Clearinghouse Rule 23-046

WISCONSIN DEPARTMENT OF HEALTH SERVICES
PROPOSED ORDER TO ADOPT PERMANENT RULES

The Wisconsin Department of Health Services proposes an order to: **repeal** DHS 10.36 (2) (b) and (Note), 10.62 (1) (b) (intro.), 1. and 2., (3) (a) and (b), (3) (a) and (b), 82.06 (2m) (Note), 101.03 (7), (30), (78s), (170s), (172s), 102.01 (5) (h), 102.03 (3) (c), 103.03 (1) (f) 5. d., 103.04 (5) (b) to (e), 103.05 (5) (a), 103.085 (1) (d) 5., (e) 1., (2), (4) and (5), 103.087 (1) (b) 3., 103.087 (1) (d) 1. and 2., (e), Table 103.087, 103.09 (3) (a), 103.11 (1) (c) 5. (Note), 107.06 (3) (b) 1., 107.09 (4) (L) and (Note), 107.11 (5) (t), 107.13 (2) (a) 6. and 7., (b), (3) (a) 4. and 7. and (b), 108.02 (9) (d) 3. b., (11) (a) (Note) (12) (f) 2. and (Note), (15) (a) (Note), 108.03 (4), 116.03 (13), 118.02 (2) (b) and (c), 118.03 (13) and (14), 150, 163 Appendices A to I, 182.03 (8), 251.03 (6); **renumber** DHS 10.62 (3) (intro.), 103.05 (5) (b), 103.11 (1) (d); **renumber and amend** DHS 10.62 (1) (intro.), (3) (intro.), 101.03 (129m), 102.03 (3) (d), 103.11 (1) (a) to (c), 108.02 (9) (d) 3. c.; **consolidate, renumber, and amend** 103.04 (5) (title) and (a), 103.087 (1) (d) (title) and 1.; **amend** DHS 1.065 (1) (b) and (3) (intro.), 10.11 (intro.), (1) and (7), 10.12 (8), 10.13 (3) and (16), 10.21 (1) (a), 10.23 (3) (a) 2. c., (6) (a) 2. (intro.), 10.32 (1) (a), 10.33 (2) (c) (title), (intro.), (d) (title) and (intro.), 10.36 (1) (a) and (b) (intro.), 10.42 (2) (a), 10.71, 10.74 13.05 (4) (c), 40.07 (2) (a) 2., 82.06 (2m), 82.24 (3) (a), 82.30, 89.26 (3) (c) 2., 89.27(3) (d), 89.29 (1m), 89.34 (12), 89.35(3), 89.52 (1), 101.03 (1), (6), (8), (15), (17r), (17t), (17w), (20), (23), (38), (41) (intro.), (a) and (b), (c) 1. to 6., (52), (65), (94r), (95), (96), (97), (149m), and (152m), 102.01 (intro.), (1), (5) (a), (b) (intro), 1., 2. (intro.) and a. to d., and (7), 102.03 (1), (3) (intro.), (a), (b), (e), (f), (g) and (h), 102.04 (1), (3) (intro.), (a) to (d), 103.01 (1) (a), 103.03 (1) (title), (a), (b) (title), (intro.), 1. to 4., (f) (title), (intro.), 1., 3. (intro.), 4. (intro.), 5. (intro.) and (c), , 6., 8., (2) (intro.), (4) (a) 1. and 2., (b), 103.04 (1) (b), (2), (3) (a) and (b), (6) (title), (a) and (b), 103.05 (1) (intro.) and (a), 103.06 (15) (a) 2., 103.07 (1) (b) (intro.) and 1., 103.07 (2) (g), 103.08 (2) (a) 2., (b), (c) 1. to 3., Table 103.085, 103.085 (title), (1) (a), (b) 1. to 4., (c), (d) 1., (e) (intro.) and 2., (f), (3) (a), (b) (intro.), (c) 1., 103.087 (1) (b) 1. and 2., (c) 1. and 4., (f) 1., 2. b., (g) 5., (i) 2., 103.09 (3) (b) and (c), 103.11 (title), (1) (title), 103.11 (2) (a) (intro.), 1. and 2., (b), (c) and (d), 104.01 (9) (b) 2. g., (12) (a) 1. (intro.) and a. to q., 105.075, 105.34 (intro.), 107.11 (2) (intro.), (a) (intro.), (c) 1., 107.112 (2) (a), 107.113 (1) (intro.), (i), (2) (intro.) and (a), (3) (a), (4) (f), 107.12 (1) (b), (c), (d) 1. and 2., (e) 1., (4) (a), 107.24 (2) (c) 1., and 4. to 6., 108.02 (9) (d) (title), 1., 2. (intro.) and a. to d., and 3. (intro.) and a., 108.02 (10) (intro.), (a), (b), (c) 1. a. to c., 2. to 6., (d), (11) (a), (12) (a) 2. and 4. to 5., (b) 2. a. to c., (15) (a), 116.02 (2) to (4), 116.03 (11) and (12), 116.04 (1), (2) (a) (intro.), 1. and 2., (b) and (c), (3) (a) and (Note), (4), (5) (c) and (d), 118.02 (2) (a), (e), 118.03 (16) (g) and (h), (25) (intro.), (a) and (b), (28) to (30), 118.06 (3) (b) 1. a. (Note), 118.07 (1) (a) to (c), 118.09 (2) (title) and (b), (3) (intro.), 124.09 (6) (b), 124.39 (3) (b), 132.13 (4) (intro.), 134.13 (9) (intro.), 134.52 (2) (c), 134.68 (2), 153.02 (17), 163.03 (61), 182.03 (10); **repeal and recreate** DHS 102.01 (4), 103.03 (1) (f) 2., 3. a. and b., 4. a. to c., 103.04 (7), 103.05 (1) (b), 103.085 (3) (b) 1. to 3., (c) 2., 103.09 (2), 118.03 (11); and **create** DHS 10.11 (1m), 10.23 (6) (a) 2. f. and g., 10.43 (2) (k), 101.03 (129m) (a) to (e), 101.03 (149f), and (149j), 102.03 (1g), (1r), (3) (d) 1. and 2., (3) (j), 102.033, 102.036, 102.04 (5), 103.01 (1) (c) to (f), 103.03 (1) (b) 2m., 5. to 8., (f) 2m., 3. d., 3m., 4m., 5m., (2) (a), (b) 1. to 4., (c) 1. to 4., (d) 1. to 4., and (e), (2m), (4) (a) 3. To 5., 103.04 (3) (bg) and (br), (8) (b) 4., 103.085 (1) (b) 5., (cm), (3) (c) 3., 103.087 (1) (f) 2. bm., (h) 3. e., 103.11 (1d), (1h), (1p) and (1t), (2) (bm), 108.02 (9) (d) 4. to 8., 116.04 (3) (Note 2), 118.03 (10d) and (10j), relating to the 2021 biennial review of rules under s. 227.29, Stats.

RULE SUMMARY

Statutes interpreted
Section 227.29, Stats.

Statutory authority

DHS 1: Sections 46.03 (18), 46.10, and 227.11 (2), Stats.

DHS 10: Sections 46.281 (1n) (b) 1., 46.286 (4) to (7), 46.287 (2) (a) 1. (intro.), 46.288, 50.02 (2) (d), and 227.11 (2), Stats.

DHS 13: Sections 146.40 (4g) and (4r), and 227.11 (2), Stats.

DHS 40: Section 51.42 (7) (b) and 227.11 (2), Stats.

DHS 82: Sections 50.02 (2) (am) 1. and 227.11 (2), Stats.

DHS 83: Sections 50.02 (2) and 227.11 (2), Stats.

DHS 89: Sections 50.034 (2) and 227.11 (2), Stats.

DHS 101 to 108: Sections 49.45 (10), 49.665 (4) and (5), and 227.11 (2).

DHS 116: Sections 253.12 (3) (a) and 227.11 (2), Stats.

DHS 118: Sections 256.25 (2) and 227.11 (2), Stats.

DHS 124: Section 50.36 (1), 50.33 (2), and 227.11 (2), Stats.

DHS 132: Sections 49.498 (14), 49.499 (2m), 50.02, 50.03, 50.095 and 50.098, and 227.11 (2), Stats.

DHS 134: Sections 50.02 (2) and (3), and 227.11 (2), Stats.

DHS 150: Sections 250.21 and 227.11 (2), Stats.

DHS 153: Sections 49.685 (8) (c), 49.687 (1), and 227.11 (2), Stats.

DHS 163: Sections 250.04 (7), 250.041, 254.115, 254.15, 254.167, 254.172, 254.176 (1) and (3), 254.178 (2), and 254.179, and 227.11 (2), Stats.

DHS 182: Sections 254.151 and 227.11 (2) Stats.

DHS 251: Sections 49.02 (7m) and 227.11 (2), Stats.

Explanation of agency authority

Under s. 227.29 (1) (a) to (e), Stats., the Department is required to complete an agency review of rules and enactments on a biennial basis and make changes to: unauthorized rules, as defined in s. 227.26 (4) (a), together with a description of the legislation that eliminated the agency's authority to promulgate any such rule; rules for which the authority to promulgate has been restricted, together with a description of the legislation that restricted that authority; rules that are obsolete or that have been rendered unnecessary, together with a description of why those rules are obsolete or have been rendered unnecessary; rules that are duplicative of, superseded by, or in conflict with another rule, a state statute, a federal statute or regulation, or a ruling of a court of competent jurisdiction, together with a citation to or the text of any such statute, regulation, or ruling; or rules that the agency determines are economically burdensome.

Explanation of agency authority for each rule chapter in the proposed rules is as follows:

DHS 1: Chapter DHS 1 interprets s. 46.03 (18), Stats., which directs the Department to establish a uniform system of fees for certain services provided or purchased by the Department or certain county departments. The Department is also directed to make collections, determine ability to pay, enforce or compromise liability and to delegate some of these responsibilities to counties. Chapter DHS 1 is therefore necessary to effectuate the purposes of the interpreted statute and to comply with s. 227.10 (1) and (2m), Stats.

DHS 10: Sections 46.286 (4) to (7), 46.287 (2) (a) 1. (intro.), 46.288, 50.02 (2) (d) direct the Department to implement rules for the family care, which is a Medicaid long-term care program that helps families arrange for appropriate long-term care services for family members for adults with physical or developmental disabilities. The rules include financial eligibility criteria and cost sharing requirements.

DHS 13: Section 140.40 (4g) and (4r), Stats., direct the department to protect clients served in specified department-regulated programs by establishing a process for reporting allegations of abuse or neglect of a client or misappropriation of client's property to the department, establishing a process for the investigation of those allegations and establishing the due process rights of persons who are subjects of the investigations.

DHS 40: Section 51.42 (7) (b), Stats., directs the Department to promulgate rules governing the provision of community mental health services. The Department determines and monitors standards and requirements to administer services for community mental health, developmental disabilities, alcoholism, and drug abuse.

DHS 82: Section 50.02 (2) (am) Stats., directs the Department to establish certification standards for the operation of adult family homes in order to protect and promote the health, safety, and welfare of persons residing in and receiving care and maintenance in those homes.

DHS 83: Section 50.02 (2), Stats., directs the Department to develop and establish regulations and standards for the care, treatment or services, and health, safety, rights, welfare, and comfort of residents in community-based residential facilities.

DHS 89: Section 50.034, Stats., directs the Department to establish standards and procedures for the certification or registration of residential care apartment complexes in order to promote the health and safety of persons residing in and receiving services from those facilities.

DHS 101–108: Sections 49.45 (10), 49.665 (3), (4) and (5), Stats., permit the department to establish rules for the purpose of administering medical assistance in Wisconsin.

DHS 116: Section 253.12 (3) (a), Stats., gives the Department authority to promulgate rules to implement the Wisconsin birth defect prevention and surveillance system established by s. 253.12, Stats.

DHS 118: Section 256.25 (2), Stats., directs the Department to promulgate rules to develop and implement a statewide trauma care system.

DHS 124: Section 50.36 (1), Stats., requires that the Department use and enforce the conditions for Medicare participation for hospitals as the minimum standards that apply to hospitals, and permits the Department to promulgate, adopt, amend, and enforce additional rules and standards for the construction, maintenance, and operation of hospitals that are necessary to provide safe and adequate care and treatment of hospital patients and to protect the health and safety of patients and employees.

DHS 132: Sections 49.498 (14), 49.499 (2m), 50.02, 50.03, 50.095 and 50.098, Stats., permit the Department to promulgate rules providing conditions for licensure of nursing homes.

DHS 134: Sections 50.02 (2) and (3), Stats., give the Department authority to promulgate rules to provide conditions of licensure for facilities that primarily serve people with developmental disabilities who require active treatment.

DHS 150: Section 250.21 (4), Stats., directs the Department to promulgate rules to administer granting grants from the appropriation under s. 20.435 (1) (bn), Stats., to reimburse small businesses for cost incurred in establishing a workplace wellness program for those employed in Wisconsin.

DHS 153: Sections 49.685 (8) (c) and 49.687 (1), Stats., direct the Department to promulgate rules to implement a program of reimbursement for the cost of blood products and supplies for use in the home care of residents of Wisconsin who have hemophilia.

DHS 163: Section 254.172, Stats., permits the Department to promulgate rules governing lead hazard reduction that the Department determines are consistent with federal law. Section 254.176, Stats., allows the Department to establish by rule certification requirements for any person who performs lead hazard reduction or lead management activity or who supervises the performance of any lead hazard reduction or lead management activity. Section 254.178, Stats., requires that the Department promulgate rules establishing requirements for the accreditation of lead training courses and approval of lead instructors. Section 254.179, Stats., requires the Department to promulgate rules for certifying dwellings as lead-safe or lead-free, including the standards that must be met for issuance of a lead-free or lead-safe certificate and the period of validity of the certificate.

DHS 182: Section 254.151, Stats., directs the Department to promulgate rules to establish criteria and procedures for the award of annual project grants from appropriations under s. 20.435 (1) (ef), Stats., to local health departments or non-profit agencies working in collaboration with local health departments on projects aimed at preventing lead poisoning or exposure to lead.

DHS 251: Section 49.02 (7m), Stats., directs the Department to promulgate rules to provide: (1) Procedures for a county relief agency to obtain a relief block grant; (2) Standards for county relief agencies to follow in making eligibility determinations under s. 49.015, Stats.; (3) Standards for waiver of an eligibility requirement under s. 49.015 (3) (b), Stats.; and (4) Procedures for appealing eligibility determinations.

Related statute or rule
Sections 227.11 (2) and 227.29, Stats. Related state and federal statutes or rules are cited, as applicable, in the plan language analysis for each rule chapter.

Plain language analysis
The Department has identified needed administrative rule changes under s. 227.29., and based on information provided to the department by the Legislative Reference Bureau. The Department proposes to make changes to all of the rules identified below.

DHS 1, relating to uniform fees, liability and collections:

- DHS 1.065 (1) (b) identifies the scope as it applies to children's long-term support parental payment limits, and cites to the community options program waiver under s. 46.27, Stats., which was repealed by 2019 Wis. Act 9. This paragraph should be amended to remove the reference to s. 46.27, Stats.
- DHS 1.065 (3) cites to DHS 1.03 (12) (c) and (21), both of which were repealed as part of CR 19-020. This subsection should be amended to remove references to the repealed rule sections.

DHS 10, relating to family care:

- DHS 10.11, authority and purpose, contains outdated references to statutory authority. The section should be amended to add s. 46.281 (1n) (b) 1.
- Sections DHS 10.11 (7), 10.12 (8), and 10.74 include references to hospitals in the scope and authority of the rule, which is no longer applicable following the repeal of s. 50.36 (2) by 2007 Wis. Act 20. These subsections should be amended to remove references to hospitals.
- DHS 10.13 contains numerous definitions that conflict with federal and state law. For example, s. DHS 10.13 (3) uses "infirmities of aging," a phrase that was replaced with "degenerative brain disorder" by 2005 Wis. Act 264, and s. DHS 10.13 (16) includes a definition of "developmental disability" that is inconsistent with s. 51.01 (5) (a), which was amended by 2005 Wis. Act 264. These definitions should be amended for consistency with federal and state law.
- DHS 10.21 (1), contracting, does not include a statutory requirement that the Department may only contract with resource centers that meet the requirements of s. 46.283, Stats. This subsection should be amended to include this statutory requirement.
- DHS 10.23 (3) (a) 2. c. and 10.71 include citations to s. DHS 10.72, which was repealed via petition, CR 19-001. These provisions should be amended to remove the reference to the repealed rule section.
- DHS 10.23 (6) (a), operational requirements for resource centers, contains outreach and public education requirements that are inconsistent with the Medicaid and CHIP Managed Care Final Rule, CMS 2390-F, information requirements. This paragraph should be amended for consistency with Medicaid managed care rule information requirements.
- DHS 10.32 (1) (a) contains age eligibility conditions that are inconsistent with ss. 46.286 (1) (a) and (3) (a) 1m., Stats. The provision should be revised to clarify that the individual must be 18 years old at the time of application.
- DHS 10.33 (2) and 10.36 (1) contains references to "intermediate" and "comprehensive" levels of care that are inconsistent with s. 46.286 (1) (a). The terminology should be changed to "nursing home" and "non-nursing home" levels.
- DHS 10.36 (2) (b) includes a provision regarding a phase-out date for non-MA eligible persons in accordance with s. 46.286 (3) (d), Stats. The cited statutory provision was repealed by 2007 Wis. Act 20. This paragraph should be stricken, as should the accompanying note.
- DHS 10.42 (2), certification, is inconsistent with Medicaid managed care rule regulations, 42 CFR 438.66(d). The subsection should be revised to require an onsite managed care organization readiness review by the Department before receiving initial family care certification.
- Section DHS 10.43 (2), certification standards, contains standards that are inconsistent with 42 CFR 438.68. The rule should be revised to add time, distance, and network adequacy standards that are consistent with regulations.
- DHS 10.62, recovery of correctly paid benefits, contains estate-recovery provisions that are inconsistent with s. 49.496, Stats., and should be revised.
- DHS 10.74, requirements for resource centers, cites to hospital referrals. Hospitals are no longer within the scope of DHS 10 due to the repeal of ss. 50.36 (2) (c), and 50.38, Stats., by 2007 Wis. Act 20. The reference to hospitals should be removed.

DHS 13, relating to reporting and investigation of caregiver misconduct: Section DHS 13.05 (4) (c) includes the phrase "infirmities of aging," which was replaced with "degenerative brain disorder" by 2005 Wis. Act 264. This subsection should be amended consistent with Act 264.

DHS 40, relating to mental health day treatment for youth: Section DHS 40.07 (2) (a) 2. requires written documentation of each staff member's qualifications, and cites to DHS 40.09 (2) to (5). Chapter DHS 40 was repealed and recreated in CR 19-018, and s. DHS 40.09 (5) no longer exists. This subdivision should be amended to remove reference to subsection (5).

DHS 82, relating to certified adult family homes: Section DHS 82.06 (2m) includes a provision regarding family care and referral that cites to s. 50.033 (2r) to (2t), which were repealed by 2007 Wis. Act 20. This subsection should be amended to remove these citations.

