,830	-$3,331,600	-$3,751,400	-$7,083,000
Total SSI-Related Payments						
GPR	$159,747,400	$158,405,400	$158,405,424	-$1,342,000	-$1,342,000	-$2,684,000
PR	24,321,200	17,872,700	17,452,937	-6,448,500	-6,868,300	-13,316,800
All Funds	$184,068,600	$176,278,100	$175,858,361	-$7,790,500	- $8,210,300	- $16,000,800
Caretaker Supplement						
Administration (PR)	$692,100	$692,100	$692,100	$0	$0	$0

11. CAREGIVER DESIGNATION FOR HOSPITAL RELEASES

Governor: Require that a hospital provide a patient or a patient's legal guardian, if applicable, at least one opportunity to designate at least one caregiver no later than 24 hours following the patient's admission to a hospital and before the patient's discharge or transfer to another hospital or facility licensed by DHS.

Require that if a patient is unconscious or otherwise incapacitated upon admission to the hospital, the hospital provide the patient or the patient's legal guardian, if applicable, with an opportunity to designate a caregiver within 24 hours following the patient's recovery of his or her consciousness or capacity.

Specify that if a patient or a patient's legal guardian declines to designate a caregiver, the hospital must promptly document that information in the patient's medical record. Provide that if a caregiver is designated, the hospital must promptly record the designation of the caregiver, the relationship of the caregiver to the patient, and the name, telephone number, and address of the caregiver in the patient's medical record.

Clarify that a patient or patient's legal guardian is not required to designate a caregiver. Specify that patient may change a designated caregiver at any time. In such an event, require that the hospital, within 24 hours, record in the patient's medical record any designation change and any new information as previously described. Clarify that designation of a caregiver under this provision does not obligate any individual to perform aftercare assistance for the patient.

Release of Medical Information. Require that if a patient or a patient's legal guardian designates an individual as a caregiver under this provision, the hospital must promptly request

the written consent of the patient or the patient's legal guardian to release medical information to the patient's designated caregiver following the hospital's established procedures for releasing personal health information and in accordance with applicable state and federal law. Further, specify that if a patient or a patient's legal guardian declines to consent to the release of medical information to the patient's designated caregiver, the hospital is not required to provide notice to the caregiver or provide information contained in the patient's discharge plan as otherwise required under this provision.

Notification and Instruction to Designated Caregivers. Provide that if a patient or patient's legal guardian designates a caregiver and consents to the release of medical information to the patient's designated caregiver as previously described, a hospital must: (a) notify the patient's designated caregiver of the patient's discharge or transfer to another hospital or facility licensed by DHS as soon as possible, which may be after the patient's physician issues a discharge order, but not less than four hours before the patient's actual discharge or transfer to the other hospital or facility; and (b) no less than 24 hours before a patient's discharge from a hospital, consult with the designated caregiver along with the patient regarding the caregiver's capabilities and limitations and issue a written discharge plan that describes a patient's aftercare assistance needs at the patient's residence.

Discharge Plan. Provide that for purposes of these provisions, a hospital must include at least all of the following in a patient's discharge plan: (a) the name and contact information of the caregiver designated under these requirements; (b) a description of all aftercare assistance tasks necessary to maintain the patient's ability to reside at home, taking into account the capabilities of the caregiver; and (c) contact information for any health care, community resources, and long-term services and supports necessary to carry out the patient's discharge plan.

Further, specify that a hospital issuing a discharge plan under this provision must provide caregivers with instruction in all aftercare assistance tasks described in the discharge plan, and must include at least all of the following: (a) a live demonstration of the tasks performed by a hospital employee or individual with whom the hospital has a contractual relationship authorized to perform the aftercare assistance task, provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law; (b) an opportunity for the caregiver and patient to ask questions about the aftercare assistance tasks; and (c) answers to the caregiver's and patient's questions provided in a culturally competent manner and in accordance with the hospital's requirements to provide language access services under state and federal law.

Confidentiality of Patient Health Care Records. Modify the individuals to whom a portion of certain health care records can be statutorily released to include a caregiver designated under these provisions as they pertain to records released that are directly relevant to the involvement of the designated caregiver in the patient's care. Further, authorize a healthcare provider to provide a designated caregiver, who is otherwise permitted to access a portion of a patient health care record, with a copy of any written discharge plan issued as previously described.

Definitions. For purposes of these provisions define: (a) "aftercare assistance" as any assistance provided by a caregiver to a patient after the patient's discharge and related to the

patient's condition at the time of discharge, including g assisting with basic activities of daily living or instrumental activities of daily living, or carrying out medical or nursing tasks, such as managing wound care, assisting in administering medications, or operating medical equipment; (b) "caregiver" as any individual, including a relative partner, friend, neighbor, or other person who has a significant relationship with a patient, who is designated as a caregiver under these provisions to provide aftercare assistance to that patient; (c)"discharge" as a patient's exit or release from a hospital to the patient's residence following an inpatient admissions; (d) "hospital," and "incapacitated" by cross reference to current definitions in Chapter 50 of the statutes; and (e) "residence" as a dwelling that the patient considers to be his or her home, but not including any rehabilitation facility, hospital, nursing home, assisted living facility, or a group home licensed by DHS.