DHS 83, relating to community-based residential facilities:

- DHS 83.24 (3) (a) includes "emergency medical technicians" as exempt from the standard precautions training. The phrase "emergency medical technician" was replaced with "emergency medical services practitioner" in 2017 Wis. Act 12, and the paragraph should be amended to use correct terminology.
- DHS 83.30 contains a provision regarding family care information and referral that cites to s. 50.035 (4p), which was repealed by 2019 Wis. Act 9. This section should be amended to remove this reference.

DHS 89, relating to residential care apartment complexes:

- DHS 89.26 (3) (b) 2., 89.27 (3) (d), 89.34 (12), 89.35 (3), and 89.52 (1) include citations to the long-term community support options program under s. 46.27, which was repealed by 2019 Wis. Act 9. These provisions should be amended to strike this reference.
- DHS 89.29 (1m) contains provisions regarding family care information and referral that cites to "s. 50.034 (5m) to (5p), Stats." Section 50.034 (5p) which was repealed by 2019 Wis. Act 9. This subsection should be amended to strike the reference to the repealed statutory subsection.

DHS 101, relating to Medical Assistance; introduction and definitions.

- DHS 101.03 (1) defines "access" and includes an eligibility bar of 18 months, which is more restrictive than the 12-month eligibility bar in s. 49.471 (8) (b) 2., Stats., and should be revised.
- DHS 101.03 (6), (7), (23), (65), (96) and (97) contains references to aid to families with dependent children ("AFDC"), a program which is no longer in effect. *See* 42 USC 1396u-1 & s. 49.015 (2), Stats. References should be amended or repealed to conform to federal and state standards.
- DHS 101.03 (8) provides a definition of "agency" that does not include a multicounty consortium under s. 49.78, Stats. The definition should be revised to include multicounty consortium.
- DHS 101.03 (15) provides a definition of "application for Medical Assistance" that is inconsistent with 42 CFR s. 435.907(a), which requires the Department to accept applications made by fax, telephone, and through the internet. The definition should be revised for consistency with these requirements.
- DHS 101.03 (17r), (17t), and (17w), refer to BadgerCare, which has been superseded by BadgerCare Plus under s. 49.471, Stats. These provisions should be amended to update the terminology and citations for BadgerCare Plus.
- DHS 101.03 (20) contains a definition of "budgetable income" that also applies to BadgerCare Plus under s. 49.471, Stats., but is not currently included. The definition should be amended for consistency with the statute.
- DHS 101.03 (23) contains a definition of "categorically needy" that is limited to eligibility for AFDC and SSI. This definition is inconsistent with federal requirements, such as 42 USC 1396a(a)(10)(A), 42 USC 1396a(e), which apply categorically needy to over 25 groups covered by federal law and the state through the Medicaid and Children's Health Insurance Program ("CHIP") State Plans. The definition should be amended for conformity with those federal requirements.
- DHS 101.03 (30) contains a definition of "conditional eligibility," which does not appear anywhere in ss. DHS 101 to 109. This subsection should be repealed.

- DHS 101.03 (38) defines "deeming," a process which also applies to BadgerCare Plus, but does not cite to s. 49.471, Stats. This provision should be amended to include a reference to s. 49.471, Stats.
- DHS 101.03 (41) includes the phrase "infirmities of aging," which was replaced with "degenerative brain disorder" by 2005 Wis. Act 264. This subsection should be amended for consistency with Act 264.
- DHS 101.03 (52) defines "emergency medical condition" in a manner inconsistent with 42 USC 1396(v)(3). This provision should be revised for consistency with the federal definition.
- DHS 101.03 (65) defines "fiscal test group" in a manner inconsistent with 42 CFR 435.603, which does not require persons to be living in the home with other members of the fiscal test group. This provision should be amended for consistency with 42 CFR 435.603.
- DHS 101.03 (78s) includes a definition of "incapacitation" which is obsolete because the Department has opted in its State plan to no longer require a parent to be incapacitated or unemployed to be eligible for Medicaid. This definition should be repealed.
- DHS 101.03 (94r) provides a definition of "medical expenses" that is inconsistent with 42 CFR 435.831(d), which does not limit medical expenses to persons applying for the Medicaid purchase plan ("MAPP"). The definition should be amended for consistency with 42 CFR 435.831(d).
- DHS 101.03 (95) provides a definition of "Medical Assistance" that cites to BadgerCare under s. 49.665, Stats., which is rendered obsolete by BadgerCare Plus under s. 49.471, Stats. The definition should be amended to remove the reference to s. 49.665, Stats.
- DHS 101.03 (96) provides a definition of "Medical Assistance group" that conflicts with budgeting procedures under 42 CFR 435.603. This definition should be amended for consistency with those budgeting policies.
- DHS 101.03 (97) includes a definition of "medically needy" that cites to the non-financial eligibility conditions of AFDC or SSI. This definition is inconsistent with ss. 49.47 (4) (c) 1. and 49.471 (7), Stats. and should be amended to remove the AFDC and SSI references.
- DHS 101.03 (129m) defines "presumptive eligibility" that is restricted to pregnant women, which is inconsistent with presumptive eligibility provisions in ss. 49.471 (5) (b) 2. and 49.473 (3), Stats., and 42 CFR 435.1010. The definition should be amended to include the expanded group to which presumptive eligibility applies.
- DHS 101.03 (149m) defines "qualified providers" and restricts it to determining presumptive eligibility of pregnant women, which is inconsistent with ss. 49.471 (5) (b) 2. and 49.473 (3), and 43 CFR 435.1010. This definition should be amended to include the expanded group that qualified providers can determine presumptive eligibility for.
- DHS 101.03 (152m) defines "remedial expense" and restricts it to MAPP, which is inconsistent with 42 CFR 435.831(e), and the definition should be amended to expand it to other categories.
- DHS 101.03 (170s) defines "standard maintenance allowance" based on s. 49.472 (4) (a) 2., Stats. The term does not appear anywhere in ss. DHS 101 to 109, and s. 49.472 (4) (a) 2., Stats., was repealed by 2017 Wis. Act 59. This subsection should be repealed.
- DHS 101.03 (172s) defines "substantial gainful activity," which is not used anywhere in ss. DHS 101 to 109. This subsection should be repealed.

<u>DHS 102, relating to Medical Assistance; application:</u>

- DHS 102.01 (intro.) contains a citation to BadgerCare under s. 49.665, which is obsolete. Additionally, ss. 49.45 to 49.497, Stats., identify additional categories of Medical Assistance which require an application. This provision should be amended to remove the obsolete reference and update for consistency with statutes.
- DHS 102.01 (1) provides that a Medical Assistance application shall be made on a form approved by the Department. 42 CFR 435.907(a) requires the Department to accept

applications submitted electronically or by phone in addition to paper forms. This subsection should be amended to include all accepted modes of application.

- DHS 102.01 (4) requires that the Department make information about applying to Medical Assistance in written form or orally. 42 CFR 435.905 requires the Department to make this information available electronically, and specifies more actions that the Department must take to assist individuals who are limited English proficient. This subsection should be amended accordingly.
- DHS 102.01 (5) (a) includes special application provisions for applicants, including that 18 year olds who are not dependents must file separate applications. BadgerCare Plus, s. 49.471, Stats., and budgeting provisions under 42 CFR 435.603(f)(3)(iv) no longer require 18-year-olds who are not dependents to file separate applications; instead, they require persons 19 years or older to do so. This paragraph should be amended to require persons 19 years or older to file separate applications.
- DHS 102.01 (5) (b) provides that unmarried couples who live together and have a child in common should have their eligibility determined together. This is inconsistent with 42 CFR 435.603(f)(1), which requires that eligibility of unmarried parents be determined separately unless one parent is tax dependent on the other. This paragraph should be amended for consistency with 42 CFR 435.603.
- DHS 102.01 (5) (h) contains provisions for determining eligibility for a minor child residing with a non-legally responsible relative. The paragraph is based on BadgerCare under s. 49.665, Stats., which was superseded by BadgerCare Plus under s. 49.471, Stats. BadgerCare Plus does not include these requirements, so the paragraph should be repealed.
- DHS 102.01 (7) includes a requirement that an application form be signed in the presence of an agency representative, but 42 CFR 435.907(a) requires the Department to accept applications submitted electronically and by phone. This section should be amended to remove this requirement.
- DHS 102.03 (1) includes verification requirements for Medical Assistance applicants. It includes an obsolete reference to BadgerCare under s. 49.665, Stats., and is inconsistent with verification exceptions provided in 42 CFR 435.952 and 42 CFR 435.956. This subsection should be amended to remove the reference to BadgerCare and update verification requirements for consistency with federal regulations.
- DHS 102.03 (3) requires that pregnancy be verified when an application is received. This is inconsistent with 42 CFR 435.956(e), which requires acceptance of self-attestation of pregnancy unless the Department has contradictory information. This paragraph should be amended for consistency with 42 CFR 435.956(e).
- DHS 102.03 (3) (c) requires verification of incapacity or unemployment for dependent child Medical Assistance eligibility. In accordance with 42 CFR 435.4—under which these verifications are no longer required—the Department has opted to exclude requirements for incapacity to be eligible for Medicaid.
- DHS 102.03 (3) (d) requires verification of social security numbers for Medical Assistance applications. 42 CFR 435.910 includes some exceptions to this requirement. This paragraph should be amended for consistency with 42 CFR 435.910.
- DHS 102.03 (3) includes subunits that are not formatted in accordance with the Administrative Rules Procedures Manual and should be amended to include periods at the end of each subunit. The subsection also includes verification of citizenship or alien status for Medical Assistance applications which are inconsistent with 42 USC 1396a (a) (46) (B) and 1396b (x) (2) and 42 CFR 432.401(a)(1), 42 CFR 435.407, and 42 CFR 435.910. This section should be amended to reflect current federal regulations.
- DHS 102.04 (1) requires an agency to conduct a personal interview with an applicant. This reference is outdated, as an interview may no longer be required as a condition of eligibility for Medicaid. *See* 42 CFR 435.907(d). The section should be amended to remove the reference to the interview.

- DHS 102.04 (3) contains references to aid to families with dependent children ("AFDC"), a program which is no longer in effect. *See* 42 USC 1396u-1, s. 49.015 (2), Stats. References should be amended or repealed to conform to federal and state standards.
- DHS 102.04 contains renewal of eligibility determination requirements which are inconsistent with 42 CFR 435.916. These paragraphs should be amended to reflect current eligibility regulations.

DHS 103, relating to Medical Assistance; eligibility:

- DHS 103 contains references to aid to families with dependent children ("AFDC"), a program which is no longer in effect. *See* 42 USC 1396u-1 & s. 49.015 (2), Stats. References should be amended or repealed to conform to federal and state standards.
- DHS 103.01 (1) (a) identifies persons eligible for Medical Assistance, but the list does not include new eligibility groups as provided in ss. 49.453, 49.454, 49.468, 49.471, and 49.473, Stats. The paragraph should be amended to include updated statutory citations and eligibility groups.
- DHS 103.01 (1) (b) explains that presumptive eligibility for pregnant women shall be determined under s. 49.465, Stats. Presumptive eligibility is also potentially available for children, women with breast or cervical cancer, and certain adults. *See* ss. 49.471 (5) (b) 2., 49.473 (3), Stats., 42 CFR 435.1010. The paragraph should be amended, and additional provisions should be created, to include these groups.
- DHS 103.03 (1) includes an outdated list of populations that are non-financially eligible for BadgerCare, and does not correctly describe current policies regarding health insurance access and coverage under s. 49.471 (8), Stats. The subsection should be updated to include all populations that are non-financially eligible for BadgerCare Plus, and for consistency with insurance access and coverage provisions in s. 49.471 (8), Stats.
- DHS 103.03 (2) provides that U.S. citizenship is required for eligibility, with some exceptions. The section does not include citations to, or inclusion of, the groups of non-citizens who are eligible for Medicaid or CHIP under 8 USC 1611, 42 USC s. 1396b(v)(4), and 43 CFR 435.406. This subsection should be amended accordingly.
- DHS 103.03 (4) requires all applicants to have social security numbers and to furnish them to the agency upon request, with several exceptions. 42 CFR 435.910 now requires exemption from the social security number for certain immigration and religious reasons. This subsection should be amended for consistency with current federal law and regulations.
- DHS 103.04 (3) (b) includes spend-down provisions. Section 49.471 (7) (b) raised the medically needy income limits for pregnant women and children, and the paragraph should be amended for consistency with the statutes.
- DHS 103.04 (5) and (7) contain provisions regarding "irregular cases" and "special BadgerCare budgeting procedures." These rules have been superseded by federal modified adjusted gross income group formation and budgeting procedures. *See* 42 CFR 435.603. These subsections should be updated to reflect current federal laws and regulations.
- DHS 103.04 (6) includes income limits for BadgerCare that are inconsistent with ss. 49.471 (4) (a) and 49.45 (23) (a), Stats. The subsection should be amended to include correct income limits for BadgerCare Plus identified in statute.
- DHS 103.04 (8) cites to s. 49.472 (3) (b) to identify the asset limit for MAPP eligibility. Section 49.472 (3) (a) added a new income deduction for out-of-pocket medical or remedial expenses, and this subsection should be amended to include citation to that statutory provision.
- DHS 103.05 (1) contains definitions of a "child-only case" involving step-parents that have been rendered obsolete under 42 CFR 435.603. This subsection should be updated to reflect these changes.
- DHS 103.05 (5) includes provisions for income limits for child-only Medical Assistance groups. These provisions are inconsistent with federal modified adjusted gross income

group formation and budgeting procedures. *See* 42 CFR 435.603. This subsection should be amended to reflect current federal laws and regulations

- DHS 103.06 (15) (a) 2. provides that independence accounts are exempt from calculating eligibility for MAPP. Section 49.46 (1) (em), Stats., makes independence accounts exempt from all forms of Medicaid, not just MAPP. The subdivision should be amended for consistency with s. 49.46 (1) (em), Stats.
- DHS 103.085 includes conditions for continuation of eligibility for BadgerCare that are inconsistent with s. 49.45 (23b), Stats. This section should be amended to reflect current statutory premium and re-enrollment restriction policies, and to update the outdated Table 103.085.
- DHS 103.087 (1) includes premium calculations that are outdated and in conflict with s. 49.472 (40), Stats. This subsection should be updated with correct premium calculations, and table 103.087 should be repealed.
- DHS 103.11 includes provisions related to presumptive eligibility, which is limited to pregnant women. Presumptive eligibility is also potentially available to additional groups, *see* ss. 49.471 (5) (b) 2., 49.473 (3), Stats., 42 CFR 435.1102, 42 CFR 435.1103, and 42 CFR 435.1110, and this section should be amended to permit qualified providers to make presumptive eligibility determinations for these groups.

DHS 104, relating to Medical Assistance; recipient rights and duties: Section DHS 104.01 (12) (a) 1. b. provides that all recipients who are members of a health maintenance organization are exempt from cost sharing, which is in not allowed under federal law. *See* 42 CFR 447.52(h), 42 CFR 447.56(a)(1)(v) and (viii). This subdivision paragraph should be repealed. Additionally, all of the subunits in subd. 1 should be revised to end with a paragraph and form a complete sentence with the introductory material, consistent with the Administrative Rules Procedures Manual.

DHS 105, relating to Medical Assistance; provider certification:

- DHS 105.01 (3) contains general conditions for provider participation in Medical Assistance. Requirements in subsection regarding collection of provider information, risk assessment, and onsite visits are inconsistent with 42 CFR 455.104, 42 CFR 455.450, and 42 USC 1396a (a) (77). This subsection should be amended for consistency with the federal laws and regulations.
- DHS 105.075 includes a citation to DHS 124.21, which was repealed as part of CR 19-135. This section should be amended to remove the citation to the repealed rule section.
- DHS 105.34 includes a provision requiring rehabilitation agencies to be certified as an outpatient rehabilitation agency, but the references to federal regulations are outdated. The section should be amended to include up-to-date federal regulations, namely 42 CFR 485.50 to 42 CFR 485.74.
- 105.39 (4) (b) 2. includes the term “emergency medical technicians.” The phrase “emergency medical technician” was replaced with “emergency medical services practitioner” in 2017 Wis. Act 12, and the paragraph should be amended to use correct terminology.
- DHS 105.49 contains a provision about Medical Assistance certification for ambulatory surgical centers, and cites to 42 CFR 416.39, which no longer exists. The section should be amended to remove this citation.

DHS 107, relating to Medical Assistance; covered services:

- DHS 107.06 (3) (b) 1. restricts Medical Assistance coverage for hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing to two circumstances. But federal law prohibits Medicaid coverage for hysterectomies for the sole purpose of sterilization. This subdivision should be repealed.

- DHS 107.065 (2) (a) includes a limitation that a nurse anesthetist must perform services under anesthesiologist's or physician's supervision. This requirement is inconsistent with s. 49.46 (2) (a), and this paragraph should be amended.
- DHS 107.09 (4) (L) includes a reference to s. 46.27, Stats., which was repealed by 2019 Wis. Act 9. This paragraph should be repealed.
- DHS 107.11 (1) (c), (2) and (5), and DHS 107.24 (2) (c) include provisions which require homebound status or that services be provided in the home for home health services. This is inconsistent with Federal Medicaid Home Health Final Rule, CMS-2348-F, which updated 42 CFR 440 and restricts the Department from requiring homebound status or provision of services in the home. These provisions should be amended to remove these requirements.
- DHS 107.11, 107.12, 107.112, 107.113, and 107.24 are currently inconsistent with s. 49.46 (2) (a) 4. (b) 6., and (bh), Stats., which allow providers acting in the provider's scope of practice to prescribe or order certain services. These sections should be amended for consistency with the statute.
- DHS 107.13 (2) (a) 6. and 7., (2) (b) and (c) 4., (3) (a) 4. and 7., and (b) require prior authorizations for outpatient psychotherapy services. On October 1, 2017, the Parity in Mental Health and Substance Use Disorder Services Final Rule, CMS-2333-F, which updated 42 CFR 438, 440, 456 and 457, and removed prior authorization requirements for outpatient psychotherapy services. These provisions should be amended or repealed to remove the prior authorization requirements for these services.

DHS 108, relating to Medical Assistance; general administration:

- DHS 108.02 (9) (d) includes provisions for the Department to withhold payments involving fraud or willful misrepresentation. These provisions are inconsistent with 42 CFR 455.23, and this paragraph should be amended for consistency with federal requirements.
- DHS 108.02 (12) (b) 2. a. contains references to aid to families with dependent children ("AFDC"), a program which is no longer in effect. *See* 42 USC 1396u-1, s. 49.015 (2), Stats. References should be amended or repealed to conform to federal and state standards.
- DHS 108.02 (10) (intro.) and (d), (11), (12) (a) 2., 4. and 5., (f) 2., and (15) cite to s. 46.27, Stats., which was repealed by 2019 Wis. Act 9. These provisions should either be repealed or amended to remove the references to s. 49.27, Stats., whichever is appropriate.
- DHS 108.03 (4) cites to s DHS 1.07 (2) (c). Chapter DHS 1 was repealed and recreated as part of CR 19-020, and s. DHS 1.07 (2) (c) no longer exists. This subsection should be amended to remove the reference to s. 1.07 (2) (c).