Clarify that nothing in these provisions shall be construed to interfere with the rights of a person authorized by law to make health care decisions on behalf of a person or be construed to create a private right of action against a hospital, a hospital employee, or any authorized agent of the hospital, or to otherwise supersede or replace existing rights or remedies.

[Bill Sections: 1060, 2279, and 2280]

12. STATEWIDE MINIMUM RATE BAND FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SUPPORTS

Governor: Require the Department to develop a statewide minimum rate band for home and community-based long-term care supports to establish equitable and sustainable minimum rates. Further, require the Department to include in its 2023-25 budget request a proposal to implement the rate band developed under this provision. Using a minimum rate band methodology would establish a fee schedule to set minimum rates paid to home and community-based long-term care providers participating in the Medicaid program.

[Bill Section: 9119(9)]

13. HOME CARE PROVIDER REGISTRY PILOT PROGRAM

Governor: Require the Department to conduct a one-year pilot program to create a home care provider registry that supports home and community-based long-term care support programs, clients that pay for home care privately, independent care workers, and vendors of the care service industry. Require that the Department use a software platform for the registry and select a vendor for the software platform using its competitive request-for-proposals procedures.

[Bill Section: 9119(12)]

14. DIRECT SUPPORT PROFESSIONAL TRAINING PILOT

Governor: Require DHS, in the 2021-23 biennium, to develop and implement a pilot

program to provide person-centered direct support professional training to achieve consistent standards in health care practice. Require DHS to provide identified standards of practice that allow health care providers the flexibility to apply the standards of practice to their existing training while also meeting the needs of patients in both community and facility settings.

Specify that any training developed and implemented under this provision must be consistent with state and federal requirements.

Require that DHS collaborate with the Department of Workforce Development, the Wisconsin Technical College System, and health care providers in developing and implementing this pilot program.

Require that DHS develop a career plan that describes the steps that lead to potential certification as a nurse aide.

[Bill Section: 9119(7)]

Community Based Behavioral Health

1. REGIONAL CRISIS RESPONSE SYSTEM GRANTS

	Funding	Positions
GPR	$17,596,100	2.00

Governor: Provide $130,500 in 2021-22 and $17,465,600 in 2022-23, and 2.0 positions, beginning in 2021-22, to establish a crisis response grant program. Create a GPR annual appropriation for the program. Of this funding, $17,298,300 in 2022-23 would fund grants and $130,500 in 2021-22 and $167,300 in 2022-23 would support 2.0 human services program coordinator positions to implement the grant programs and provide ongoing monitoring of funded facilities. Of the funding provided for grants, $12,298,300 would be designated for grants to regional crisis centers that offer a continuum of crisis services, and $5,000,000 would be for grants to support stand-alone crisis stabilization facilities.

Require DHS to award grants under the program as follows: (a) grants to entities to provide a continuum of crisis response services, including mental health crisis urgent care and observation centers, crisis stabilization and inpatient psychiatric beds, and crisis stabilization facilities; and (b) no more than five grants to fund services at facilities providing crisis stabilization services, based on criteria established by the Department.

Authorize the Department to certify crisis urgent care and observation centers and establish criteria by rule for the certification of crisis urgent care and observation centers. Specify that if the Department establishes a certification process for crisis urgent care and observation centers, no person may operate a crisis urgent care and observation center without having a certification. Specify that the Department may limit the number of certifications it grants to operate crisis urgent care and observation centers. Authorize the Department to promulgate emergency rules

establishing the criteria for the certification for crisis urgent care and observation centers, notwithstanding current law prerequisites for emergency rules.

The administration indicates that the intent would be to award two grants for regional crisis centers, which would support a crisis urgent care and observation center, a 15-bed crisis stabilization facility, and two inpatient psychiatric beds. These centers would accept individuals taken into custody under emergency detention procedures under Chapter 51 of the statutes, conduct medical clearances, and assist with admission to other facilities as needed to reduce law enforcement time needed for emergency detention.

The administration indicates that five grants would be made for crisis stabilization facilities to assist adults who require short-term crisis stabilization in a community-based care setting.

[Bill Sections: 393, 1061, 1062, and 9119(18)]

2. LAW ENFORCEMENT-BEHAVIORAL HEALTH SERVICES COLLABORATION GRANTS

GPR	$2,500,000

Governor: Provide $1,250,000 annually in the appropriation for crisis program enhancement grants and require DHS to make grants of at least that amount each fiscal year to establish and enhance law enforcement and behavioral health services emergency response collaboration programs. Specify that grant recipients must match at least 25% of the grant amount awarded for the purpose that the grant is received.

Under current law, the Department is authorized to provide grants of up $250,000 each biennium to counties to enhance behavioral health crisis programs to serve individuals in rural areas. Under this item, the program would be expanded to provide grants to municipalities or counties to establish collaborative programs between law enforcement agencies and behavioral health programs.

[Bill Sections: 784 and 785]

3. COUNTY CRISIS CALL CENTER SUPPORT

GPR	$1,847,200

Governor: Provide $923,600 annually in a new appropriation for grants to support mental health professionals to provide supervision and consultation to individuals who support crisis call center services. Require DHS to make grants for this purpose and specify that each county or multicounty program that receives supervision and consultation services from a grant recipient must contribute at least 10 percent of the costs of the services that the grant recipient incurs for the purpose that the grant is received.

The administration indicates that the intent of this provision is to provide crisis line support during non-business hours for smaller counties that do not have 24-hour crisis lines, as well as to provide statewide backup for other county crisis lines during periods of high call volume.

[Bill Sections: 394 and 787]

4. MILWAUKEE MOBILE CRISIS UNIT ENHANCEMENT

GPR	$1,700,000

Governor: Provide $850,000 annually in the appropriation for crisis program enhancement grants and require DHS to make a grant of at least that amount each fiscal year to a county with a population of more than 750,000 (Milwaukee County) to enhance mobile crisis teams. A mobile crisis team consists of mental health professionals who provide emergency response services in the community to individuals who are experiencing a mental health crisis. The administration indicates that the intent of this grant is to support additional staff for Milwaukee County's existing mobile crisis team, to expand its capacity to respond to crisis situations.

[Bill Sections: 784 and 786]

5. CRISIS INTERVENTION TRAINING GRANTS

GPR	$750,000

Governor: Provide $375,000 annually for mental health crisis intervention training for law enforcement and correctional officers. Base funding for the program is $125,000, so the proposed increase would provide a total of $500,000 annually for the program. Currently, DHS contracts with the Wisconsin section of the National Alliance on Mental Illness (NAMI) to conduct mental health crisis team training for law enforcement agencies. By statute, DHS is required to award a grant of $250,000 per biennium for training. The bill would increase funding for the program, but would not adjust the statutory grant amount. DOA indicates that the intent was to increase the statutory grant amount to match the appropriation.

6. BEHAVIORAL HEALTH TECHNOLOGY GRANTS

GPR	$2,000,000

Governor: Provide $2,000,000 in 2022-23 for DHS to provide as grants to behavioral health providers to implement electronic health records systems and connect to health information exchanges. Create an annual GPR appropriation for making grants. A health information exchange allows a provider to access their patients' records, such as test results, prescribed medications, and services patients received, including information relating to services rendered by other providers. The Wisconsin Statewide Health Information Network (WISHIN) serves as the health information exchange for providers in Wisconsin.

[Bill Section: 387]

7. DEAF, HARD OF HEARING, AND DEAF-BLIND BEHAVIORAL TREATMENT PROGRAM

GPR	$1,936,000

Governor: Provide $1,936,000 in 2022-23 to provide behavioral health treatment services for individuals who are deaf, hard of hearing, or deaf-blind and authorize DHS to distribute not more than that amount in each fiscal year, beginning in 2022-23, to a statewide provider of these services. The administration indicates that the funding would be used for services provided by healthcare providers that are fluent in American Sign Language. The funding is based on estimated cost of supporting eight personnel for providing and coordinating services, including salary, fringe

benefits, supplies and services, and accommodations.

[Bill Section: 780]

8. CHILD PSYCHIATRY CONSULTATION PROGRAM

GPR	$1,000,000

Governor: Provide $500,000 annually to increase from $1,500,000 to $2,000,000 the annual funding for the child psychiatry consultation program. Under the program, DHS contracts with the Medical College of Wisconsin to provide professional consultation services to assist primary care physicians and clinics in providing care to pediatric patients with mental health care needs. Currently, consultation services are provided to practitioners in Milwaukee County and counties in northern Wisconsin. The administration indicates that the funding increase is intended to expand consultation services statewide.

9. MILWAUKEE TRAUMA RESPONSE GRANT

GPR	$900,000

Governor: Provide $450,000 annually and require DHS to make a grant of that amount annually for the City of Milwaukee trauma response team. The administration indicates that the funding would allow the City of Milwaukee to expand its trauma response initiative, a collaboration between the Milwaukee Police Department and Wraparound Milwaukee mobile urgent treatment team. The team provides services to children who have witnessed or been exposed to potentially traumatic events to prevent long-term impacts of the exposure to traumatic events.

[Bill Section: 781]

10. PEER-RUN RESPITE CENTER PHONE LINE SUPPORT

GPR	$627,600

Governor: Provide $313,800 annually to fund phone line support to supplement phone service provided by peer-run respite centers.

Currently, the Department provides grants to support the operating costs of four peer-run respite centers in the state. These facilities provide services, including short-term residential stays, to individuals who need support to cope with mental illness or substance abuse. The peer-run respite centers are staffed by individuals who have successfully completed mental health or substance abuse treatment. In addition to in-person service, the peer-run respite centers provide a 24-hour non-emergency phone line to assist individuals. This item would provide funding to support a supplemental call center to provide backup to the staff at the four peer-run respite centers during periods of high call volume or when staff are providing in-person service. DHS would contract for six additional peer specialists to staff the supplemental phone service.

11. MEDICATION-ASSISTED TREATMENT EXPANSION

GPR	$1,500,000

Governor: Provide $500,000 in 2021-22 and $1,000,000 in 2022-23 to fund grants to develop or support entities that offer medication-assisted treatment. Require DHS to award grants

of up to those amounts in the biennium and up to $1,000,000 annually thereafter. The administration indicates that the grants would be used to expand access to medication-assisted treatment for individuals with opioid use disorder in underserved or high-need areas. Medication-assisted treatment involves the regular use of medications to block the effects of or reduce craving for opioids, and is used in combination with counseling and behavioral therapies.