DHS 116, relating to Wisconsin birth defect prevention and surveillance system:

- DHS 116.02 (2), (3), (4), 116.03 (11) to (13), 116.04 (1), (2) (a) (intro.), 1. and 2., (b), (c), (3) and (3) (Note), (4) and (5) (c) and (d) make reference to "suspected" birth defects. These provisions are inconsistent with s. 253.12, Stats., which only requires reporting of diagnosed conditions, and should be amended accordingly.
- DHS 116.03 (11) includes a definition of registry that is obsolete and inconsistent with s. 253.12 (3) (a) 1. The definition should be amended to remove the current language and include a citation to s. 253.12 (3) (a) 1.
- DHS 116.04 (3) (a) cites to Appendix B, which identifies the content required for a report. Following 2017 Wis. Act 59, the Department created F-40054: Confidential Birth Defects Registry Report, which includes all of the core data items contained in Appendix B and is available electronically or in paper form. This paragraph should be amended to include a reference to this form, and a note explaining how to access it.
- DHS 116.04 (4) includes a requirement that reports shall be submitted within 15 calendar days after a birth defect is identified. This requirement is burdensome as it is not consistent with the practice of most hospitals. Reports are submitted via the Wisconsin Electronic Disease Surveillance System (WEDSS), and most hospitals submit reports on a monthly basis. This subsection should be amended to require that reports be submitted to the

Department on a monthly basis, or within 30 days of identification of the birth defect, whichever is later.

- DHS 116.04 (5) (d) includes provisions about referring a child with a defect to a local health officer or Birth to 3 Program. These provisions conflict with DHS 90.07 (2) and (3), and the paragraph should be amended for consistency with DHS 90.07 (2) and (3).

DHS 118, relating to trauma care:

- DHS 118.02 (2) (e), 118.03 (13), (14), (16) (h), (28) and (30), 118.06 (3) (b) 1. a. (Note), 118.07 (1) (a) to (c), and 118.09 are outdated because they use "first responder"—a term which was replaced with "emergency medical responder" by 2017 Wis. Act 12. These provisions should be amended to replace "first responder" with "emergency medical responder."
- DHS 118.02 (2) (a) to (c), 118.03 (11), (16) (g), (25) (intro.), (a) and (b), (28), (29), and (30), 118.06 (3) (b) 1. a. (Note), and 118.07 (1) (b) use variations of "emergency medical technician" or "EMT" that are outdated following 2017 Wis. Act 12, which eliminated most of the variations of EMT from Chapter 256, Stats. These provisions should be amended for consistency with current terminology used in Chapter 256, Stats.

DHS 124, relating to hospitals:

- DHS 124.09 (6) (b) includes a reference to "emergency medical technicians." The phrase "emergency medical technician" was replaced with "emergency medical services practitioner" in 2017 Wis. Act 12, and the paragraph should be amended to use correct terminology.
- DHS 124.39 (3) (b) includes a provision regarding the Department's review of an application for critical access hospital status that cites to DHS 124.40, which was repealed as part of CR 19-135. This paragraph should be amended to remove the reference to the repealed rule section.

DHS 132, relating to nursing homes:

- DHS 132.13 (4) includes the phrase "infirmities of aging," which was replaced with "degenerative brain disorder" by 2005 Wis. Act 264. This subsection should be amended consistent with Act 264.

DHS 134, relating to facilities serving people with developmental disabilities:

- DHS 134.13 (9) includes the phrase "infirmities of aging," which was replaced with "degenerative brain disorder" by 2005 Wis. Act 264. This subsection should be amended consistent with Act 264.
- DHS 134.52 (2) (c) cites to s. 50.04 (2m), Stats., which was repealed by 2019 Wis. Act 9. This paragraph should be amended to remove this reference.
- DHS 134.68 (2) cites to DHS 124.17 (3), which was repealed as part of CR 19-135. This subsection should be amended to remove this reference.

DHS 150, relating to grants for the workplace wellness programs: This rule chapter was based on s. 250.21, which includes a sunset provision that "no grants shall be administered under this section after December 31, 2018." Section 250.21 (3), Stats. This rule chapter is obsolete and should be repealed.

DHS 153, relating to reimbursement for blood products and supplies used in the home care of hemophilia: Section DHS 153.02 (17) cites to s. DWD 11.15, which was repealed in 2002. This subsection should be repealed.

DHS 163, relating to certification for the identification, removal, and reduction of lead-based paint hazards:

- DHS 163.03 (61) includes a definition of lead-based paint that is in conflict with 40 CFR 745.103. Specifically, s. DHS 163.03 (61) defines "lead-based paint" as containing more than 0.06% lead by weight, or more than 0.7 milligrams lead per square centimeter in the dried film of applied paint. 40 CFR 745.103 defines it as equal to or in excess of 1.0 milligram per square centimeter or 0.5% by weight. This subsection should be amended.
- All of the DHS 163 Appendices have been rendered obsolete or outdated by the repeal of NR 661.04 (2) and subchapter V of Chapter NR 662, and CR 19-110, which removed all references to the appendices in DHS 163. These Appendices should be repealed.

DHS 182, relating to lead poisoning or lead exposure prevention grants. Section DHS 182.03 (8) and (10) include, respectively, definitions of "lead exposure" and "lead poisoning" that are in conflict with the definitions of those terms provided in s. 254.11 (9), Stats. These subsections should be amended to be consistent with the statutory definitions.

DHS 251, relating to county relief programs: Section DHS 251.03 (6) cites to s. 49.053 (1m), Stats., which was repealed by 1995 Wis. Act 27. This subsection should be repealed.

Summary of, and comparison with, existing or proposed federal regulations
Summary and comparison of federal regulations are provided in the plain language analysis, as applicable, for each rule chapter.

Comparison with rules in adjacent states

Illinois:
Not applicable - the proposed rule order is based on the requirements in s. 227.29, Stats.

Iowa:
Not applicable - the proposed rule order is based on the requirements in s. 227.29, Stats.

Michigan:
Not applicable - the proposed rule order is based on the requirements in s. 227.29, Stats.

Minnesota:
Not applicable - the proposed rule order is based on the requirements in s. 227.29, Stats.

Summary of factual data and analytical methodologies
The Department relied upon requirements under s. 227.29, Stats., and information provided to the Department by the Legislative Reference Bureau.

Analysis and supporting documents used to determine effect on small business
The proposed rules are not anticipated to have an impact on small businesses

Effect on small business
The proposed rules are not anticipated to have an impact on small businesses.

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Statement on quality of agency data
The information used by the Department to prepare the proposed rules complies with s. 227.14 (2m), Stats.

Place where comments are to be submitted and deadline for submission
Comments may be submitted to the agency contact person that is listed above until the deadline given in the upcoming notice of public hearing. The notice of public hearing and deadline for submitting comments will be published in the Wisconsin Administrative Register and to the department's website, at https://www.dhs.wisconsin.gov/rules/permanent.htm. Comments may also be submitted through the Wisconsin Administrative Rules Website, at https://docs.legis.wisconsin.gov/code/chr/active.

RULE TEXT

SECTION 1. DHS 1.065 (1) (b) and (3) (intro.) are amended to read:

DHS 1.065 (1) (b) This section applies to children's services of a type that may be reimbursed under a waiver under the disabled children's long-term support program as defined in s. 46.011 (1g), Stats., regardless of whether those services are actually reimbursed under that program, under the community integration program waivers under s. 46.275, 46.277 or 46.278, Stats., ~~under the community options program waiver under s. 46.27 (11), Stats.~~, or otherwise with federal, state or county funds.

DHS 1.065 (3) DETERMINING PARENTAL PAYMENT LIMITS. The county administrative agency shall determine the parental payment limit for each child receiving services covered by this section. ~~Notwithstanding s. DHS 1.03 (12) (c) and (21), the~~ The county administrative agency shall determine the parental payment limit for services covered by this section in the following manner:

SECTION 2. DHS 10.11 (intro.) and (1) are amended to read:

DHS 10.11 **Authority and Purpose**. This chapter is promulgated under the authority of ss. 46.281 (1n) (b) 1., 46.286 (4) to (7), 46.287 (2) (a) 1. (intro.), 46.288, 50.02 (2) (d), and 227.11 (2) (a), Stats., to implement a program called family care that is designed to help families arrange for appropriate long-term care services for older family members and for adults with physical or developmental disabilities. The chapter does all the following:

DHS 10.11 (1) Establishes functional ~~and financial~~ eligibility criteria~~, entitlement criteria and cost sharing requirements for the family care benefit, including divestment of assets, treatment of trusts and spousal impoverishment protections~~ for the family care benefit.

SECTION 3. DHS 10.11 (1m) is created to read:

DHS 10.11 (1m) Establishes financial eligibility criteria, entitlement criteria and cost sharing requirements for the family care benefit, including divestment of assets, treatment of trusts and spousal impoverishment protections.

SECTION 4. DHS 10.11 (7), 10.12 (8), and 10.13 (3) and (16) are amended to read:

DHS 10.11 (7) Establishes requirements for the provision of information about the family care program to prospective residents of long-term care facilities and for referrals to resource centers by ~~hospitals and~~ long-term care facilities.

DHS 10.12 (8) ~~Hospitals, nursing~~ Nursing homes, community-based residential facilities, residential care apartment complexes and adult family homes that are required to provide information to patients, residents and prospective residents and make certain referrals to an aging and disability resource center.

DHS 10.13 (3) “Adult protective services" means protective services for individuals with intellectual disabilities and other developmental disabilities, for individuals with ~~infirmities of aging~~ degenerative brain disorder, for individuals with chronic mental illness, and for individuals with other like incapacities incurred at any age as defined in s. 55.02, Stats.

DHS 10.13 (16) “Developmental disability" ~~means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, intellectual disability, or another neurological condition closely related to intellectual disability or requiring treatment similar to that required for intellectual disability, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. “Developmental disability" does not include senility that is primarily caused by the process of aging or the infirmities of aging~~ has the meaning provided in s. 50.01 (5) (a), Stats.

SECTION 5. DHS 10.21 (1) (a) is amended to read:

DHS 10.21 (1) (a) Comply with the general requirements specified in s. 46.283, Stats., and s. DHS 10.22.

SECTION 6. DHS 10.23 (3) (a) 2. c. and (6) (a) 2. (intro.) and a. are amended to read:

DHS 10.23 (3) (a) 2. c. The person is seeking admission to a nursing home, community-based residential facility, adult family home, or residential care apartment complex, subject to the exceptions under ~~ss. DHS 10.72 (4) and~~ s. DHS 10.73 (4) (a).

DHS 10.23 (6) (a) 2. ~~Within 6 months after the family care benefit is available to all eligible persons in its service area, provide~~ Provide information about family care to all eligible persons who are members of a target population served by a CMO that operates in the county and who are residents of nursing homes, community-based residential facilities, adult family homes and residential care apartment complexes in the geographic area of the resource center. The information provided shall cover all of the following:

a. The family care benefit, and the opportunities for enrollee choice within the benefit, including the opportunity for self-management of service funding under s. DHS 10.44 (2) (d) and (6), which populations are subject to mandatory enrollment, which populations are subject to voluntary enrollment, which populations are ineligible, and the right to disenroll in accordance with 42 CFR 438.56.

SECTION 7. DHS 10.23 (6) (a) 2. f. and g. are created to read:

DHS 10.23 (6) (a) 2. f. The requirements and performance of available care management organizations as set forth in 42 CFR 438.66.

g. Any cost-sharing that will be imposed on members.

SECTION 8. DHS 10.32 (1) (a) is amended to read:

DHS 10.32 (1) (a) *Age*. The person is at least 18 years of age ~~or will attain the age of 18 years on any day of the calendar month in which the person applies~~ at the time of application.

SECTION 9. DHS 10.33 (2) (c) (title) and (intro.), (d) (title) and (intro.), and 10.36 (1) (a) and (b) (intro.) are amended to read:

DHS 10.33 (2) (c). ~~*Comprehensive functional capacity*~~ *Nursing home level*. A person is functionally eligible at the ~~comprehensive~~ nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screening:

DHS 10.33 (2) (d) ~~*Intermediate functional capacity*~~ *Non-nursing home level.* A person is functionally eligible at the ~~intermediate~~ non-nursing home level if the person is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others, as is evidenced by a finding from application of the functional screening that the person needs assistance to safely or appropriately perform either of the following:

DHS 10.36 (1) (a) The person meets the conditions of functional eligibility at the ~~comprehensive~~ nursing home level under s. DHS 10.33 (2) (c).

DHS 10.36 (1) (b) The person meets the conditions of functional eligibility at the ~~intermediate~~ non-nursing home level under s. DHS 10.33 (2) (d) and at least one of the following applies:

SECTION 10. DHS 10.36 (2) (b) and (Note) are repealed.

SECTION 11. DHS 10.42 (2) (a) is amended to read:

DHS 10.42 (2) (a) To obtain and retain certification, an organization shall submit all information and documentation required by the department, in a format prescribed by the department, including comments it has obtained from each regional long-term care advisory committee in the area it proposes to serve. For initial certifications or when a currently certified organization will provide or arrange for the provision of services to new eligibility groups, the organization shall submit to an onsite readiness review as described under 42 CFR 438.66 (d). The department shall review and make a determination on the application within 90 calendar days of receipt of a complete application containing complete and accurate supporting documentation that the organization meets the standards under s. DHS 10.43. The department may conduct any necessary investigation to verify that the information submitted by the organization is accurate. The organization shall consent to disclosure by any third party of information the department determines is necessary to review the application.

SECTION 12. DHS 10.43 (2) (k) is created to read:

DHS 10.43 (2) (k) A provider network that meets the department's quantitative network adequacy standards.

SECTION 13. DHS 10.62 (1) (intro) is renumbered DHS 10.62 (1) and amended to read:

DHS 10.62 (1) RECOVERY FROM THE ESTATE OF AN ENROLLEE. The department shall file a claim against the estate of an enrollee to recover ~~for the costs of the family care benefits provided under s. 46.286, Stats., on and after January 1, 2000~~ all medical assistance services provided to an individual 55 years or older while the individual was enrolled in family care. Recoveries from the estates of all family care enrollees shall be made in accordance with the provisions in ss. 49.496 (1), (3), (6m), and (7), and 49.849, Stats., and s. DHS 108.02 (11) and (12)~~, except as follows:~~. The amount to be recovered under this section shall be equal to the amount of the total capitated payment made by the department to the CMO for the enrollee.

SECTION 14. DHS 10.62 (1) (b) (intro.), 1., and 2. are repealed.

SECTION 15. DHS 10.62 (3) (intro.) is renumbered DHS 10.62 (3) and amended to read:

DHS 10.62 (3) USE OF FUNDS. The department shall deposit amounts recovered under this section ~~as follows:~~ to the appropriation under s. 20.435 (4) (im), Stats.

SECTION 16. DHS 10.62 (3) (a) and (b) are repealed.

SECTION 17. DHS 10.71 and 10.74 are amended to read:

DHS 10.71 **Certification by secretary of availability of resource center**. When the secretary determines that a resource center is prepared to receive referrals from ~~hospitals and~~ long-term care facilities under ~~ss.~~ s. DHS ~~10.72 and~~ 10.73, the secretary shall certify to each county~~, hospital~~ and long-term care facility that serves residents of the geographic area served by the resource center the date on which the resource center is first available to provide pre-admission consultation and functional and financial screens for the family care benefit. To facilitate phase-in of services of resource centers, the secretary may certify that the resource center is available for a specified target population or for specified facilities in the area of the resource center. The secretary may make more than one certification for a resource center during the time that it phases in its services.

DHS 10.74 **Requirements for resource centers.** The department shall establish, through its contracts with resource centers, minimum timeliness requirements for completion of resource center duties related to responding to referrals from ~~hospitals and~~ long-term care facilities. Minimum timeliness requirements shall specify that the resource center initiate contact with the person who was referred or the person's designated representative as soon as practical following receipt of a request or referral for the screen or for long-term care services. The resource center's initial contact is for the purpose of informing the person about the family care benefit and the availability of functional and financial eligibility and cost-sharing screens and long-term care options consultation, and for setting an appointment to provide further consultation and to conduct the screen. The consultation provided by the resource center shall meet the requirements for long-term care options counseling under s. DHS 10.23 (2) (b) and shall be provided in conjunction with performance of the functional and financial eligibility and cost-sharing screens or at another mutually agreed upon time.

SECTION 18. DHS 13.05 (4) (c) is amended to read:

DHS 13.05 (4) (c) If an individual believes that a person employed by or under contract with an entity has abused or neglected or misappropriated the property of a client who is aged 60 or older or subject to ~~the infirmities of aging~~ degenerative brain disorder and who either does not reside in a nursing home or community-based residential facility licensed under ch. 50, Stats., or receive services from a home health agency licensed under ch. 50, Stats., the individual or entity may file a report with the agency designated by the county board to serve as the lead agency for elder abuse in accordance with s. 46.90, Stats. The lead elder abuse agency designated under s. 46.90 (2), Stats., shall notify the department that it has received the report.

SECTION 19. DHS 40.07 (2) (a) 2. is amended to read:

DHS 40.07 (2) (a) 2. Written documentation of each staff member's qualifications per s. DHS 40.09 (2) to ~~(5)~~ (4).

SECTION 20. DHS 82.06 (2m) is amended to read:

DHS 82.06 (2m) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. DHS 10.13 (42), is available for the home under s. DHS 10.71, an adult family home shall provide information to prospective residents and refer residents and prospective residents to an aging and disability resource center as required under ~~s. 50.033 (2r) to (2t),~~ ss.

50.034 (5m) to (5p) and (8), 50.035 (4m) to (4p) and (11), and 50.04 (2g) to (2i), Stats., and s. DHS 10.73.

SECTION 21. DHS 82.06 (2m) (Note) is repealed.

SECTION 22. DHS 83.24 (3) (a) and 83.30 are amended to read:

DHS 83.24 (3) (a) Emergency medical ~~technicians~~ services practitioners. .

DHS 83.30 **Family care information and referral**. If the secretary of the department has certified that a resource center, as defined under s. DHS 10.13 (42), is available for the facility under s. DHS 10.71, the CBRF shall provide information to prospective residents and refer residents and prospective residents to an aging and disability resource center as required under s. 50.035 (4m) ~~to (4p)~~ and (4n), Stats., and s. DHS 10.73. .

SECTION 23. DHS 89.26 (3) (c) 2., 89.27 (3) (d), 89.29 (1m), 89.34 (12), 89.35 (3), and 89.52 (1) are amended to read:

DHS 89.26 (3) (c) 2. The county department or aging unit designated to administer the medicaid waiver for those tenants whose services are paid for under s. ~~46.27 (11) or~~ 46.277, Stats.

DHS 89.27 (3) (d) The initial service agreement and any renewals of the service agreement shall be dated and signed by a representative of the facility; by the tenant or by the tenant's guardian, if any, and all other persons with legal authority to make health care or financial decisions for the tenant; and by the county for a tenant whose services are funded under s. ~~46.27 (11) or~~ 46.277, Stats. The facility shall provide a copy of the service agreement to all parties who signed the agreement.

DHS 83.29 (1m) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. DHS 10.13 (42), is available for the residential care apartment complex under s. DHS 10.71, the residential care apartment complex shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.034 (5m) ~~to (5p)~~ and (5n), Stats., and s. DHS 10.73.