[Bill Section: 782]

12. SUBSTANCE USE HARM REDUCTION GRANT

GPR	$500,000

Governor: Provide $250,000 annually for substance use harm reduction grants and authorize DHS to make grants of up to that amount annually to organizations with comprehensive harm reduction strategies for the development or support of substance use harm reduction programs, as determined by the Department. A harm reduction approach to opioid use disorder includes strategies such as providing safe syringe access to prevent infection and supervised use facilities to prevent overdose, used along with substance use disorder treatment.

[Bill Section: 783]

13. METHAMPHETAMINE ADDICTION TREATMENT GRANTS

GPR	$450,000

Governor: Provide $150,000 in 2021-22 and $300,000 in 2022-23 for grants to provide training to substance use disorder treatment providers on treatment models for methamphetamine addiction. The funding would be provided in a new appropriation established for this purpose. The administration indicates that grants would be used to train substance abuse treatment professionals in the use of techniques for addressing addiction to stimulants, such as methamphetamine.

[Bill Section: 392]

14. SUBSTANCE USE DISORDER TREATMENT PLATFORM

GPR	$300,000

Governor: Provide $300,000 in 2022-23 for the development of a substance use disorder treatment platform that allows for the comparison of treatment programs in the state. Require DHS to contract for the development of the platform in 2022-23, expending no more than $300,000 for that purpose. The administration indicates that the platform would be an on-line substance use disorder treatment program aggregator to locate, compare, and review available treatment programs in the state.

[Bill Section: 9119(19)]

15. BEHAVIORAL HEALTH BED TRACKER

GPR	$150,000

Governor: Provide $100,000 in 2021-22 and $50,000 in 2022-23 to develop and maintain

a real-time system to track the availability of peer run respite, crisis stabilization, and inpatient psychiatric beds. Modify a current law provision that requires DHS to award a grant for the development and operation of a system to track the availability of inpatient psychiatric beds to specify that the system for which the grant is provided shall also track the availability of peer run respite and crisis stabilization beds. Modify other statutory provisions relating to the users of the system and reporting of bed availability to the system to reflect these changes.

Require DHS to award a grant of $100,000 in 2021-22 and $50,000 annually thereafter for the system, and delete the requirement that the grant must be provided to an entity that the Department contracts with for the collection and dissemination of health care information related to hospitals and ambulatory surgical centers (currently the Wisconsin Hospital Association). Under current law, DHS is required to award a grant of $80,000 in 2015-16 and $30,000 annually thereafter for the inpatient psychiatric bed tracking system.

The funding under this item, when added to the base level of funding for the inpatient psychiatric bed tracking system, would make available total funding of $130,000 in 2021-22 and $80,000 in 2022-23. DOA indicates that the administration's intent is to continue providing an annual grant to the Wisconsin Hospital Association to maintain the inpatient psychiatric bed tracking system, while contracting separately for a system to track other behavioral treatment bed capacity.

[Bill Sections: 385 and 1063]

Care and Treatment Facilities

1. MENDOTA MENTAL HEALTH UNIT FORENSIC STAFFING

	Funding	Positions
GPR	$6,056,400	36.50

Governor: Provide $3,028,200 annually and 36.5 positions, beginning in 2021-22, to staff a 14-bed unit for adult forensic patients in the building at the Mendota Mental Health Institute that houses the Mendota Juvenile Treatment Center (MJTC). Although the unit currently serves adult forensic patients, in 2021 DHS plans to transfer the current staff to new forensic units that will be available following the completion of a renovation project in the adjacent Lorenz Hall. This item would provide additional funding and positions to continue operating the 14-bed unit in the MJTC building for adult forensic patients. The administration indicates that additional forensic treatment space is needed to reduce the number of forensic patients awaiting admission to the Mendota Mental Health Institute. Without additional staffing, the MJTC adult forensic unit would close with the opening of the Lorenz Hall units.

Of the additional funding, $2,623,100 annually would be budgeted for salary and fringe benefit costs, while the remaining $405,100 annually would be budged for supplies and services costs associated with these positions.

2. PERMANENT POSITIONS FOR FORENSIC UNITS AT SAND RIDGE SECURE TREATMENT CENTER

	Funding	Positions
GPR	$5,308,600	36.50

Governor: Provide $2,654,300 annually and 36.5 positions, beginning in 2021-22, to replace expiring project positions and funding used to staff two treatment units for forensic patients at the Sand Ridge Secure Treatment Center (SRSTC) in Mauston. The two units, with a total of 40 beds, were opened in vacant space at SRSTC to provide additional capacity for male forensic patients. The 2019-21 budget act provided project positions and funding to staff these units. Since these project positions expire on June 30, 2021, the position authority and associated funding is removed in the 2021-23 biennium under the removal of non-continuing elements standard budget adjustment. This item would provide permanent position authority and an equivalent level of funding to provide ongoing staffing for the SRSTC units.

Forensic patients are persons who are committed for treatment by courts as the result of a criminal proceeding. Forensic patients include: (a) persons charged with an offense and whose competency to proceed to trial is questioned; (b) persons deemed not competent to stand trial as the result of mental illness present at the time of the trial; and (c) persons who are found not guilty by reason of mental disease or mental defect present at the time that the offense was committed. DHS has used the SRSTC units for males who are committed as the result of being found not guilty by reason of mental disease or defect, who would otherwise be committed to the Mendota Mental Health Institute. Since Mendota has a waiting list for forensic admissions, the SRSTC units reduce the number of patients with court ordered commitments who are held in county jails prior to admission.

3. OVERTIME SUPPLEMENT

GPR	$11,655,200
PR	6,703,600
Total	$18,358,800

Governor: Provide $9,179,400 ($5,827,600 GPR and $3,351,800 PR) annually to fully fund anticipated overtime costs at the Department's care and treatment residential facilities. The funding under this item reflects the administration's estimate of the difference between actual overtime costs at each facility and the amount that would be provided under the overtime standard budget adjustment.

The following table shows, by facility and fund source, the annual overtime increase provided under the standard budget adjustment, the funding increase provided under this item, and the total funding that would be provided annually to support overtime costs under the bill.

Annual Overtime Funding for DHS Care and Treatment Facilities, by Source
Governor's Bill

Facility	Standard Budget Adjustments GPR	PR	Total	Overtime Funding Under This Item GPR	PR	Total	Total Annual Overtime Budget GPR	PR	Total
Mendota MHI	$1,623,500	$550,600	$2,174,100	$3,164,800	$1,073,300	$4,238,100	$4,788,300	$1,623,900	$6,412,200
Winnebago MHI	504,100	1,660,800	2,164,900	327,000	1,077,300	1,404,300	831,100	2,738,100	3,569,200
WI Resource Center	1,040,700	0	1,040,700	852,700	0	852,700	1,893,400	0	1,893,400
Sand Ridge STC	323,900	0	323,900	1,483,100	0	1,483,100	1,807,000	0	1,807,000
Central WI Center	0	2,628,800	2,628,800	0	1,090,100	1,090,100	0	3,718,900	3,718,900
Southern WI Center	0	2,163,900	2,163,900	0	15,100	15,100	0	2,179,000	2,179,000
Northern WI Center	0	403,600	403,600	0	96,000	96,000	0	473,700	473,700
Total	**$3,492,200**	**$7,407,700**	**$10,899,900**	**$5,827,600**	**$3,351,800**	**$9,179,400**	**$9,319,800**	**$10,759,500**	**$20,079,300**

4. CONTRACTED MENTAL HEALTH SERVICES

GPR	$1,069,200

Governor: Reduce funding by $63,700 in 2021-22 and increase funding by $1,132,900 in 2022-23 to fund projected costs of the Division of Care and Treatment Services contracts for community-based treatment and monitoring services for individuals in the forensic and sexually violent persons programs.

The estimates for each of the contracted treatment services use a caseload growth factor, based on recent trends, and a 1.6% annual inflationary adjustment to the per-client costs. These adjustments are applied to the actual caseload and costs in 2019-20. Because caseload and costs in 2020-21 are projected to be lower than the base level funding for several of these services, the total adjustment to the base is negative in 2021-22.

The following table shows the base funding for each type of contract, the estimated 2021-23 costs in each category, and the difference between the base and the estimated cost. Below the table is an explanation of each category. In prior years, the Department treated the court liaison contract as part of the base for outpatient competency exams, but since this is a distinct function, the table shows this contract separately, with $0 for the base.

Program/Contract	2020-21 Base	Estimated Funding Need 2021-22	2022-23	Funding Change 2021-22	2022-23
Supervised Release	$6,384,400	$6,051,700	$6,519,600	-$332,700	$135,200
Conditional Release	5,621,900	5,556,200	5,747,700	-65,700	125,800
Treatment to Competency	3,081,300	3,132,400	3,455,000	51,100	373,700
Outpatient Competency Exams	2,765,300	2,572,700	2,705,100	-192,600	-60,200
Court Liaison	0	168,600	171,300	168,600	171,300
DOC Contracts	1,575,000	1,882,600	1,962,100	307,600	387,100
Total	$19,427,900	$19,364,200	$20,560,800	-$63,700	$1,132,900

Supervised Release Services. The supervised release program provides community-based

treatment to individuals who are found to be sexually violent persons (SVPs) under Chapter 980 of the statutes. SVPs are committed to DHS and provided institutional care at the Sand Ridge Secure Treatment Center in Mauston, but may petition the court for supervised release if at least 12 months have elapsed since the initial commitment order was entered, since the most recent release petition was denied, or since the most recent order for supervised release was revoked.

Conditional Release Services. The conditional release program provides treatment to individuals who have been found not guilty by reason of mental disease or defect and are either immediately placed on conditional release following the court's finding or following release from one of the state's mental health institutes.

Treatment to Competency Services. DHS contracts with a vendor to provide outpatient treatment services to individuals who are determined to be incompetent to proceed to a criminal trial if a court determines that the individual is likely to be competent within 12 months, or within the time of the maximum sentence specified for the most serious offense with which the defendant is charged. These services are delivered on an outpatient basis for individuals who, based on an assessment of their risk level, are able to live in the community, or in county jails, as an alternative to admitting those individuals to one of the mental health institutes for treatment.