DHS 89.34 (12) CONFIDENTIALITY OF RECORDS. To have his or her medical, personal and financial records kept confidential consistent with all applicable federal and state statutes, rules and regulations. For the purposes of registration, certification and administration, staff of the residential care apartment complex, the department, and any county department or aging unit designated to administer the medicaid waiver for those tenants whose services are paid for under s. ~~46.27 (11) or~~ 46.277, Stats., shall have access to a tenant's records without the tenant's consent, but may not disclose the information except as permitted by law.

DHS 89.35 (3) The residential care apartment complex shall provide a written summary of the grievance, findings, conclusions and any action taken as a result of the grievance to the tenant, the tenant's designated representative, if any, and, for tenants whose services are funded under s. ~~46.27 (11) or~~ 46.277, Stats., the county department or aging unit designated to administer the medical assistance waiver.

DHS 89.52 (1) The certified residential care apartment complex shall have a contract with the county agency which administers the medical assistance waiver under s. ~~46.27 (11) or~~ 46.277, Stats., if it receives those funds.

SECTION 24. DHS 101.03 (1) and (6) are amended to read:

DHS 101.03 (1) “Access," for purposes of BadgerCare Plus, means a family member living in the household has the ability to sign up and be covered by an employer's group health plan in the current month, or had the ability to sign up and be covered in any or all of the ~~18~~ 12 months prior to the application or redetermination of BadgerCare Plus eligibility.

DHS 101.03 (6) “AFDC" means aid to families with dependent children, a public assistance program under Title IV-A of the Social Security Act of 1935, ~~as amended~~ which was in effect until July 16, 1996, and s. 49.19, Stats.

SECTION 25 DHS 101.03 (7) is repealed.

SECTION 26. DHS 101.03 (8) and (15) are amended to read:

DHS 101.03 (8) “Agency" means the county department of social services, or human services, a multi-county consortium under s. 49.78 (1m), Stats., a single-county consortium under s. 49.78 (1r), Stats., or a tribal agency which administers income maintenance programs.

DHS 101.03 (15) “Application for medical assistance" means the process of ~~completing and~~ signing and submitting a department-approved application ~~form~~ online, by telephone, by fax, by mail, or in person, by which action a person indicates to the agency authorized to accept the application a desire to receive MA.

SECTION 27. DHS 101.03 (17r), (17t), (17w), (20), and (23) are amended to read:

DHS 101.03 (17r) “BadgerCare Plus" means the MA-related program established under s. ~~49.665~~ 49.471, Stats.

DHS 101.03 (17t) “BadgerCare Plus fiscal test group" means all members of the BadgerCare Plus group and all persons who are financially responsible for all members of the BadgerCare Plus group ~~who live in the same household as the person for whom they are legally responsible and who are not SSI recipients~~.

DHS 101.03 (17w) “BadgerCare Plus group" means all persons listed on an application for BadgerCare Plus who meet nonfinancial eligibility requirements.

DHS 101.03 (20) “Budgetable income" means earned and unearned income that is considered available for determining financial eligibility for MA under ~~s. 49.46 (1) or 49.47 (4),~~ subch. IV of ch. 49, Stats., and ch. DHS 103.

DHS 101.03 (23) “Categorically needy" means the group of persons who meet the nonfinancial and financial eligibility conditions to be eligible for ~~AFDC or SSI~~ MA under 42 USC 1396a (a) (10) (A) and (e), 1396d (p), 1396r-6, and designated as covered groups in Wisconsin under the state plan.

SECTION 28. DHS 101.03 (30) is repealed.
SECTION 29. DHS 101.03 (38), (41) (intro.), (a) and (b), (c) 1. to 6., (52), and (65) are amended to read:

DHS 101.03 (38) “Deeming" means a process by which income and assets are considered available to applicants or recipients for the purpose of determining financial eligibility for MA under s. 49.46 (1) ~~or,~~ 49.47 (4), or 49.471, Stats., and ch. DHS 103.

DHS 101.03 (41) “Developmental disability" means intellectual disability or a related condition such as cerebral palsy, epilepsy, or autism, but excluding mental illness and ~~infirmities of aging~~ degenerative brain disorder, which ~~is~~ meets all of the following criteria:

(a) ~~Manifested~~ Is manifested before the individual reaches age 22~~;~~.
(b) ~~Likely~~ Is likely to continue indefinitely~~; and~~.

DHS 101.03 (41) (c) 1. Self-care~~;~~.
2. Understanding and use of language~~;~~.
3. Learning~~;~~.
4. Mobility~~;~~.
5. Self-direction~~;~~.
6. Capacity for independent living~~; and~~.

DHS 101.03 (52) “Emergency services" means those services ~~which are~~ necessary to ~~prevent the death or serious impairment of the health of the individual~~ treat an emergency medical condition, including labor and delivery, that without immediate medical attention could reasonably be expected to result in placing the individual’s health in serious jeopardy, seriously impair bodily functions, or seriously disable any body part or bodily organ.

DHS 101.03 (65) “Fiscal test group" means all members of the medical assistance group and all persons who are financially responsible for members of the medical assistance group who live in the same household as the person for whom they are legally responsible and who are not SSI ~~or AFDC~~ recipients. .

SECTION 30. DHS 101.03 (78s) is repealed.

SECTION 31. DHS 101.03 (94r), (95), (96), and (97) are amended to read:

DHS 101.03 (94r) “Medical expense" means a cost paid by a medicaid purchase plan recipient, an institutionalized person, or someone receiving home and community-based services for goods or services that have been prescribed or provided by a medical practitioner licensed in Wisconsin or another state. The cost is not reimbursable by another source such as medicare, medical assistance, private insurance or an employer. Medical expenses may be used to expend excess income during a spend-down period.

DHS 101.03 (95) “Medical assistance" or “MA" means the assistance program operated by the department under ss. 49.43 to 49.497 ~~and 49.665~~, Stats., any services or items under ss. 49.45 to 49.497, Stats., and this chapter and chs. DHS 102 to 108, or any payment or reimbursement made for these services or items.

DHS 101.03 (96) “Medical assistance group" or “MA group" means all persons listed on an application for MA who meet nonfinancial eligibility requirements, except that each ~~AFDC recipient,~~ SSI recipient~~,~~ ~~and each child with no legally responsible relative~~ comprises a separate MA group. .

DHS 101.03 (97) “Medically needy" means the group of persons who meet the non-financial eligibility conditions for ~~AFDC or SSI~~ MA, but whose income exceeds the financial eligibility limits for those ~~programs~~ categorically needy MA groups. Medically needy eligibility exists if applicant’s income does not exceed, for the applicant’s family size, the income limits under. s. 49.47 (4) (c) 1. or 49.471 (7), Stats.

SECTION 32. DHS 101.03 (129m) is renumbered DHS 101.03 (129m) (intro.) and amended to read:

DHS 101.03 (129m) “Presumptive eligibility" means eligibility of ~~a pregnant woman for MA coverage of ambulatory prenatal care and other services, as determined under s. 49.465 (2), Stats.~~, any of the following, prior to application and determination of MA eligibility under ss. 49.46 (1), ~~and~~ 49.47 (4), 49.471, Stats., and ch. DHS 103~~.~~:

SECTION 33. DHS 101.03 (129m) (a) to (e) are created to read:

DHS 101.03 (129m) (a) A pregnant woman for MA coverage of ambulatory prenatal care and other services, as determined under s. 49.465 (2), Stats.
(b) A child for MA coverage, as determined under s. 49.471 (5) (b) 2.

(c) A woman diagnosed with breast or cervical cancer or precancerous conditions for MA coverage, as defined under s. 49.473 (3), Stats.
d) An adult age 19 to 64, or a parent or caretaker for MA coverage, as determined under 42 CFR 435.1110.
(e) An individual for family planning benefits, as determined under 42 CFR 435.1110.

SECTION 34. DHS 101.03 (149f) and (149j) are created to read:

DHS 101.03 (149f) "Qualified hospital" means a hospital that is qualified to determine presumptive eligibility of children, pregnant women, parents, caretakers, adults ages 19 through 64, and woman diagnosed with breast or cervical cancer or precancerous conditions for MA coverage, and individuals for family planning benefits, in accordance with 42 CFR 435.1110(b).

DHS 101.03(149j) "Qualified partner" means an entity that is qualified to determine presumptive eligibility of children for MA coverage, as ascertained by the department in accordance with 42 USC 1396r-1a (b) (3).

SECTION 35. DHS 101.03 (149m) and (152m) are amended to read:

DHS 101.03 (149m) "Qualified provider" means a provider who is qualified to determine presumptive eligibility of children, women with breast or cervical cancer or precancerous conditions, and pregnant women for MA coverage, as ascertained by the department in accordance with 42 USC 1396a (a) ~~(10)~~ (47).

DHS 101.03 (152m) "Remedial expense" means a cost paid by a medicaid purchase plan recipient, an institutionalized person, or someone receiving home and community-based services under 42 USC 1396n that may be considered to be related to that person's health, employment or disability. The cost is not reimbursable by another source such as medicare, medical assistance, private insurance or an employer. Remedial expenses may be used to expend excess income during a spend-down period.

SECTION 36. DHS 101.03 (170s) and (172s) are repealed.

SECTION 37. DHS 102.01 (intro.) and (1) are amended to read:

DHS 102.01 Application for medical assistance (MA) shall be made pursuant to s. 49.47 (3), Stats., for medically indigent persons, s. 49.46, Stats., for categorically needy persons s. 49.473, Stats., for women diagnosed with breast or cervical cancer or precancerous conditions, and s. ~~49.665~~ 49.471, Stats., for persons under BadgerCare Plus, and this chapter. Applications shall be made and reviewed in accordance with the following provisions:

DHS 102.01 (1) RIGHT TO APPLY. Any person may apply for MA. ~~Application~~ The application shall be made ~~on a form prescribed by the department and available from an agency~~ via the department's internet website over the telephone, by fax, on a paper form, or in person with the agency.

SECTION 38. DHS 102.01 (4) is repealed and recreated to read:

DHS 102.01 (4) ACCESS TO INFORMATION.

(a) Persons inquiring about or applying for MA shall be given all of the following information by the agency in electronic and paper formats, and orally as appropriate:
1. The MA eligibility requirements.
2. All available MA services.
3. The rights and responsibilities of MA applicants and members.

(b) Information must be provided to applicants and members in plain language and in an accessible and timely manner.
(c) Applicants and members must be informed of the availability of accessible information and language services and how to access language services or auxiliary aids. At minimum, the agency must provide non-English language taglines indicating the availability of language services.
(d) For individuals who are limited English proficient, the agency must provide language services including oral interpretations and written translations at no cost to the individual.
(e) For individuals with disabilities, the agency must provide auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act, 42 USC 12101.

SECTION 39. DHS 102.01 (5) (a), (b) (intro.), 1., 2. (intro.), and a. to d. are amended to read:

DHS 102.01 (5) (a) When a person ~~18~~ 19 years of age or older is living in the household of the primary person but is not the primary person~~,~~ or the primary person's spouse, ~~or a dependent 18-year-old as defined in s. 49.19 (1) (a), Stats.~~, the agency shall determine the eligibility of that person and that person's spouse or child, if any, separately from the rest of the persons listed on the application.

(b) When an unmarried man and woman reside together and have a minor child-in-common, the agency shall determine the eligibility of the man and woman together on one application if the man is the father of the child, which shall be determined as follows:

1. If both the woman and the man are available, the man shall be considered the father of the child if his name is on the birth record, if ~~a court proceeding has established~~ paternity has been established under ch. 767, Stats., or if a completed statement of paternity form has been signed by him and the mother and has been mailed or delivered to the agency.

2. If only the man is in the home and the woman is not available to participate in the steps necessary to fulfill the requirements of subd. 1., the man shall be determined to be the father of the child if any of the following circumstances apply:

a. His name is on the birth records~~;~~.

b. He provides the agency with an affidavit in which he states that he is the child's father and proves that he and the child's mother lived together at the time of conception~~;~~.

c. He files with the department a declaration of paternal interest under s. 48.025, Stats., and proves that he and the child's mother lived together at the time of conception~~;~~.

d. He provides the agency with a written statement in which he acknowledges his paternity and proves that he and the child's mother lived together at the time of conception~~; or~~.

SECTION 40. DHS 102.01 (5) (h) is repealed.

SECTION 41. DHS 102.01 (7) is amended to read:

DHS 102.01 (7) SIGNING THE APPLICATION. Each application ~~form~~ submitted online, over the telephone, by fax, or on paper shall be signed by the applicant or the applicant's caretaker relative defined under s. DHS 101.03 (22g), legal guardian, authorized representative or, where the applicant is incompetent or incapacitated, by someone acting responsibly for the applicant. When an institutionalized person who is applying for MA or an institutionalized recipient whose eligibility for MA is being redetermined has a community spouse, both the institutionalized spouse and his or her spouse, their authorized representatives or someone acting responsibly for the institutionalized spouse or his or her spouse shall sign the application form. Failure of either spouse or that person's authorized representative or someone acting responsibly on behalf of either spouse to sign the application form shall result in ineligibility for the institutionalized spouse under s. DHS 103.075. Except as provided under s. DHS 103.075 (5) (e), the agency shall proceed to determine eligibility for the institutionalized spouse under s. DHS 103.04 (4). ~~The application shall be signed in the presence of an agency representative except when an institution superintendent makes application for public assistance on behalf of a resident pursuant to s. 49.84 (1), Stats.~~ The signatures of 2 witnesses are required when the application is signed with a mark. In this subsection, “community spouse" and “institutionalized spouse" have the meanings prescribed in s. DHS 103.075 (3) (a) and (e).

SECTION 42. DHS 102.03 (1) is amended to read:

DHS 102.03 (1) An agency that has complied with subs. (1g) and (1r) shall deny an application for MA ~~shall be denied~~ when the applicant or recipient is able to produce required verifications but refuses or fails to do so, except that a refusal or failure by an applicant for MA to verify assets does not affect eligibility for BadgerCare Plus under s. ~~49.665~~ 49.471, Stats. If the applicant or recipient is not able to produce verifications, or requires assistance to do so, the agency may not deny assistance but shall proceed immediately to verify the data elements.

SECTION 43. DHS 102.03 (1g) and (1r) are created to read:

DHS 102.03 (1g) An individual shall not be required to provide additional information or documentation if it is not required to determine eligibility for the type of Medicaid or BadgerCare Plus, under ch. 49, subch. IV, Stats., that the member is requesting.

(1r) An individual shall not be required to provide additional information of documentation unless information needed by the agency cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information by or on behalf of the individual. Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are at or below the applicable standard for MA.

SECTION 44. DHS 102.03 (3) (intro.), (a) and (b) are amended to read:

DHS 102.03 (3) ~~The~~ Each of the following items shall be verified when applicable:

(a) Income~~;~~.

(b) Pregnancy, ~~including a pregnancy which is the basis of nonfinancial eligibility under s. DHS 103.03 (1) (b) 1.;~~ when the agency has information that contradicts the member's self-attestation. If there is no contradictory information, the agency shall accept the member's self-attestation of pregnancy.

SECTION 45. DHS 102.03 (3) (c) is repealed.

SECTION 46. DHS 102.03 (3) (d) is renumbered DHS 102.03 (3) (d) (intro.), and amended to read:

DHS 102.03 (3) (d) Social security number~~;~~, subject to all of the following requirements:

SECTION 47. DHS 102.03 (3) (d) 1. and 2. are created to read:

DHS 102.03 (3) (d) 1. Services must not be denied or delayed to an otherwise eligible individual pending issuance or verification of the individual's social security number by the Social Security Administration.

2. Any of the following individuals are not required to provide a social security number:

a. Individuals who are deemed eligible for MA, based on being born to a pregnant woman eligible for MA in Wisconsin, until they turn 1 year of age.

b. Individuals who are not eligible to receive a social security number.

c. Individuals who do not have a social security number and may only be issued a social security number for a valid non-work reason in accordance with 20 CFR 422.104.

d. Individuals who refuse to obtain a social security number because of well-established religious objections, as defined under 42 CFR 435.910 (h) (3).

SECTION 48. DHS 102.03 (3) (e) is amended to read:

DHS 102.03 (3) (e) Age~~;~~.

SECTION 49. DHS 102.03 (3) (f), (g) and (h) are amended to read:

DHS 102.03 (3) (f) Citizenship ~~or alien status,~~ subject to s. DHS 102.033.

DHS 102.03 (3) (g) Disability, blindness, or both~~;~~.

(h) Assets~~; and~~.

SECTION 50. DHS 102.03 (3) (j) is created to read:

DHS 102.03 (3) (j) Immigration status, subject to s. DHS 102.036.

SECTION 51. DHS 102.033 is created to read:

DHS 102.035 **Verification of United States Citizenship.**
(1) The agency shall verify citizenship through a data match with the Social Security Administration. If citizenship cannot be verified through a data match with the Social Security Administration, the agency must verify citizenship in the manner described in 42 CFR 435.407, except that any of the following are exempt from the requirement to verify citizenship:

(a) Individuals receiving supplemental security income benefits under 42 USC 1381-1383f.
(b) Individuals entitled to or enrolled in any part of Medicare.
(c) Individuals receiving disability insurance benefits under 42 USC 423 or monthly benefits under 42 USC 402, based on the individual's disability.
(d) Individuals who are in foster care and who are assisted under 42 USC 621-629m, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under 42 USC 670-679c.
(e) Individuals who are or were deemed eligible for MA in Wisconsin on or after July 1, 2006, based on being born to a pregnant woman eligible for MA.

(2) The agency shall not re-verify or require an individual to re-verify citizenship at a renewal of eligibility or upon a subsequent application following a break in coverage.
(3) If citizenship cannot be promptly verified, a reasonable opportunity period of 95 days shall be provided to applicants during which efforts must continue to obtain verification or, if necessary, request documentation. Benefits may not be delayed, denied, reduced, or terminated during the reasonable opportunity period if the individual is otherwise eligible for MA. A reasonable opportunity period shall only be granted once for verification of an individual's U.S. citizenship.

SECTION 52. DHS 102.036 is created to read:

DHS 102.036 **Verification of Immigration Status.**
(1) The agency shall verify immigration status of persons declaring a satisfactory immigration status either through the electronic service established by the U.S. department of health and human services, or the department of homeland security.
(2) Persons applying for MA emergency services provided under 42 USC 1396b(v) or applying for an unborn child under s. 49.471, Wis. Stats. shall not be required to verify their immigration status.
(3) If immigration status cannot be promptly verified, a reasonable opportunity period of 95 days shall be provided to applicants during which efforts must continue to obtain verification or, if necessary, request documentation. Benefits shall not be delayed, denied, reduced, or terminated during the reasonable opportunity period if the individual is otherwise eligible for MA. An additional reasonable opportunity period may be granted when a change in immigration status is reported.
(4) Unless the individual reports a change in immigration status or information is received that indicates a potential change in the individual's status, the agency shall not re-verify or require an individual to re-

verify immigration status at a renewal of eligibility or upon a subsequent application following a break in coverage.