Outpatient Competency Examination. Chapter 971 of the statutes prohibits courts from trying, convicting, or sentencing an individual if the individual lacks substantial mental capacity to understand the proceedings or assist in his or her own defense. Courts may order DHS to conduct competency examinations, which may be performed either on an inpatient basis by DHS staff at the state mental institutes, or on an outpatient basis in jails and locked units of other facilities by contracted staff.

Court Liaison Services. The Department contracts for the cost of court liaison services, used to provide consultation to courts regarding mental health issues for individuals in the judicial system. In the 2019-21 biennium, the Department contracted for these services as part of the outpatient competency examination program.

Department of Corrections Contracts. DHS contracts with the Department of Corrections for the supervision of clients in the conditional release and supervised release programs. The contract includes supervision, transportation escort, and global positioning system (GPS) monitoring.

A separate item in the bill, summarized below, would provide funding to allow DHS to contract for additional treatment services for forensic patients under conditional release using an assertive community treatment model.

5. ASSERTIVE COMMUNITY TREATMENT CONTRACT

GPR	$4,547,600

Governor: Provide $2,273,800 annually to allow the Department to contract for treatment delivered under an assertive community treatment model for individuals with serious mental illness that are involved in the criminal justice system. The assertive community treatment model uses a team approach to provide intensive services for individuals transitioning from institutional

setting to the community. As used for a forensic population (forensic assertive community treatment, or FACT) the treatment focuses on risks and needs associated with criminal behavior. Individual services can include psychiatric and substance abuse treatment, housing and employment assistance, family education, medication management, and assistance with court proceedings, as applicable. The administration indicates that the intent is to divert these individuals away from hospitalization, re-arrest, and incarceration. Service teams would be targeted to areas of the state with the highest number of forensic referrals. The funding in the bill is the estimated cost of staffing FACT teams sufficient to serve approximately 100 individuals, plus the non-federal share of costs of Medicaid-funded services for FACT clients.

6. FOOD AND VARIABLE NONFOOD SUPPLIES AND SERVICES

GPR	$8,150,400
PR	17,353,400
Total	$25,503,800

Governor: Increase funding for food and variable nonfood supplies and services at the DHS care and treatment facilities as follows.

Food. Provide $291,100 ($249,300 GPR and $41,800 PR) in 2021-22 and $435,500 ($344,500 GPR and $91,000 PR) in 2022-23 to fund projected increases in food costs. These estimates are based on the Department's population projections for its seven facilities, and the assumption that average food costs will increase by 2.8% annually. The Department's base budget for food at its facilities is $4,727,900 ($3,153,500 GPR and $1,574,400 PR).

Variable Nonfood Supplies and Services. Provide $9,408,800 ($2,270,700 GPR and $7,138,100 PR) in 2021-22 and $15,368,400 ($5,285,900 GPR and $10,082,500 PR) in 2022-23 to fund projected increases in nonfood supplies and services costs that vary with resident populations. These costs include medical services, medical supplies, prescription drugs, and clothing. The estimates are based on facility-specific inflationary cost projections, which reflect differences in medical supplies, services, and medications used by residents and patients at these facilities. The Department's base budget for variable nonfood supplies and services is $40,410,900 ($24,968,100 GPR and $15,442,800 PR).

7. MENTAL HEALTH INSTITUTES FUNDING SPLIT

	Funding	Positions
GPR	- $1,239,900	- 8.39
PR	1,239,900	8.39
Total	$0	0.00

Governor: Reduce funding by $582,500 GPR in 2021-22 and $657,400 GPR in 2022-23 and increase PR funding by corresponding amounts, and convert 7.68 GPR positions in 2021-22 and 8.39 GPR positions in 2022-23 to PR positions, to reallocate, by source, funding for services provided at the state mental health institutes. This funding adjustment reflects the administration's estimates of the percentage of patients whose care will be funded with GPR and PR at the Mendota and Winnebago mental health institutes in the 2021-23 biennium.

The share of each facility's costs funded by GPR and PR is based on the composition of patient population. The state is responsible for the cost of caring for forensic patients, which it has generally funded with GPR. The cost of caring for civilly-committed patients is funded from program revenues paid by counties and third-party payers. As part of each biennial budget, base

funding for services provided to both forensic and civil patients, primarily personnel costs, is adjusted to match anticipated changes in the relative share of forensic and civil patients at each facility. For the 2021-23 biennium, DHS anticipates that PR-funded civil patients will increase as a share of the total patient population at both Mendota and Winnebago, resulting in a shift from GPR funding and position to PR funding and positions for certain facility-wide services.

8. DEBT SERVICE

GPR	- $4,248,600

Governor: Reduce funding by $2,290,400 in 2021-22 and by $1,958,200 in 2022-23 to reflect estimates of debt service payments on bonds issued for capital projects at DHS care and treatment facilities. Base debt service funding is $19,848,300. With the estimated reductions, total debt service payments are estimated at $17,557,900 in 2021-22 and $17,890,100 in 2022-23.