SECTION 53. DHS 102.04 (1) is amended to read:

DHS 102.04 (1) DECISION DATE. As soon as possible but not later than 30 days from the date the agency receives a signed application completed to the best of the applicant's ability, the agency shall ~~conduct a personal interview with the applicant and shall~~ determine the applicant's eligibility for MA. If a delay in processing the application occurs because of a delay in securing necessary information, the agency shall notify the applicant in writing that there is a delay in processing the application, specify the reason for the delay, and inform the applicant of his or her right to appeal the delay under s. 49.45 (5), Stats. If medical examination reports are needed to determine disability or blindness, the agency shall make the disability decision no later than 60 days from the date the agency receives the signed application.

SECTION 54. DHS 102.04 (3) (intro.) and (a) to (d) are amended to read:

DHS 102.04 (3) REVIEW OF ELIGIBILITY. A recipient's eligibility shall be redetermined in any of the following circumstances:

(a) When information previously obtained by the agency concerning anticipated changes in the individual's situation indicates the need for redetermination~~;~~.

(b) Promptly after a report is obtained which indicates a change in the individual's circumstances that may affect eligibility~~;~~.

(c) ~~Within~~ In accordance with sub. (5), no more frequently than once every 12 months ~~after the date of initial eligibility is determined~~ for ~~AFDC-related persons and~~ persons eligible for BadgerCare Plus or Medicaid under s. 49.46 (1) (a) 15. or 49.47 (4) (a) 1., Stats.~~;~~

(d) ~~Within 365 days after the date eligibility was last determined~~ At least every 12 months for SSI−related persons and persons eligible for the medicaid purchase plan, in accordance with sub. (4), except that when a person is determined to be permanently blind or disabled ~~no further determination shall be made of that disability unless the county agency becomes aware of information that would affect the determination of permanent disability~~ the agency may consider their blindness or disability as continuing until it is determined that they are no longer blind or disabled~~; and~~.

SECTION 55. DHS 102.04 (5) is created to read:

DHS 102.04 (5) PROCEDURES FOR REVIEWING ELIGIBILITY .

(a) A review of eligibility under sub. (3) (c) or (d) shall be conducted without requiring information from the individual if the agency is able to do so based on reliable information contained in the recipient's case record or more current information available to the agency, including but not limited to information accessed through data bases accessed by the agency.

(b) If the agency is able to redetermine eligibility based on such information, the agency shall notify the recipient of all of the following:

1. The eligibility determination and basis.
2. The requirement that the recipient must inform the agency if any of the information contained in such notice is inaccurate, but that the recipient is not required to sign and return such notice if all information provided on such notice is accurate.

(b) If the agency cannot redetermine eligibility in accordance with sub. (5) (a), the agency shall do all of the following:

1. Provide the recipient with all of the following:
    a. A renewal form containing information available to the agency that is needed to renew eligibility.
    b. At least 30 days from the date of the renewal form to respond and provide any necessary information and to sign the renewal form.
    c. Notice of the agency's intended action concerning the renewal of eligibility.
2. Verify any information provided by the recipient.
3. Reconsider in a timely manner the eligibility of a person who is terminated for failure to submit the renewal form or necessary information, if the person subsequently submits the renewal form within 90 days after the date of termination without requiring a new application.

SECTION 56. DHS 103.01 (1) (a) is amended to read:

DHS 103.01 (1) (a) Eligibility for medical assistance shall be determined pursuant to ss. 49.453, 49.454, 49.455, 49.46 (1), 49.468, 49.47 (4), 49.471, ~~and~~ 49.472 and 49.473, Stats., and this chapter, except that medical assistance shall be provided without eligibility determination to persons receiving SSI ~~or those persons who would currently be eligible under the AFDC program that was in place on July 16, 1996 in this state pursuant to s. 49.19, Stats~~.

SECTION 57. DHS 103.01 (1) (c) to (f) are created to read:

DHS 103.01 (1) (c) Presumptive eligibility for children shall be determined under s. 49.471 (5) (b) 2., Stats., and this chapter.

(d) Presumptive eligibility for parents, caretakers, and adults ages 19 through 64 shall be determined under 42 CFR 435.1110, and this chapter.

(e) Presumptive eligibility for women diagnosed with breast or cervical cancer or precancerous conditions shall be determined under s. 49.473 (3), Stats., and this chapter.

(f) Presumptive eligibility for family planning benefits for individuals shall be determined under 42 CFR 435.1110, and this chapter.

SECTION 58. DHS 103.03 (1) (title), (a), (b) (title), (intro.), 1. and 2. are amended to read:

DHS 103.03 (1) ~~AFDC~~ BADGERCARE PLUS−RELATEDNESS~~,~~ OR SSI−RELATEDNESS ~~OR BADGERCARE ELIGIBILITY~~. (a) *Requirement*. To be non−financially eligible for MA, an applicant shall be ~~AFDC~~ BadgerCare Plus−related~~,~~ or SSI−related ~~or meet the non−financial requirements under par. (f) for BadgerCare~~.

(b) ~~*AFDC*~~ *BadgerCare Plus−related persons.* In this subsection, "~~AFDC~~ BadgerCare Plus−related" means a person who meets one of the following conditions:

1. The person is pregnant and meets the conditions specified in ~~s. 49.46 (1) (a) 1m. or 9., 49.465 or 49.47 (4) (ag) 2. or (am) 1.~~ ss. 49.471 (4) (a) 1., 1g., or 1m., Stats.~~;~~

2. The person is a ~~dependent child as defined in s. 49.19 (1) (a), Stats., or is a~~ child under age 19 who meets the conditions specified in s. ~~49.46 (1) (a) 10. or 49.47 (4) (a) 1. or (am) 2.~~ 49.471 (4) (a) 3., 3g., 3m. or 7., Stats.~~;~~, and under par. (f).

SECTION 59. DHS 103.03 (1) (b) 2m. is created to read:

DHS 103.03 (1) (b) 2m. The person is an unborn child as defined in s. 49.471 (1) (k), Stats., and meets the conditions under par. (f).

SECTION 60. DHS 103.03 (1) (b) 3. and 4. are amended to read:

DHS 103.03 (1) (b) 3. The person is a caretaker relative or a caretaker relative's spouse if the spouse resides with the caretaker relative's child who meets the conditions specified in s. 49.471 (4) (a) 4. or 7., Stats.~~; or~~

4. The person is a foster child under 19 years of age living in a foster home licensed under s. 48.62, Stats., or a group home licensed under s. 48.625, Stats., is a child under the care of a subsidized guardianship under s. 48.623, Stats., or is a child in an adoption assistance placement under s. 48.975, Stats.

SECTION 61. DHS 103.03 (1) (b) 5. to 8. are created to read:

DHS 103.03 (1) (b) 5. The person is a former foster care recipient and meets the conditions specified under s. 49.471 (4) (a) 5, Stats.

6. The person meets the conditions to receive family planning services under s. 49.45 (24s), Stats.

7. The person is diagnosed with tuberculosis and meets the conditions under s. 49.46 (1) (a) 15., Stats.
8. The person is at least 19, but under 21 years of age and resides in an intermediate care facility, skilled nursing facility, or inpatient psychiatric hospital and meets the conditions under s. 49.47 (4), Stats.

SECTION 62. DHS 103.03 (1) (f) (title), (intro.), and 1. are amended to read:

DHS 103.03 (1) (f) *BadgerCare Plus eligibility.* To be non−financially eligible for BadgerCare Plus, a person shall meet all of the following conditions:

1. The person ~~is under age 19, a custodial parent living with his or her child who is under age 19 or the spouse of a custodial parent if the spouse resides with the custodial parent's child who is under the age of 19~~ meets one of the conditions in par. (b).

SECTION 63. DHS 103.03 (1) (f) 2. is repealed and recreated to read:

DHS 103.03 (1) (f) 2. Except as provided in subd. 5m., the person is a child age 1 through 5 with household income over 191% of the federal poverty line or age 6 through 18 with household income over 156% of the federal poverty line, and does not have health insurance coverage that meets both of the following criteria:

a. The health insurance coverage is provided by an employer that pays 80% of the premium or coverage is provided under the state of Wisconsin employee health plan.

b. The health insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

SECTION 64. DHS 103.03 (1) (f) 2m. is created to read:

DHS 103.03 (1) (f) 2m. The person is an unborn child and the unborn child's mother does not have health insurance coverage that covers services provided in a service area that is within a reasonable driving distance from the person's residence.

SECTION 65. DHS 103.03 (1) (f) 3. (intro) is amended to read:

DHS 103.03 (1) (f) 3. ~~The~~ Except as provided in subd. 5m., the person is a child age 1 through 5 with household income over 191% of the federal poverty line or age 6 through 18 with household income over 156% of the federal poverty line, and the person does not have access to ~~family~~ coverage under a group health insurance plan ~~offered by an employer for which the employer pays 80% of the cost, excluding any deductibles or co−payments that may be required under the plan, or to a state employee health plan through any of the following~~ that meets all of the following criteria:

SECTION 66. DHS 103.03 (1) (f) 3. a. and b. are repealed and recreated to read:

DHS 103.03 (1) (f) 3. a. The health insurance coverage is provided by an employer that pays 80% of the premium or coverage is available under the state of Wisconsin employee health plan.

b. The health insurance coverage would begin within 3 calendar months following the BadgerCare Plus application filing date, the BadgerCare Plus annual renewal month, or the start date of the employment through which the child can access the health insurance coverage.

c. The health insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

SECTION 67. DHS 103.03 (1) (f) 3. d. and 3m. are created to read:

DHS 103.03 (1) (f) 3. d. The health insurance policy is through the child's employer, the employer of the child's spouse when the spouse is residing with the child, or the employer of the child's parent, step-parent or other caretaker relative residing with the child.

DHS 103.03 (1) (f) 3m. If the person is an unborn child, the unborn child's mother does not have access to coverage under a group health insurance plan that meets all of the following criteria:

a. The health insurance coverage is provided by an employer that pays 80% of the premium or coverage is available under the state of Wisconsin employee health plan.

b. The health insurance coverage would begin within 3 calendar months following the BadgerCare Plus application filing date, the BadgerCare Plus annual renewal month, or the start date of the employment through which the mother can access the health insurance coverage.

c. The health insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

d. The health insurance policy is through the mother's employer or the employer of the mother's spouse when the spouse is residing with the mother.

e. When the mother is under 19 years old, the health insurance coverage is through the employer of the mother's parent, step-parent, or other caretaker relative residing with the mother.

SECTION 68. DHS 103.03 (1) (f) 4. (intro.) is amended to read:

DHS 103.03 (1) (f) 4. Except as provided in subd. 5. or 5m., ~~the applicant for BadgerCare~~ if the person is a child ages 1 through 5 with household income over 191% of the federal poverty level or if the person is a child ages 6 through 18 with household income over 156% of the federal poverty line and did not, at any time in the ~~18~~ 12 months immediately preceding application for BadgerCare Plus, have access to employer−subsidized health care coverage~~,~~ or a state employee's health plan. The ~~applicant~~ child is ineligible for BadgerCare Plus the first day of the month that the employer's plan would have provided coverage for the ~~recipient~~ child if the family had been enrolled in the plan. The ~~applicant~~ child remains ineligible for each month that coverage would have been available up to ~~18~~ 12 months from the month the failure to enroll in the plan occurred~~.The insurance the applicant had access to shall have been available only through one of the following~~ if the health insurance plan meets all of the following criteria:

SECTION 69. DHS 103.03 (1) (f) 4. a. to c. are repealed and recreated to read:

DHS 103.03 (1) (f) 4. a. The health insurance coverage is provided by an employer that pays 80% of the premium or coverage is available under the state of Wisconsin employee health plan.

b. The health insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

c. The health insurance policy is through the child's employer, the employer of the child's spouse when the spouse is residing with the child, or the employer of the child's parent, step−parent or other caretaker relative residing with the child.

SECTION 70. DHS 103.03 (1) (f) 4m. is created to read:

DHS 103.03 (1) (f) 4m. Except as provided in subd. 5., if the person is an unborn child, the unborn child's mother did not, at any time in the 12 months immediately preceding application for BadgerCare Plus, have access to employer−subsidized health care coverage, or a state employee's health plan. The unborn child is ineligible for BadgerCare Plus the first day of the month that the employer's plan would have provided coverage for the unborn child's mother if the family had been enrolled in the plan. The unborn child remains ineligible for each month that coverage would have been available up to 12 months from the month the failure to enroll in the plan occurred if the health insurance plan meets all of the following criteria:

a. The health insurance coverage is provided by an employer that pays 80% of the premium or coverage is available under the state of Wisconsin employee health plan.

b. The health insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

c. The health insurance policy is provided through the mother's employer, the employer of the mother's spouse when the spouse is residing with the mother, or the employer of the mother's parent, step−parent or other caretaker relative residing with the child, if the mother is under 19 years of age.

SECTION 71. DHS 103.03 (1) (f) 5. (intro.) and (c) are amended to read:

DHS 103.03 (1) (f) 5. The ~~18~~ 12 month period in ~~subds.~~ subds. 4. and 4m. does not apply if one of the following statements is true about access to employer−subsidized health care coverage:

DHS 103.03 (1) (f) 5. c. A member of the family was eligible for other health insurance coverage or MA at the time the employee failed to enroll in the employer−subsidized health care coverage and no member of the group was eligible at that time for BadgerCare ~~at that time~~ Plus with an assistance group income above 156% of the federal poverty line.

SECTION 72. DHS 103.03 (1) (f) 5. d. is repealed.

SECTION 73. DHS 103.03 (1) (f) 5m. is created to read:

DHS 103.03 (1) (f) 5m. A child is exempt from the health insurance coverage requirements in subds. 2, 3, and 4, if they meet any of the following criteria.

a. The child is younger than 19 years old, has met a deductible, and is in the deductible period.

b. The child is in an extension.

c. The person is age 18 and was in foster care, subsidized guardianship, or court-ordered kinship care on the date they turned 18 years old.

d. The child is pregnant.

SECTION 74 DHS 103.03 (1) (f) 6. and 8. are amended to read:

DHS 103.03 (1) (f) 6. The person is not eligible for MA under ~~AFDC~~ BadgerCare Plus−related or SSI−related criteria in this chapter.

DHS 103.03 (1) (f) 8. A person has not chosen to receive ~~AFDC~~ BadgerCare Plus−related or SSI− related MA through a spend−down, as described in s. DHS 103.08 (2) (a), or has chosen to end a spend−down period at any time prior to the date at which the expenditure or obligation of excess income has been achieved.

SECTION 75. DHS 103.03 (2) (intro.) is amended to read:

DHS 103.03 (2) CITIZENSHIP. U.S. citizenship shall be a requirement for eligibility for MA, except that ~~an alien lawfully admitted for permanent residency may be eligible, including an alien lawfully present in the United States as a result of s. 203 (a) 7. (8. USC 1153), 207 (c) (8. USC 1157), 208 (8 USC 1158) or 212 (d) 5 (8 USC 1182) of the immigration and nationality act, an alien granted lawful temporary resident status under s. 245A (8 USC 1255a), 210 (8 USC 1160) or 210A (8 USC 1161) of the immigration and nationality act or an alien otherwise permanently residing in the United States under color of law within the meaning of 42 CFR 435.408 the following persons who are not US citizens may also be eligible for MA.~~ the following persons who are not U.S. citizens may also be eligible for MA:

SECTION 76. DHS 103.03 (2) (a), (b) 1. to 4., (c) 1. to 4., (d) 1. to 4., and (e) are created to read:

DHS 103.03 (2) (a) A U.S. National from American Samoa or Swains Island.
(b) A citizen of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau who meets all of the following requirements:

1. Has declared, or someone legally responsible for the individual has declared, that the individual has a satisfactory immigration status.
2. Has provided satisfactory documentary evidence of their status.
3. Has their status verified with the U.S. Department of Homeland Security.
4. Is lawfully residing in the U.S.

(c) A qualified non-citizen as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 USC 1641, who meets all of the following requirements:

1. Has declared, or someone legally responsible for the individual has declared, that the individual has a satisfactory immigration status.
2. Has provided satisfactory documentary evidence of a qualified non-citizen status.
3. Has their qualified non-citizen status verified with the U.S. Department of Homeland Security.
4. If subject to the 5-year bar under 8 USC 1613, has been in the United States for 5 years with a qualified non-citizen status.

(d) A child under age 19, a pregnant woman or an individual under age 21 residing in an IMD who is a noncitizen lawfully residing in the U.S. as allowed under 42 USC 1396b (v) (4), who meets all of the following requirements:

1. Has declared, or someone legally responsible for the individual has declared, that the individual has a satisfactory immigration status.
2. Has provided satisfactory documentary evidence of lawfully residing in the U.S.
3. Has their lawful residence status verified with the U.S. Department of Homeland Security.

SECTION 77. DHS 103.03 (2m) is created to read:

DHS 103.03 (2m) LIMITATION ON MEDICAL ASSISTANCE FOR NONCITIZENS. A noncitizen who does not meet the conditions in sub. (2) (a), (b), (c), or (d) may not receive medical assistance benefits except as provided under s. 49.45 (27), Stats.

SECTION 78. DHS 103.03 (4) (a) 1. and 2. are amended to read:

DHS 103.03 (4) (a) 1. An alien who is requesting medical assistance only for emergency services~~; or~~.
2. A child who is eligible for medical assistance under 42 USC 1396a (e) (4). During the time that the child is eligible under 42 USC 1396a (e) (4), the agency shall use the mother's ~~social security~~ MA identification number.

SECTION 79. DHS 103.03 (4) (a) 3. to 5. are created to read:

DHS 103.03 (4)(a) 3. An individual who is not eligible to receive a social security number.
4. An individual who does not have a social security number and may only be issued a social security number for a valid non-work reason in accordance with 20 CFR 422.104.

5. An individual who refuses to obtain a social security number because of well-established religious objections as defined in 42 CFR 435.910.

SECTION 80. DHS 103.03 (4) (b) is amended to read:

(b) If an applicant who is required to furnish a social security number under par. (a) does not have a social security number, application for the number shall be made by or on behalf of the applicant to the federal social security administration. If there is a refusal to furnish a number or apply for a number, the person for whom there is a refusal is not eligible for MA. The department may not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's social security number

SECTION 81. DHS 103.04 (1) (b), (2), and (3)(a) and (b) are amended to read:

DHS 103.04 (1) (b) The ~~AFDC~~ BadgerCare Plus−related categorically needy income standard for MA applicants shall be the appropriate ~~AFDC assistance~~ standard as specified in ~~s. 49.19 (11) (am) 1m., Stats., except that persons who are ineligible to receive AFDC solely because of the application of s. 49.19 (11) (e), Stats., which specifies that payments that are not whole dollar amounts shall be rounded down to the nearest whole dollar, shall receive MA as categorically needy~~ s. DHS 103.03 (1) (a) ~~The AFDC−related categorically needy asset standard shall be the same as that set out in s. 49.19 (4), Stats.~~.

DHS 103.04 (2) MEDICALLY NEEDY. If the MA group or fiscal test group is not eligible as categorically needy, the medically needy standard shall be applied. ~~Persons~~ SSI-related persons who meet non−financial conditions for eligibility and meet the income and assets criteria set forth in s. 49.47 (4) (b) and (c), Stats., and this chapter~~, except for AFDC−related adult caretakers who are not blind, disabled or age 65 or older,~~ shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47 (6), Stats., and chs. DHS 101 through 108.