9. FUEL AND UTILITIES

GPR	- $766,600

Governor: Reduce funding by $455,000 in 2021-22 and $311,600 in 2022-23 to reflect an estimate of GPR-funded fuel and utilities costs at the Division of Care and Treatment Services residential facilities. With these adjustments, total GPR-funded fuel and utility funding would be $5,563,600 in 2021-22 and $5,707,000 in 2022-23. The bill would not modify funding for fuel and utility costs supported by the Division's program revenue general program operations budget.

10. MENDOTA JUVENILE TREATMENT CENTER -- FUNDING TRANSFER FROM DOC

Governor: Delete a statutory provision that specifies the amounts that the Department of Corrections (DOC) must transfer to DHS in each fiscal year for the staffing costs of the Mendota Juvenile Treatment Center (MJTC) and, instead, require DOC to reimburse DHS an amount for the cost of providing services for juveniles placed at MJTC at a per person daily cost specified by DHS.

Under current law, DOC is required to transfer $1,365,500 from a GPR appropriation and an amount from a PR appropriation that is typically adjusted annually to fund estimated MJTC costs, net of the GPR transfer. In 2020-21, the PR transfer was set at $5,429,000, which when added to the GPR transfer, establishes a total transfer of $6,794,500. Under this item, the transfer would be determined based on a daily rate set by DHS. A separate item, summarized under "Corrections -- Juvenile Corrections" would authorize DOC to assess counties for juveniles a per person daily rate at the same rate that DHS charges DOC for MJTC services.

[Bill Sections: 775, 2696, and 2697]

Departmentwide

1. STANDARD BUDGET ADJUSTMENTS

	Funding	Positions
GPR	$15,752,400	- 36.50
FED	- 16,158,500	- 3.00
PR	12,892,400	0.00
SEG	- 7,200	0.00
Total	$12,479,100	- 39.50

Governor: Provide $6,369,700 ($7,876,200 GPR, -$7,949,100 FED, $6,446,200 PR, and -$3,600 SEG) in 2021-22 and $6,109,400 ($7,876,200 GPR, -$8,209,400 FED, $6,446,200 PR, and -$3,600 SEG) in 2022-23, and the reduction of 37.5 positions (-36.5 GPR positions and -1.0 FED position) in 2021-22 and a reduction of 39.5 positions (-36.5 GPR positions and -3.0 FED positions) in 2022-23, to reflect the net effect of the following standard budget adjustments: (a) turnover reduction (-$3,610,800 GPR, -$1,984,100 FED, and -$2,783,200 PR annually); (b) removal of non-continuing elements (-$2,654,300 GPR, -$95,400 FED, -36.5 GPR positions, and -1.0 FED position in 2021-22, and -$2,654,300 GPR, -$355,700 FED, -36.5 GPR positions, and -3.0 FED positions in 2022-23); (c) full funding of continuing salaries and fringe benefits ($9,558,000 GPR, -$4,538,100 FED, -$207,400 PR, and $900 SEG annually); (d) overtime ($3,492,200 GPR and $7,407,700 PR annually); (e) night and weekend salary differentials ($2,075,600 GPR, $101,300 FED, and $2,259,000 PR annually); (f) full funding of lease and directed moves costs (-$984,500 GPR, -$1,432,800 FED, -$229,900 PR, and -$4,500 SEG annually); and (g) minor transfers between appropriations of the same fund source ($0 annually).

2. FEDERAL REVENUE REESTIMATES

FED	$55,323,900

Governor: Provide $26,437,900 in 2021-22 and $28,886,000 in 2022-23 to reflect the net effect of funding adjustments to certain federal appropriations that are not included in other items in the Governor's budget.

The following table shows the base funding amount for each appropriation affected by this item, the funding change under this item, the net funding changes to these appropriations under other items in the Governor's budget, and the total amount that would be budgeted in each appropriation under the Governor's budget recommendations.

Federal Revenue Funding Reestimate

	Base	2021-22 Reestimate	2021-22 Other Items	2021-22 Total	2022-23 Reestimate	2022-23 Other Items	2022-23 Total
Public Health							
Medical Assistance -- State Administration	$1,655,000	$343,100	$56,100	$2,054,200	$343,100	$56,100	$2,054,200
Federal Projects Operations	33,338,600	10,309,100	-48,400	43,599,300	10,309,100	-84,900	43,562,800
Maternal and Child Health Block Grant – Aids/Local Assistance	6,498,700	501,300	0	7,000,000	501,300	0	7,000,000
Elderly Programs – Aids	29,802,000	132,900	0	29,934,900	132,900	0	29,934,900
Medicaid Services							
FSET – Vendor Contracts	17,623,700	4,333,400	0	21,957,100	6,791,700	186,500	24,601,900
Care and Treatment Services							
Federal Program Operations – MA State Administration	958,700	61,700	177,600	1,198,000	61,700	177,600	1,198,000
Federal Project Aids	12,220,600	3,665,800	0	15,886,400	3,665,800	0	15,886,400
Federal Block Grant Local Assistance – Substance Abuse Block Grant – Counties	7,533,000	2,223,800	0	9,756,800	2,223,800	0	9,756,800
Federal Block Grant Local Assistance	1,826,500	5,358,700	0	7,185,200	5,358,700	0	7,185,200
Federal Block Grant Operations – Substance Abuse Block Grant	2,400,600	97,000	-19,300	2,478,300	97,000	-19,300	2,478,300
Community Mental Health Block Grant – Operations	978,100	215,900	170,500	1,364,500	215,900	170,500	1,364,500
Disability and Elder Services							
Social Services Block Grant – Transfer	6,131,400	10,000	0	6,141,400	7,700	0	6,139,100
Social Services Block Grant – Local Assistance	20,887,500	227,200	0	21,114,700	219,300	0	21,106,800
General Administration							
Income Augmentation Receipts	1,418,100	-1,042,000	0	376,100	-1,042,000	0	376,100
Total		**$26,437,900**			**$28,886,000**		

3. PROGRAM REVENUE REESTIMATES

PR	$9,823,400

Governor: Provide $4,911,700 annually to reflect the net effect of funding adjustments to certain program revenue appropriations.