DHS 103.04 (3) EXCESS INCOME CASES. (a) In this subsection, "spend–down period" means the period during which excess income may be expended or obligations to expend excess income may be incurred for the purpose of obtaining ~~AFDC~~ BadgerCare Plus−related or SSI−related MA eligibility, as described under s. DHS 103.08 (2) (a).
(b) When an SSI−related ~~or AFDC−related~~ fiscal test group is found ineligible as medically needy and excess income is the only reason, the group may expend or incur obligations to expend the excess income above the appropriate medically needy income limit pursuant to s. 49.47 (4) (c) 2., Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47 (6), Stats., and chs. DHS 101 to 108 for the balance of the spend−down period.

SECTION 82. DHS 103.04 (3) (bg) and (br) are created to read:

DHS 103.04 (3) (bg) When a child is found ineligible for BadgerCare Plus-related MA solely under s. DHS 103.03(1)(f), the BadgerCare Plus-related fiscal test group may expend or incur obligations to expend the excess income above the appropriate income limit pursuant to s. 49.471 (7) (b) 2., Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47 (6), Stats., and chs. DHS 101 to 108 for the balance of the spend−down period.

DHS 103.04 (3) (br) When a pregnant woman is found ineligible for BadgerCare Plus-related MA solely under s. DHS 103.03(1)(f), the BadgerCare Plus-related fiscal test group may expend or incur obligations to expend the excess income above the appropriate income limit pursuant to s. 49.471 (7) (b) 1., Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47 (6), Stats., and chs. DHS 101 to 108 for the balance of the spend−down period.

SECTION 83. DHS 103.04 (5) (title) and (a) are consolidated, renumbered DHS 103.04 (5), and amended to read:

DHS 103.04 (5) IRREGULAR CASES. Mixture of ~~AFDC~~ BadgerCare Plus and SSI−relatedness. When there is a mixture in an MA group of ~~AFDC~~ BadgerCare Plus−relatedness and SSI−relatedness, ~~AFDC−related financial eligibility procedures shall be used except when no minor child is in the home, in which case SSI−related procedures shall be used~~ each individual will be tested using the appropriate modified adjusted gross income rules under sub. (7) or SSI-related standards.

SECTION 84. DHS 103.04 (5) (b) to (e) are repealed.

SECTION 85. DHS 103.04 (6) (title), (a), and (b) are amended to read:

DHS 103.04 (6) BADGERCARE PLUS. (a) ~~A group that~~ An individual who meets the requirements of s. DHS 103.03 (1) (f) and (2) to (9) and the income limits in this subsection ~~or in s. DHS 103.085 (6)~~ is eligible for BadgerCare Plus.

(b) For all ~~applicant~~ children under age 19, pregnant women and individuals requesting only family planning services under s. 49.45 (24s), Stats., in BadgerCare Plus fiscal test groups, the income limit is ~~185%~~ 306% of the poverty line~~, or a lower percentage of the poverty line established by the department in accordance with s. 49.665 (4) (at), Stats~~.

SECTION 86. DHS 103.04 (7) is repealed and recreated to read:

DHS 103.04 (7) SPECIAL BADGERCARE PLUS BUDGETING PROCEDURES.

(a) *Definition*. In this subsection, "MAGI" means modified adjusted gross income, as defined in 42 USC 435.603 (e).

(b) *MAGI budgeting rules.* MAGI rules shall be used to determine eligibility for BadgerCare Plus. For eligibility determinations, all of the following apply:

1. MAGI rules in this section shall be used to determine financial eligibility for individuals who are BadgerCare Plus-related individuals under s. DHS 103.03 (1) (b), except for individuals under s. DHS 103.03 (1) (b) 4. and 5., and who are non-financially eligible for BadgerCare Plus under s. DHS 103.03 (f).

2. MAGI income shall be determined by doing all of the following:

a. Identifying the members of each individual's BadgerCare Plus fiscal test group per sub. (7) (b), and determining the group size.

b. Adding the countable income per sub. (7) (d) of all members of the individual's BadgerCare Plus fiscal test group per sub. (7) (c).

c. Comparing the total income of each individual's BadgerCare Plus fiscal test group to the federal poverty line for that group's size.

(c) *BadgerCare Plus fiscal test group*. Persons are included in an individual's BadgerCare Plus fiscal test group based on whether the individual meets any of the following conditions

1. 'Tax rules.' If the individual expects to file a federal tax return and will not be claimed as a tax dependent of another person, the person's BadgerCare Plus fiscal test group shall consist of the tax filer, the tax filer's spouse, and any dependents the tax filer is claiming. All of the following rules apply to the BadgerCare Plus fiscal test group:

a. If there is a pregnant woman in the group, the BadgerCare Plus fiscal test group shall include the number of expected babies.

b. Whether the individual is a tax filer, a dependent of a tax filer, and who is a tax dependent of the individual is based on the individual's plans for the same calendar year's taxes in which eligibility is being determined.

c. A tax filer may claim persons living outside their home as their tax dependents.

d. A tax filer may claim a deceased child as a tax dependent in the tax year the child died.

e. A tax filer may file jointly with a deceased spouse in the tax year the spouse died.

f. A BadgerCare Plus fiscal test group shall include deployed military members who are spouses or tax dependents of the tax filer.

g. A BadgerCare Plus fiscal test group shall include the individual's spouse if living with the individual, even if they are filing taxes separately.

h. A BadgerCare Plus fiscal test group shall include the individual's spouse when they are living apart if they are filing taxes jointly.

i. A BadgerCare Plus fiscal test group shall not include the individual's spouse, if they are living apart and are filing taxes separately or not planning to file taxes.

j. A tax dependent's BadgerCare Plus fiscal test group shall include the same individuals as the tax filer's, even if the tax dependent is also a tax filer, except that a BadgerCare Plus fiscal test group will be based on par. (b) 2. if the person is under age 19, lives with one parent and is being claimed as a tax dependent by a parent outside of the home; the person is being claimed as a tax dependent by someone who is not their parent or spouse; or the person is under age 19, lives with both parents and the parents are not filing taxes jointly.

2. 'Relationship rules.' If a person meets an exception in par. (b) 1. j. of this section or they are not tax filers or tax dependents, the person's BadgerCare Plus fiscal test group shall include of any of the following people living in the same home:

a. If the person is under 19, the person's parents, spouse, siblings under age 19, and children.

b. If the person is over age 19, the person's spouse and children under age 19.

c. If there is a pregnant woman in the group, the number of expected infants.

d. Deployed military members.

3. 'Former foster care youth.' A former foster care youth's BadgerCare Plus fiscal test group shall only include the person, except that if the person's spouse is also a former foster care youth, the BadgerCare Plus fiscal test group shall include the spouse.

4. 'Family planning services.' For family planning services, the BadgerCare Plus fiscal test group shall only include the one person.

(d) *Budgeting income for the BadgerCare Plus fiscal test group*.

1. The MAGI-based countable income defined in par. (d), of all persons in the BadgerCare Plus fiscal test group shall be included when determining eligibility except that the income of a child under age 19 or a tax dependent of a group member is only counted if the child or tax dependent is expected to be required to file a tax return for the current year.

2. If a person's income is budgeted for the BadgerCare Plus fiscal test group, his or her deductions will be counted for that group.

3. If a person is filing a joint tax return with his or her spouse, the person's deductions may offset the spouse's income even if the person has no income.

(e) *MAGI-based countable income*. MAGI-based countable income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in 26 USC 36B (d) (2) (B), subject to any of the following exceptions:

1.MAGI-based countable income will include any Social Security benefits, tax-exempt Interest, and foreign earned income.

2. Taxable lump sum payments are only counted in the month received.

3. Educational scholarships, awards, or fellowships used for educational purposes are not counted, even if taxable.

4. American Indian/Alaska Native specified income at 42 CFR 435.603 (e) (3) is not counted.

SECTION 87. DHS 103.04 (8) (b) 4. is created to read:

DHS 103.04 (8) (b) 4. Medical and remedial expenditures and long-term care costs in excess of $500 per month incurred by the individual or, if the individual and spouse are living together, the spouse.

SECTION 88. DHS 103.05 (1) (intro.) and (a) are amended to read:

DHS 103.05 (1) MEANING OF CHILD−ONLY CASE. A child−only case exists when any of the following occur:

(a) A family has been determined financially ineligible for ~~AFDC~~ BadgerCare Plus−related MA only and there is a child in the family who is SSI−related but not receiving SSI payments~~;~~.

SECTION 89. DHS 103.05 (1) (b) is repealed and recreated to read:

(b) A child under age 19 is not living with a parent.

SECTION 90. DHS 103.05 (1) (c) to (e) are repealed.

SECTION 91. DHS 103.05 (5) (a) is repealed.

SECTION 92. DHS 103.05 (5) (b) is renumbered DHS 103.05 (5).

SECTION 93. DHS 103.06 (15) (a) 2. is amended to read:

DHS 103.06 (15) (a) 2. All contributions to the recipient's independence account or accounts, including interest, dividends, or other gains from the principal, shall be treated as an exempt asset for the purpose of calculating eligibility for ~~the medicaid purchase plan~~ any SSI-related MA.

SECTION 94. DHS 103.07 (1) (b) (intro.) and 1. are amended to read:

DHS 103.07 (1) (b) *Allocation of institutionalized person's income to dependents outside the institution*. Except as provided under s. DHS 103.075 (6), no allocation may be made from an institutionalized applicant's or recipient's income to a spouse who is eligible for SSI but who refuses to obtain SSI. Except as provided under s. DHS 103.075 (6), no allocation may be made to a spouse or to minor children under the spouse's care if the spouse or any of the children are receiving ~~AFDC or~~ SSI. Otherwise, allocations shall be made as follows:

1. If the spouse is caring for a minor child for whom either the institutionalized person or the spouse is legally responsible, the AFDC assistance standard as specified in s. 49.19 (11) (am) 1m., Stats., plus expenses that would be allowed under s. DHS 103.04 (3) shall be used to determine the need of the spouse and children. If their total net income is less than their need, income of the institutionalized person shall be allocated in an amount sufficient to bring the spouse's and children's income up to their monthly need. In this subdivision, "total net income" means income equal to unearned income plus ~~net~~ earned income~~, and "net earned income" means income equal to gross earned income minus work−related expenses according to requirements of AFDC. Income disregards of the AFDC program under 45 CFR 233.20 (a) shall be used as appropriate in computing income~~.

SECTION 95. DHS 103.07 (2) (g) is amended to read:

DHS 103.07 (2) (g) *Income disregards*. Income disregards ~~of the AFDC program under 45 CFR 233.20 (a) and~~ of the SSI program under 20 CFR 416.1112 and 416.1124 shall be used as appropriate.

SECTION 96. DHS 103.08 (2) (a) 2., (b), and (c) 1. to 3. are amended to read:

DHS 103.08 (2) (a) 2. The ~~AFDC~~ BadgerCare Plus−related or SSI−related MA group shall be eligible as of the date within the spend−down period on which the expenditure of excess income or the obligation to expend excess income is achieved.

DHS 103.08 (2) (b) If the amount of the monthly excess income changes before the expenditure or obligation of excess income is achieved, the expenditure or obligation of excess income for the remainder of the 6–month period shall be recalculated. When the size of the ~~AFDC~~ BadgerCare Plus −related or SSI−related MA group changes, the monthly income limit shall be adjusted appropriately to the size of the new group, and the amount of excess income to be expended or obligated shall be adjusted accordingly. If any change is reported that may affect eligibility, the eligibility of the entire ~~AFDC~~ BadgerCare Plus −related or SSI−related MA group may be redetermined and, if there is determined to be excess income, a new spend–down period shall be established.

DHS 103.08 (2) (c) 1. Once the expenditure or obligation of excess income has been achieved, the ~~AFDC~~ BadgerCare Plus −related or SSI−related MA group shall be eligible for the balance of the 6–month spend–down period, unless it is determined that assets have increased enough to make the MA group ineligible, or that a change in circumstances has caused someone in the MA group to become ineligible for non−financial reasons.

2. If the entire group is determined ineligible, the MA benefits shall be discontinued with proper notice. If only one person in the MA group is determined ineligible for non−financial reasons, only that person's ~~AFDC~~ BadgerCare Plus −related or SSI−related MA benefits shall, with proper notice, be discontinued. The other person or persons in the MA group continue their eligibility until the end of the 6–month period.

3. If the size of the MA group increases due to the addition of a child, that child is eligible for benefits during the rest of the spend–down period. An adult caretaker who enters the ~~AFDC~~ BadgerCare Plus −related or SSI−related MA group, except a woman who is medically verified as pregnant or a person who is SSI–related, is not eligible for benefits during the remainder of the spend–down period.

SECTION 97. DHS 103.085 (title), (1) (a), and (b) 1. to 4. are amended to read:

DHS 103.085 **Conditions for continuation of eligibility for BadgerCare Plus.** (1) PREMIUMS.
(a) *Authority*. Subject to s. ~~49.665 (5)~~ 49.471 (10) (b) 2., Stats., and this section, a ~~group~~ child under the age of 19 eligible for BadgerCare Plus may be required to pay a premium.

(b) *Applicability*. 1. A ~~group~~ child under age 19 eligible for BadgerCare Plus with budgetable income at or below ~~150%~~ 201% of the poverty line is not required to pay a premium toward the cost of the health care coverage.

2. Except as provided in subd. 3., ~~or~~ 4., or 5., a ~~group~~ child under age 19 eligible for BadgerCare Plus with budgetable income above ~~150%~~ 201% of the poverty line shall pay a premium toward the cost of the health care coverage.

3. A BadgerCare Plus applicant group does not owe a premium for the first month of BadgerCare Plus unless a member of the BadgerCare Plus fiscal test group was an MA recipient in the previous month.

4. A BadgerCare Plus applicant group does not owe a premium for the first month of BadgerCare Plus unless a member of the BadgerCare Plus fiscal test group was a BadgerCare Plus recipient in the previous 12 months.

SECTION 98. DHS 103.085 (1) (b) 5. is created to read:

DHS 103.085 (1) (b) 5. A child under the age of 19 shall not be required to pay a premium if any of the following apply:

a. The child is a Native American or an Alaskan Native.
b. The child is under age 1.
c. The child is pregnant.
d. The child is eligible under s. 49.471 (4) (a) 5., Stats.
e. The child is eligible under s. 49.471 (4) (a) 7., Stats.
f. The child is eligible under s. 49.471 (7) (b) 2., Stats.

SECTION 99. DHS 103.085 (1)(c) and Table 103.085 are amended to read:

(c) *Amounts*. A ~~group~~ child eligible for BadgerCare Plus required under this subsection to pay a premium shall pay the amount indicated in the schedule provided in Table 103.085, except as provided under sub. (cm). Income for each child's BadgerCare Plus fiscal test group shall be determined according to s. DHS 103.07.

Table 103.085
BadgerCare Plus Premium Schedule

Monthly Income as a Percentage of the Poverty Line		**Monthly Premium**
From	**To**	
~~$ 1,000~~ Above 201%	~~$ 1,499.99~~ 210.99%	$ ~~30~~ 10
~~$ 1,500~~ 211%	~~$ 1,999.99~~ 220.99%	$ ~~45~~ 10
~~$ 2,000~~ 221%	~~$ 2,499.99~~ 230.99%	$ ~~60~~ 10
~~$ 2,500~~ 231%	~~$ 2,999.99~~ 240.99%	$ ~~75~~ 15
~~$ 3,000~~ 241%	~~$ 3,499.99~~ 250.99%	$ ~~90~~ 23
~~$ 3,500~~ 251%	~~$ 3,999.99~~ 260.99%	$ ~~105~~ 34
~~$ 4,000~~ 261%	~~$ 4,499.99~~ 270.99%	$ ~~120~~ 44
~~$ 4,500~~ 271%	~~$ 4,999.99~~ 280.99%	$ ~~135~~ 55
~~$ 5,000~~ 281%	~~$ 5,499.99~~ 290.99%	$ ~~150~~ 68
~~$ 5,500~~ 291%	~~$ 5,999.99~~ 300.99%	$ ~~165~~ 82
~~$ 6,000~~ 301%	~~$ 6,499.99~~ 306%	$ ~~180~~ 97.53
~~$ 6,500~~	~~$ 6,999.99~~	~~$ 195~~
~~$ 7,000~~	~~$ 7,499.99~~	~~$ 210~~
~~$ 7,500~~	~~$ 7,999.99~~	~~$ 225~~
~~$ 8,000~~	~~$ 8,499.99~~	~~$ 240~~
~~$ 8,500~~	~~$ 8,999.99~~	~~$ 255~~
~~$ 9,000~~	~~$ 9,499.99~~	~~$ 270~~
~~$ 9,500~~	~~$ 9,999.99~~	~~$ 285~~
~~$ 10,000~~	~~$ 10,499.99~~	~~$ 300~~
~~$ 10,500~~	~~$ 10,999.99~~	~~$ 315~~

SECTION 100. DHS 103.085 (1) (cm) is created to read:

DHS 103.085 (1)(cm) *Caps on premiums*. Families must pay either the combined premiums for all of the children required to pay or an amount equal to five percent of the family's countable monthly income, whichever is less.

SECTION 101. DHS 103.085 (1) (d) 1. is amended to read:

DHS 103.085 (1)(d) *Payment*. 1. ~~A group~~ All children otherwise eligible for BadgerCare Plus ~~that is~~ in a family who are required to pay a premium under this section shall pay the premium amount in full to the agency before the agency may certify the ~~group's~~ children's initial eligibility for BadgerCare Plus.

SECTION 102. DHS 103.085 (1) (d) 5. is repealed.

SECTION 103. DHS 103.085 (1) (e) (intro.) is amended to read:

DHS 103.085 (1)(e) *Refunds*. The department shall issue a refund for a premium which has been paid ~~in advance~~ when the premium is for one of the following:

SECTION 104. DHS 103.085 (1) (e) 1. is repealed.

SECTION 105. DHS 103.085 (1) (e) 2. and (f) amended to read:

DHS 103.085 (1) (e) 2. A month that the ~~group's~~ child's budgetable income drops to or below ~~150%~~ 200% of the poverty line and the change in income that brought the ~~group's~~ child's budgetable income to or below ~~150%~~ 200% of the poverty line was reported within 10 days of the date the change occurred.

DHS 103.085 (1)(f) *Consequence of failure to pay BadgerCare Plus premiums*. A ~~group~~ child required to pay a premium shall be ineligible for re−enrollment for the period specified in sub. (3) when the group fails to pay its premium within the time specified in par. (d).

SECTION 106. DHS 103.085 (2) is repealed.

SECTION 107. DHS 103.085 (3) (a) is amended to read:

(3) RE−ENROLLMENT RESTRICTION. (a) *Period of ineligibility*. A BadgerCare Plus group that fails to make a premium payment under sub. (1~~) or quits BadgerCare under sub. (2)~~ is not eligible for BadgerCare Plus for a period of at least ~~6~~ 3 consecutive calendar months following the date that BadgerCare Plus eligibility ends, unless one of the circumstances in par. (b) applies. Eligibility is restored as described in par. (c). After ~~6~~ 3 calendar months, the ~~group~~ child shall be eligible for BadgerCare Plus ~~only~~ if ~~all past premiums due are paid in full or 12 calendar months have passed after the expiration of BadgerCare eligibility, whichever is sooner~~ otherwise eligible.

SECTION 108. DHS 103.085 (3) (b) (intro.) is amended to read:

DHS 103.085 (3) (b) The restriction on re-enrollment under this section does not apply ~~if the failure to pay premiums was due to a circumstance beyond the group's control, provided that all past due premiums have been paid in full. A circumstance beyond the group's control includes~~ for any of the following reasons:

SECTION 109. DHS 103.085 (3) (b) 1. to 3. are repealed and recreated to read:

DHS 103.085 (3) (b) 1. The failure to pay premiums was due to a circumstance beyond the group's control, provided that all past due premiums have been paid in full. A circumstance beyond the group's control includes any of the following:

a. A problem with an electronic funds transfer from a bank account to the BadgerCare Plus program.
b. A problem with an employer's wage withholding.
c. An administrative error in processing the premium.
d. A fair hearing decision.

2. The child's income decreases to at or below 201% of the poverty line.

3. Payment is received in full for all owed premiums before the end of the three-month restrictive re-enrollment period.

SECTION 110. DHS 103.085 (3) (c) 1. is amended to read:

DHS 103.085 (3)(c) 1. For a ~~BadgerCare group~~ child with a reason under par. (b) 1. for the re−enrollment restriction not to apply, BadgerCare Plus eligibility shall be restored for any months that the group had been closed during the restriction period, provided that payment of any outstanding premiums owed is made and the ~~group~~ child was otherwise eligible for BadgerCare Plus in those months.

SECTION 111 DHS 103.085 (3) (c) 2. is repealed and recreated to read:

DHS 103.085 (3)(c) 2. For a child with a reason under par. (b) 3. for the re−enrollment restriction not to apply, BadgerCare Plus eligibility shall be restored for any calendar months that the child's BadgerCare Plus fiscal test group's income was at or below 201% of the poverty line and the child was otherwise eligible for BadgerCare Plus in those months.

SECTION 112. DHS 103.085 (3) (c) 3. is created to read:

DHS 103.085 (3)(c) 3. For a child with a reason under par. (b) 4. for the re−enrollment restriction not to apply, BadgerCare Plus eligibility shall be restored for all months that the child had been ineligible during the restriction period, provided that payment of any outstanding premiums owed is made and the child is otherwise eligible for BadgerCare Plus in those months.

SECTION 113. DHS 103.085 (4) and (5) are repealed.

SECTION 114. DHS 103.087 (1) (b) 1. and 2. are amended to read:

DHS 103.087 (1)(b) *Applicability*. 1. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is ~~at or~~ above ~~150%~~ 100% of the poverty line for the applicable household size shall pay a monthly premium and the applicant shall pay all retroactive premium amounts assessed or other premium payments due.

2. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is at or below ~~150%~~ 100% of the poverty line for the applicable household size ~~need not~~ pay does not owe a monthly premium.

SECTION 115. DHS 103.087 (1) (b) 3. is repealed.

SECTION 116. DHS 103.087 (1) (c) 1. and 4. are amended to read:

DHS 103.087 (1)(c) *Premium amounts*. 1. An applicant or recipient eligible for the medicaid purchase plan shall pay a monthly premium in accordance with this subsection ~~and the premium schedule in Table 103.087~~.

4. The applicant's or recipient's monthly premium shall be ~~calculated by locating the sum of the monthly adjusted unearned income plus the monthly adjusted earned income on the premium schedule in Table 103.087~~ at least $25.

SECTION 117. DHS 103.087 (1) (d) (title) and 1. are consolidated and renumbered DHS 103.087 (1)(d) and amended to read:

DHS 103.087 (1) (d) *Calculating the monthly adjusted earned and unearned income*. 1. An applicant's or recipient's monthly adjusted ~~unearned~~ income shall be calculated by subtracting ~~the monthly income disregards in subd. 1. a. to c.~~ from ~~100% of the~~ applicant's or recipient's gross monthly countable earned and unearned income, their actual out-of-pocket medical and remedial expenses, long-term care costs, and impairment-related work expenses.

SECTION 118. DHS 103.087 (1) (d) 1. and 2., and (1) (e) are repealed.

SECTION 119. DHS 103.087 (1) (f) 1. and 2. b. are amended to read:

DHS 107.087 (1) (f) 1. ~~The sum of the amounts determined in pars. (d) and (e) shall be applied to the premium schedule in Table 103.087. If the sum of the monthly adjusted earned and monthly adjusted unearned income is greater than $1025.00, the total monthly premium amount is the exact amount of the sum.~~ An applicant or recipient shall pay 3 percent of his or her adjusted earned and unearned monthly income under par. (d) that is in excess of 100 percent of the poverty line plus $25.

DHS 107.087 (1) (f) 2. b. A change in the poverty line ~~or SSI federal or state benefit payment rate~~.

SECTION 120. DHS 103.087 (1) (f) 2. bm. is created to read:

DHS 107.087 (1) (f) 2. bm. A change in the SSI federal or state benefit payment rate, except that an annual cost of living adjustment to the SSI benefit payment rates will not affect the monthly premium amount until after the subsequent change in the poverty line.

SECTION 121. DHS 103.087 (1) (g) 5. is amended to read:

DHS 103.087 (1)(g) 5. ~~An~~ The applicant or recipient ~~may~~ shall pay monthly ~~premiums in advance, but only for the months in the applicant's or recipient's current medicaid review period~~ premium amounts in full.

SECTION 122. DHS 103.087(1) (h) 3. e. is created to read:

DHS 103.087(1) (h) 3.e. Approval for a temporary premium waiver because the department has determined that paying the premium would be an undue hardship on the individual.

SECTION 123. DHS 103.087 (1) (i) 2. is amended to read:

DHS 103.087 (1)(i)2. A medicaid purchase plan participant who fails to make his or her monthly premium payments in the medicaid purchase plan shall be ineligible for a period of ~~at least 6~~ 3 consecutive calendar months following the date that the medicaid purchase plan eligibility ends except for any month during that period when the recipient's individual income does not exceed 100 percent of the poverty line. ~~After 6~~ During these 3 calendar months, the person shall be eligible for the medicaid purchase plan only if all past premiums due are paid in full or ~~12 calendar months have passed since the expiration of medicaid purchase plan eligibility, whichever is sooner~~ a hardship waiver has been granted

for the months the past due premiums are owed or a combination of the two. After these three calendar months have passed, a medicaid purchase plan recipient can be eligible.

SECTION 124. Table 103.087: Medicaid Purchase Plan Premium Schedule is repealed.

SECTION 125. DHS 103.09 (2) is repealed and recreated to read:

DHS 103.09 (2) FOUR−MONTH CONTINUATION OF ELIGIBILITY. (a) When a parent, caretaker, or pregnant person eligible for BadgerCare Plus has an increase in MAGI-based countable monthly income under s. DHS 103.04 (7) (d) that exceeds 100% of the federal poverty line, BadgerCare Plus eligibility for the persons identified in (c) will continue for four months when the conditions in (b) are met. Eligibility shall be discontinued when the person is no longer a resident of Wisconsin.

(b) To receive a four-month continuation of BadgerCare Plus eligibility, all of the following conditions must be met by the parent, caretaker or pregnant person:

1. The monthly income increase which caused the countable income to exceed 100% of the poverty line must be due solely to one of the following:
    a. Increased spousal support income.
    b. Increased spousal support income along with other unearned income.
2. There has been no increase in earned income.
3. The person receiving the spousal support is eligible for BadgerCare Plus with monthly income at or below 100% of the poverty line at the time the income increased to over 100% of the poverty line.
4. The person must have been enrolled in BadgerCare Plus with monthly income that was at or below 100% of the poverty line for at least three of the six months immediately preceding the month in which the monthly income went above 100% of the poverty line.
5. The person must otherwise meet the BadgerCare Plus eligibility criteria for persons with monthly income below 100% of the poverty line.

(c) When a parent, caretaker, or pregnant person eligible for BadgerCare Plus meets the condition in (b), any of the following persons in the home, who otherwise meet the BadgerCare Plus eligibility criteria are eligible for BadgerCare Plus for four months past the month in which income exceeded 100% of the poverty line:

1. The parent, caretaker or pregnant person who received the spousal support,
2. All children whose parent or caretaker relative qualify for four months of continued eligibility under this subsection is eligible for the same four months of continued eligibility, provided that they are eligible for BadgerCare Plus in the month prior to the increase in countable income and one of the following applies:
    a. The child is under age one, and the parent or caretaker had MAGI-based countable income at or below 306% of the poverty line and is not eligible under ss. 49.471(4)(a)2. or 2m.
    b. The child is age one through five and the parent or caretaker had MAGI-based countable income at or below 191% of the poverty line.
    c. The child is age six through 18 and the parent or caretaker had MAGI-based countable income at or below 156% of the poverty line.

SECTION 126. DHS 103.09 (3) (a) is repealed.

SECTION 127. DHS 103.09 (3) (b) and (c) are amended to read:

DHS 103.09 (3) (b) When ~~an MA~~ a parent or caretaker relative in a BadgerCare Plus group becomes ineligible ~~for AFDC~~ due to an increase in earned income ~~or an increase in hours of employment or a combination of increased earned income and increased hours of employment~~, eligibility for ~~MA~~ BadgerCare Plus shall continue for 12 months from the date that ~~AFDC~~ eligibility was terminated provided that at least one member of the ~~MA~~ BadgerCare Plus group received ~~AFDC~~ BadgerCare Plus for at least 3 of the 6 months immediately preceding the month in which ~~AFDC~~ BadgerCare Plus was discontinued and at least one member of the ~~MA~~ BadgerCare Plus group is continuously employed during that period.

(c) When ~~an MA~~ a parent or caretaker relative in a BadgerCare Plus group becomes ineligible for ~~AFDC~~ BadgerCare Plus due to an increase in earned income, or to a combination of an increase in earned income and in increase in ~~child~~ spousal support payments, and has received ~~an AFDC~~ BadgerCare Plus in at least 3 of the 6 months immediately preceding the month in which ineligibility begins, eligibility for ~~MA~~ BadgerCare Plus shall continue for 12 months from the date that ~~AFDC~~ BadgerCare Plus eligibility was terminated. The 6 months preceding the month in which ineligibility begins includes the month in which the ~~MA~~ BadgerCare Plus group became ineligible for ~~AFDC~~ BadgerCare Plus if the ~~MA~~ group was eligible for and received ~~AFDC~~ BadgerCare Plus for that month.

SECTION 128. DHS 103.11 (title) and (1) (title) are amended to read:

DHS 103.11 **Presumptive eligibility for pregnant women, family planning only services, and women diagnosed with breast or cervical cancer or precancerous conditions**.

(1) REQUIREMENTS FOR PREGNANT WOMEN.

SECTION 129. DHS 103.11 (1) (intro.) is renumbered DHS 103.11 (1) and amended to read:

Pregnant women may be determined presumptively eligible for MA on the basis of ~~verification of~~ a statement of pregnancy, and preliminary household and financial information ~~about family income~~ provided by the applicant. That determination shall be made by providers or hospitals designated by the department who are qualified in accordance with this section. ~~A provider qualified to make determinations of presumptive eligibility shall meet the following requirements:~~

SECTION 130. DHS 103.11 (1) (a) to (c) are renumbered DHS 103.11 (1d) (a) to (c) and amended to read:

DHS 103.11 (1m) (a) Be certified as an MA provider under ch. DHS 105~~; and~~.

(b) Provide one or more of the following services~~:~~.

1. Outpatient hospital services~~:~~.

2. Rural health clinic services~~; or~~.

3. Clinic services furnished by or under the direction of a physician~~; and~~.

(c) Receive funding or participate in a program under~~:~~.

1. The migrant health center or community health center programs under section 329 or 330 of the public health service act~~;~~.

2. The maternal and child health services block grant programs~~;~~.

3. The special supplemental food program for women, infants and children under section 17 of the child nutrition act of 1966~~;~~.

4. The commodity supplemental food program under D.4 (a) of the agriculture and consumer protection act of 1973~~; or~~.

5. A state prenatal ~~[perinatal]~~ program; and

SECTION 131. DHS 103.11 (1) (c) 5. (Note) is repealed.

SECTION 132. DHS 103.11 (1) (d) is renumbered DHS 103.11 (1m) (d).

SECTION 133. DHS 103.11 (1d) (1h) (1p), and (1t) are created to read:

DHS 103.11 (1d) PROVIDER REQUIREMENTS A provider qualified to make determinations of presumptive eligibility for pregnant women, and women diagnosed with breast or cervical cancer or precancerous conditions shall meet the following requirements:

DHS 103.11 (1h) REQUIREMENTS FOR FAMILY PLANNING ONLY SERVICES. Individuals may be determined presumptively eligible for family planning services, as defined in s. 253.07 (1) (b), Stats., on the basis of preliminary individual and financial information provided by the applicant. That determination shall be made by hospitals designated by the department who are qualified in accordance with this section.

(1p) REQUIREMENTS FOR WOMEN DIAGNOSED WITH BREAST OR CERVICAL CANCER OR PRECANCEROUS CONDITIONS. Women may be determined presumptively eligible for MA on the basis of a diagnosis of breast or cervical cancer or precancerous conditions if they meet the requirements in s. 49.473 (2) (a) through (e), Stats.

(1t) HOSPITAL REQUIREMENTS. A hospital qualified to make determinations of presumptive eligibility for pregnant women, family planning only services, and women diagnosed with breast or cervical cancer or precancerous conditions shall meet all of the following requirements:

(a) Be certified for MA as a general hospital under s. DHS 105.07.

(b) Notify the state Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

(c) Have not been disqualified by the department for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the department.

SECTION 134. DHS 103.11 (2) (a) (intro.), 1. and 2., (b), (c) and (d) are amended to read:

(2) DUTIES AND RESPONSIBILITIES. (a) A qualified provider or hospital shall ascertain presumptive MA eligibility for a pregnant woman or a woman diagnosed with breast or cervical cancer or precancerous conditions or presumptive family planning services eligibility for an individual by:

1. ~~Verifying or obtaining verification of the woman's pregnancy; and~~ Determining on the basis of preliminary information that the applicant's household or individual information meets the applicable non-financial requirements set by the department.9

2. Determining on the basis of preliminary information that the ~~woman's family~~ applicant's household or individual income meets the applicable income limits set by the department.

(b) The provider or hospital shall inform the ~~woman~~ applicant, in writing, of the determination of presumptive eligibility ~~and that she has 14 calendar days from the date of the determination to file an application for MA eligibility with the county department of social services~~.

(c) Within 5 working days following the date on which the determination was made, the provider or hospital shall in writing notify the department ~~and the agency where the woman will apply for MA eligibility~~ of the ~~woman's~~ applicant's presumptive eligibility.

(d) In the event that the provider or hospital determines that ~~a woman~~ the applicant is not presumptively eligible, the provider or hospital shall inform ~~her~~ the applicant that he or she may file an application for MA eligibility at the county department of social services.

SECTION 135. DHS 103.11 (2) (bm) is created to read:

DHS 103.11 (2) (bm) In the event that the provider or hospital determines that the applicant is presumptively eligible, the provider or applicant shall explain to the applicant that the presumptive eligibility is for a temporary enrollment period and to file an application for MA eligibility with the county department of social services.

SECTION 136. DHS 104.01 (9) (b) 2. g. and 104.01 (12) (a) 1. (intro.) and a. to q. are amended to read:

DHS 104.01 (9) (b) 2. g. ~~An AFDC~~ A child is removed from the home as a result of judicial determination or voluntarily placed in foster care by a legal guardian;.

DHS 104.01 (12) (a) 1. Recipients of MA are liable for payment of any copayment or deductible amount established by the department pursuant to s. 49.45 (18), Stats., for the cost of a service, except as provided in this subsection. The recipient shall pay the copayment or deductible to the provider of service. Copayments or deductibles are not required~~:~~ in each of the following circumstances:

a. ~~From recipients who are nursing home residents;~~ A recipient is a resident in a nursing home.

b. ~~From recipients who are members of a health maintenance organization or other prepaid plan for those services provided by the HMO or PHP;~~ Former foster care youth also known as individuals under the age of 26 who were in foster care under the responsibility of any state when they turned 18 years old.

c. ~~From any~~ A recipient ~~who~~ is under age ~~18~~ 19~~;~~.

d. ~~For services furnished to~~ A recipient is a pregnant women ~~if~~ and the services relate to the pregnancy, or to any medical condition which may complicate the pregnancy when it can be determined from the claim submitted that the recipient was pregnant~~;~~.

e. ~~For~~ Services provided are emergency hospital and ambulance services and emergency services related to the relief of dental pain~~;~~.

f. ~~For~~ Services provided are family planning services and related supplies~~;~~.

g. ~~For~~ Services provided are transportation services by a specialized medical vehicle~~;~~.
h. ~~For~~ Services provided are transportation services provided through or paid for by a county social services department~~;~~.
i. ~~For~~ Services provided are home health services or for home nursing services if a home health agency is not available~~;~~.
j. ~~For~~ Services provided are outpatient psychotherapy services received over 15 hours or $500, whichever comes first, during one calendar year~~;~~.
k. ~~For~~ Services provided are occupational, physical or speech therapy services received exceeding 30 hours or $1,500 for any one therapy, whichever occurs first, during one calendar year~~;~~.
L. ~~Case~~ Services provided are case management services provided under s. DHS 107.32~~;~~.
m. ~~Personal~~ Services provided are personal care services provided under s. DHS 107.112~~;~~.
n. ~~Hospice~~ Services provided are hospice care services~~;~~.
o. ~~Alcohol~~ Services provided are alcohol and other drug abuse (AODA) day treatment services~~;~~.
p. ~~Respiratory~~ Services provided are respiratory care for ventilator−assisted recipients provided under s. DHS 107.113~~; or~~.
q. ~~Community~~ Services provided are community support program (CSP) services provided under s. DHS 107.13 (6).

SECTION 137. DHS 105.075 is amended to read:

DHS 105.075 **Rehabilitation hospitals**. For MA certification, a rehabilitation hospital shall be approved as a general hospital under s. 50.35, Stats., and ch. DHS 124~~, including the requirements for rehabilitation services under s. DHS 124.21~~, and shall meet the conditions of participation for medicare and shall have a utilization review plan that meets the requirements of 42 CFR 456.101. No facility determined by the department or the federal health care financing administration to be an institution for mental disease (IMD) may be certified as a rehabilitation hospital under this section.

SECTION 138. DHS 105.34 (intro.) is amended to read:

DHS 105.34 **Rehabilitation agencies**. For MA certification on or after January 1, 1988, a rehabilitation agency providing outpatient physical therapy, or speech and language pathology form, or occupational therapy shall be certified to participate in medicare as an outpatient rehabilitation ~~agency~~ facility under 42 CFR ~~405.1702 to 405.1726~~ 485.50 to 485.74.

SECTION 139. DHS 107.06 (3) (b) 1. is repealed.

SECTION 140. DHS 107.09 (4) (L) and (Note) are repealed.