The following table shows the base funding amount for each appropriation, the funding change under this item, the net funding changes to these appropriations under other items in the bill, and the total amount that would be budgeted in each appropriation under the Governor's budget recommendations.

Program Revenue Funding Reestimates

	Base	2021-22 Reestimate	2021-22 Other Items	2021-22 Total	2022-23 Reestimate	2022-23 Other Items	2022-23 Total
Public Health							
Elderly Nutrition	$445,500	$54,500	$0	$500,000	$54,500	$0	$500,000
Asbestos Abatement Certification	687,500	4,100	12,800	704,400	4,100	12,800	704,400
Medicaid Services							
Interagency and Intra-agency aids	22,384,400	2,615,600	-2,482,100	22,517,900	2,615,600	-1,705,900	23,294,100
Interagency and Intra-agency Local Assistance	845,300	154,700	0	1,000,000	154,700	0	1,000,000
Care and Treatment Services							
Center	1,446,400	249,100	0	1,695,500	249,100	0	1,695,500
Interagency and Intra-agency Programs	3,291,500	1,735,400	180,600	5,207,500	1,735,400	180,600	5,207,500
Quality Assurance							
Health Facilities License Fees	951,700	98,300	8,300	1,058,300	98,300	8,300	1,058,300
General Administration							
Administrative and Support Personnel	3,416,000	-2,500,000	-59,300	856,700	-2,500,000	-59,300	856,700
Bureau of Information Technology Services	17,495,500	2,500,000	-373,500	19,622,000	2,500,000	-373,500	19,622,000
Total		**$4,911,700**			**$4,911,700**		

4. EQUITY OFFICER POSITION

	Funding	Positions
GPR	$145,500	1.00

Governor: Provide $63,800 in 2021-22 and $81,700 in 2022-23 and 1.0 GPR position, beginning in 2021-22, to create an agency equity officer position. The agency equity officer would be responsible for coordinating with other agency equity officers and identifying opportunities to advance equity in government operations. For additional information, see "Administration -- General Agency Provisions."

5. HUMAN RESOURCES SHARED SERVICES

	Positions
PR	- 1.00

Governor: Delete 1.0 PR position, beginning in 2021-22, as part of a multi-agency modification to transfer positions that currently perform personnel management functions in other agencies to DOA. Reallocate $110,900 annually in base salary and fringe benefits funding for the position to instead fund supplies and services, which DHS would use to pay assessments to DOA for human resources services DOA provides to the agency. For more information, see "Department of Administration -- Personnel Management."

6. ADMINISTRATIVE TRANSFERS

	Funding	Positions
FED	$1,244,800	7.00
PR	- 1,244,800	- 7.00
Total	$0	0.00

Governor: Reduce PR funding by $622,400 annually and increase FED funding by corresponding amounts, and convert 7.0 PR positions to FED positions, beginning in 2021-22, to reflect the net effect of position transfers that occurred within the Department in the 2019-21 biennium. These transfers are intended to more accurately align base staff costs with funding sources that reflect the positions' current responsibilities.

7. STATUTORY CHANGES RELATED TO MARIJUANA

Governor: Specify that for purposes of the FoodShare employment and training program's drug screening, testing, and treatment requirements, "controlled substance" has the definition provided in 21 USC 802 (6) of federal law, except "controlled substance" does not include tetrahydrocannabinols in any form, including tetrahydrocannabinols contained in marijuana, obtained from marijuana, or chemically synthesized.

Specify that, unless otherwise required by federal law, a hospital, physician, procurement organization, or other person may not determine the ultimate recipient of an anatomical gift made upon a donor's death based solely upon a positive test for the use of marijuana by a potential recipient. For more information, see "Marijuana-Related Provisions".

[Bill Sections: 1053, 2291, and 2292]

8. OPIOID AND METHAMPHETAMINE DATA SYSTEM -- AGENCY COLLABORATION

Governor: Require the Department of Administration to collaborate with, and collect data from, the Departments of Health Services, Corrections, Justice, Safety and Professional Services, and Children and Families and any other applicable agencies for the opioid and methamphetamine data system, which would be created under the bill. See "Administration -- Information Technology."

9. PUBLIC OPTION STUDY -- COLLABORATION WITH OCI

Governor: Require DHS, the Office of the Commissioner of Insurance (OCI), or DHS in consultation with OCI, to conduct an analysis and actuarial study of the creation of an option for individuals to purchase health coverage that is publicly provided or administered. For additional information on this item, see "Insurance -- Health."