SECTION 141. DHS 107.11 (2) (intro.), (a) (intro.), and (c) 1. are amended to read:

DHS 107.11 (2) COVERED SERVICES. Services provided by an agency certified under s. DHS 105.16 which are covered by MA are those reasonable and medically necessary services required ~~in the home~~ to treat the recipient's condition. Covered services are: skilled nursing services, home health aide services and medical supplies, equipment and appliances ~~suitable for use in the recipient's home~~, and therapy and speech pathology services which the agency is certified to provide. These services are covered only when performed according to the requirements of s. DHS 105.16 and provided in a ~~recipient's~~ place ~~of residence which is~~ other than a hospital or nursing home. ~~Home health skilled nursing and therapy services are covered only when provided to a recipient who, as certified in writing by the recipient's physician, is confined to a place of residence except that intermittent, medically necessary, skilled nursing or therapy services are covered if they are required by a recipient who cannot reasonably obtain these services outside the residence or from a more appropriate provider. Home health aide services may be~~

~~provided to a recipient who is not confined to the home, but services shall be performed only in the recipient's home.~~ Services are covered only when included in the written plan of care with supervision and coordination of all nursing care for the recipient provided by a registered nurse. Home health services include:

(2) (a) Skilled nursing services provided ~~in a recipient's home~~ under a plan of care which requires less than 8 hours of skilled nursing care per calendar day and specifies a level of care which the nurse is qualified to provide. These are:

(2) (c) 1. These are services ~~provided in the recipient's home~~ which can only be safely and effectively performed by a skilled therapist or speech pathologist or by a certified therapy assistant who receives supervision by the certified therapist according to 42 CFR 484.32 ~~for a recipient confined to his or her home~~.

SECTION 142. DHS 107.11 (5) (t) is repealed.

SECTION 143. DHS 107.112 (2) (a) is amended to read:

DHS 107.112 (2)(a) Prior authorization is required for personal care services in excess of ~~250~~ 50 hours per calendar year.

SECTION 144. DHS 107.113 (1) (intro.), (i), (2) (intro.) and (a), (3) (a), and (4) (f) are amended to read:

DHS 107.113 (1) COVERED SERVICES. Services, medical supplies and equipment necessary to provide life support for a recipient who has been hospitalized for at least 30 consecutive days for his or her respiratory condition and who is dependent on a ventilator for at least 6 hours per day shall be covered services when these services are provided to the recipient in the recipient's home. A recipient receiving these services is one who~~, if the services were not available in the home, would require them as an inpatient in a hospital or a skilled nursing facility,~~ has adequate social support ~~to be treated at home and desires to be cared for at home,~~ and is one for whom respiratory care can safely be provided in ~~the home~~ any setting in which normal life activities take place, other than a hospital; nursing facility, intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under medical assistance for inpatient services that include room and board. Respiratory care shall be provided as required under ss. DHS 105.16 and 105.19 and according to a written plan of care under sub. (2) signed by the recipient's ~~physician~~ provider acting within the scope of the provider's practice for a recipient who lives in a residence that is not a hospital or a skilled nursing facility. Respiratory care includes:

> (1) (i) Case coordination activities performed by the registered nurse designated in the plan of care as case coordinator. These activities include coordination of health care services provided to the recipient ~~at home and coordination of these services~~ with any other health or social service providers serving the recipient.

(2) PLAN OF CARE. A recipient's written plan of care shall be based on the orders of a ~~physician~~ provider acting within the scope of the provider's practice, a visit to the recipient's home by the registered nurse and consultation with the family and other household members. The plan of care established by a home health agency or independent provider for a recipient to be discharged from a hospital shall consider the hospital's discharge plan for the recipient. The written plan of care shall be reviewed, signed and dated by the recipient's ~~physician~~ provider and renewed at least every 62 days and whenever the recipient's condition changes. Telephone orders shall be documented in writing and signed by the ~~physician~~ provider within 10 working days. The written ~~physician's~~ provider's plan of care shall include:

(a) ~~Physician orders~~ Orders by a provider acting within the scope of the provider's practice for treatments provided by the necessary disciplines specifying the amount and frequency of treatment;

(3) (a) All services covered under sub. (1) and all home health services under s. DHS 107.11 provided to a recipient receiving respiratory care shall be authorized prior to the time the services are rendered. Prior authorization shall be renewed every 12 calendar months if the respiratory care under this section is still needed. The prior authorization request shall include the name of the registered nurse who is responsible for coordination of all care provided under the MA program for the recipient ~~in his or her home~~. Independent MA−certified respiratory therapists or nurses in private practice who are not employees of or contracted to a home health agency but are certified under s. DHS 105.19 (1) (b) to provide respiratory care shall include in the prior authorization request the name and license number of a registered nurse who will participate, on 24−hour call, in emergency assessment and management and who will be available to the respiratory therapist for consultation and assistance.

(4) (f) In the event that a recipient receiving respiratory care services ~~at home who~~ is discharged from the care of one respiratory care provider and admitted to the care of another respiratory care provider continues to receive services ~~at home~~ under this section, the admitting provider shall coordinate services with the discharging provider to ensure continuity of care. The admitting provider shall establish the recipient's plan of care as provided under sub. (2) and request prior authorization under sub. (3).

SECTION 145. DHS 107.12 (1) (b), (c), (d) 1. and 2., (e) 1., and (4) (a) are amended to read:

DHS 107.12 (1) (b) Private duty nursing services provided by a certified registered nurse in independent practice are those services prescribed by a ~~physician~~ provider acting within the scope of the provider's practice which comprise the practice of professional nursing as described under s. 441.001 (4), Stats., and s. N 6.03. Private duty nursing services provided by a certified licensed practical nurse are those services which comprise the practice of practical nursing under s. 441.001 (3), Stats., and s. N 6.04. An LPN may provide private duty nursing services delegated by a registered nurse as delegated nursing acts under the requirements of ch. N 6 and guidelines established by the state board of nursing.

(1) (c) Services may be provided only when prescribed by a ~~physician~~ provider acting within the scope of the provider's practice and the prescription calls for a level of care which the nurse is licensed and competent to provide.

(1) (d) 1. A written plan of care, including a functional assessment, medication and treatment orders, shall be established for every recipient admitted for care and shall be incorporated in the recipient's medical record within 72 hours after acceptance in consultation with the recipient and the recipient's ~~physician~~ provider acting within the scope of the provider's practice and shall be signed by the ~~physician~~ provider within 20 working days following the recipient's admission for care. The ~~physician's~~ provider's plan of care shall include, in addition to the medication and treatment orders:

(1) (d) 2. The written plan of care shall be reviewed and signed by the recipient's ~~physician~~ provider acting within the scope of the provider's practice as often as required by the recipient's condition, but not less often than every 62 days. The RN shall promptly notify the ~~physician~~ provider of any change in the recipient's condition that suggests a need to modify the plan of care.

(1) (e) 1. Except as provided in subd. 2., drugs and treatment shall be administered by the RN or LPN only as ordered by the recipient's ~~physician~~ provider acting within the scope of the provider's practice or his or her designee. The nurse shall immediately record and sign oral orders and shall obtain the ~~physician's~~ provider's countersignature within 10 working days.

(4) (a) Any services not included in the ~~physician's~~ provider's plan of care;

SECTION 146. DHS 107.13 (2) (a) 6. and 7., (b), (3) (a) 4. and 7. and (b) and are repealed.

SECTION 147. DHS 107.24 (2) (c) 1., and 4. to 6. are amended to read:

DHS 107.24 (2) (c) 1. Occupational therapy assistive or adaptive equipment. This is medical equipment used ~~in a recipient's home~~ to assist a disabled person to adapt to the environment or achieve independence in performing daily personal functions. Examples are adaptive hygiene equipment, adaptive positioning equipment and adaptive eating utensils.

4. Other home health care durable medical equipment. This is medical equipment used ~~in a recipient's home~~ to increase the independence of a disabled person or modify certain disabling conditions. Examples are patient lifts, hospital beds and traction equipment.

5. Oxygen therapy equipment. This is medical equipment used ~~in a recipient's home~~ for the administration of oxygen or medical formulas or to assist with respiratory functions. Examples are a nebulizer, a respirator and a liquid oxygen system.

6. Physical therapy splinting or adaptive equipment. This is medical equipment used ~~in a recipient's home~~ to assist a disabled person to achieve independence in performing daily activities. Examples are splints and positioning equipment.

SECTION 148. DHS 108.02 (9) (d) (title) 1., 2. (intro) and a. to d., and 3. (intro.) and a. are amended to read:

DHS 108.02 (9) (d) ~~*Withholding*~~ *Suspension of payment involving fraud* ~~*or willful misrepresentation*~~. 1. The department ~~may withhold~~ may suspend MA payments~~, in whole or in part,~~ to a provider ~~upon receipt of reliable evidence that the circumstances giving rise to the need for withholding of payments involve fraud or willful misrepresentation under the MA program~~ after the department determines there is a credible allegation of fraud for which an investigation is pending under the MA program against an individual or entity unless the department has good cause, as provided in subd. 6., to not suspend payments or to suspend payment only in part. ~~Reliable evidence of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges for those activities against the provider or one of its agents or employees by a prosecuting attorney.~~ A credible allegation of fraud is an allegation which has been verified by the department, from any source. Allegations are credible when they have indicia of reliability and the department has reviewed all allegations, facts, and evidence carefully. The department shall act judiciously on a case-by-case basis and will make referrals as appropriate. The department may withhold payments without first notifying the provider of its intention to withhold the payments. A provider is entitled to a hearing under s. DHS 106.12.

2. The department shall send written notice to the provider of the department's ~~withholding~~ suspension of MA program payments within 5 days after taking that action unless requested in writing by a law enforcement agency to temporarily withhold such notice. Law enforcement requests may last up to 30 days and may be renewed in writing up to twice and in no event may exceed 90 days. The notice shall

~~generally set forth the allegations leading to the withholding, but need not disclose any specific information concerning the ongoing investigation of allegations of fraud and willful misrepresentation. The notice shall~~ state all of the following:

a. ~~State that~~ That payments are being withheld in accordance with this paragraph and 42 CFR 455.23~~;~~.

b. ~~State that~~ That the withholding action is for a temporary period, as defined under subd. 3., and cite the circumstances under which ~~withholding~~ the suspension of payments will be terminated~~;~~.

c. ~~Specify when~~ When appropriate, which type of MA claims ~~withholding~~ or business units of a provider for which suspension is effective~~; and~~.

d. ~~Inform the provider that~~ That the provider has a right to submit to the department written evidence regarding the allegations of fraud ~~and willful misrepresentation~~ for consideration by the department. The provider shall be informed of this right.

3. ~~Withholding~~ Suspension of the provider's payments shall be temporary. ~~Withholding~~ Suspension of payment may not continue after any of the following circumstances occurs:

a. The department or prosecuting authorities ~~determines after a preliminary investigation that~~ determine there is not sufficient evidence of fraud ~~or willful misrepresentation by the provider to require referral of the matter to an appropriate law enforcement agency pursuant to 42 CFR 455.15 and, to the extent of the department's knowledge, the matter is not already the subject of an investigation or a prosecution by a law enforcement agency or a prosecuting authority;~~.

SECTION 149. DHS 108.02 (9) (d) 3. b. is repealed.

SECTION 150. DHS 108.02 (9) (d) 3. c. is renumbered DHS 108.02 (9)(d) 3. b. and amended to read:

DHS 108.02 (9)(d) 3. b. Legal proceedings relating to the provider's alleged fraud ~~or willful misrepresentation~~ are completed and charges against the provider have been dismissed. In the case of a conviction of a provider for criminal or civil forfeiture offenses, those proceedings shall not be regarded as being completed until all appeals are exhausted. In the case of an acquittal in or dismissal of criminal or civil forfeiture proceedings against a provider, the proceedings shall be regarded as complete at the time of dismissal or acquittal regardless of any opportunities for appeal which the prosecuting authority may have

SECTION 151. DHS 108.02 (9) (d) 4. to 8. are created to read:

DHS 108.02 (9) (d) 4. The department shall document in writing the termination of a suspension.

5. Whenever a department investigation leads to the initiation of a payment suspension in whole or part, the department shall make a fraud referral to the department of justice medicaid fraud control and elder abuse unit. The fraud referral shall be made in writing, conform to fraud referral performance standards, and be provided to the department of justice medicaid fraud control and elder abuse unit no later than the next business day after the suspension is enacted. If the department of justice medicaid fraud control and elder abuse unit accepts the fraud referral for investigation, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed. On a quarterly basis the department shall request certification from the department of justice medicaid fraud control and elder abuse unit that any matter accepted on the basis of a referral continues to be under investigation. If the

department of justice medicaid fraud control and elder abuse unit declines to accept the fraud referral for investigation, the payment suspension shall be discontinued.

6. The department may find that good cause exists not to suspend payments or to not continue a previously imposed payment suspension if any of the following are applicable:

a. Law enforcement officials have requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

b. Other available remedies implemented by the department more effectively or quickly protect MA funds.

c. The department determines, based upon the submission of written evidence by the provider, that the suspension should be removed.

d. Beneficiary access to items or services would be jeopardized by a payment suspension if the provider is the sole community physician or the sole source of essential specialized services in a community or the provider serves a large number of beneficiaries within a health resources and services administration-designated medically underserved area.

e. Law enforcement declines to certify that a matter continues to be under investigation.

f. The department determines that payment suspension is not in the best interests of the MA program.

7. The department may find that good cause exists to suspend payments in part, or to convert a previously imposed payment suspension in whole to one only in part, to a provider against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

a. Beneficiary access to items or services would be jeopardized by a payment suspension in whole or part because provider is the sole community physician or the sole source of essential specialized services in a community, or the provider serves a large number of beneficiaries within a health resources and services administration-designated medically underserved area.

b. The department determines, based upon the submission of written evidence by the provider, that the suspension should be imposed only in part.

c. The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of the provider and the department determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

d. Law enforcement declines to certify that a matter continues to be under investigation.

e. The department determines that payment suspension is not in the best interests of the MA program.

8. The department shall do all of the following relative to documentation and record retention:

a. Maintain for a minimum of 5 years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including all notices of suspension of payment in whole or part, all fraud referrals to the department of justice medicaid

fraud control and elder abuse unit, all quarterly certifications of continuing investigation status by law enforcement, and all notices documenting the termination of a suspension.

b. Maintain for a minimum of 5 years from the date of issuance all materials documenting each instance where a payment was not imposed, imposed only in part, or discontinued for good cause. This type of documentation shall include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the department anticipates such a good cause will exist.

c. Annually report to the Secretary of the U.S. Health and Human Services.

SECTION 152. DHS 108.02 (10) (intro.) (a), (b), (c) 1. a. to c., 2. to 6., and (d) are amended to read:

DHS 108.02 (10) ESTATE RECOVERY. The department shall file a claim against the estate of a recipient or client or against the estate of the surviving spouse of a recipient or client as provided in ss. ~~46.27 (7g),~~ 49.496~~,~~ and 49.849, Stats., and s. 46.27 (7g), Stats., to recover only the following:

(a) The amount of medical assistance paid on or after October 1, 1991, on behalf of the recipient while the recipient resided in a nursing home~~;~~.

(b) The amount of medical assistance paid on or after July 1, 1995, on behalf of the recipient while the recipient was an inpatient in a hospital and was required to contribute to the cost of care pursuant to s. DHS 103.07 (1) (d)~~;~~.

(c) The amount of medical assistance paid on or after July 1, 1995, for any of the following services provided to the recipient under the medical assistance program or any federal medical assistance waiver program under 42 USC 1396n (c) or 1396u after the recipient attained 55 years of age~~:~~.

1. ~~The~~ Each of the following home health services~~:~~.

a. Skilled nursing services specified in s. DHS 107.11 (2) (a)~~:~~.

b. Home health aide services specified in s. DHS 107.11 (2) (b)~~; and~~.

c. Therapy and speech pathology services specified in s. DHS 107.11 (2) (c)~~:~~.

2. Private duty nursing services specified in s. DHS 107.12~~:~~.

3. Home and community−based waiver services provided pursuant to a waiver authorized under 42 USC 1396n (c) or 1396u~~:~~.

4. Inpatient covered hospital services specified in s. DHS 107.08 (1) (a) provided during a period of time in which the recipient was approved to have home and community−based waiver services funded pursuant to 42 USC 1396n (c) or 1396u~~:~~.

5. Inpatient services which are billed separately by providers and which are listed as non−covered hospital services in s. DHS 107.08 (4) (d) provided during a period of time in which the recipient was approved to have home and community−based waiver services funded pursuant to 42 USC 1396n (c) or 1396u~~; and~~.

6. Legend drugs under s. DHS 107.10 provided during a period of time in which the recipient was approved to have home and community−based waiver services funded pursuant to 42 USC 1396n (c) or 1396u~~; and~~.

(d) The amount of long−term community support services paid on or after January 1, 1996, on behalf of a client for services funded under s. 46.27 (7), Stats., after the client attained 55 years of age.

SECTION 153. DHS 108.02 (11) (a) is amended to read:
DHS 108.02 (11) (a) The department may make adjustments to and settle estate claims and liens filed under s. ~~46.27 (7g),~~ 49.496~~,~~ or 49.849, Stats., and s. 46.27 (7g), 2017 Stats., to obtain the fullest amount practicable.

SECTION 154. DHS 108.02 (11) (a) (Note) is repealed.

SECTION 155. DHS 108.02 (12) (a) 2., 4. to 5., and (b) 2. a. to c. are amended to read:

DHS 108.02 (12) (a) 2. "Decedent" means a deceased recipient or the deceased surviving spouse of a recipient who received benefits that are subject to recovery under s. ~~46.27 (7g),~~ 49.496~~,~~ or 49.849, Stats. and s. 46.27 (7g), 2017 Stats.

4. "Recipient" means a person who received services funded by medical assistance or the long−term community support program under s. 46.27 (7), 2017 Stats.

5. "Waiver applicant" means a beneficiary or heir of a decedent who requests the department to waive an estate claim filed by the department pursuant to s. ~~46.27 (7g),~~ 49.496~~,~~ or 49.849, Stats, and s. 46.27 (7g), 2017 Stats.

DHS 108.02 (12) (b) 2. a. The waiver applicant would become or remain eligible for supplemental security income (SSI), food stamps under 7 USC 2011 to 2029, ~~aid to families with dependent children (AFDC),~~ or medical assistance if the department pursued its claim~~;~~.

b. A decedent's real property is used as part of the waiver applicant's business, which may be a working farm, and recovery by the department would affect the property and would result in the waiver applicant losing his or her means of livelihood~~; or~~.

c. The waiver applicant is receiving general relief, relief to needy Indian persons (RNIP) or veterans benefits based on need under s. 45.40 (1m), Stats.

SECTION 156. DHS 108.02 (12) (f) 2. and (Note) are repealed.

SECTION 157. DHS 108.02 (15) (a) is amended to read:

DHS 108.02 (15) (a) Except as provided in par. (b), estate recovery requirements of ss. ~~46.27 (7g),~~ 49.496~~,~~ and 49.849, Stats., and s. 46.27 (7g), 2017 Stats., and sub. (11) apply to recipients of the medicaid purchase plan.

SECTION 158. DHS 108.02 (15) (a) (Note), and DHS 108.03 (4) are repealed.

SECTION 159. DHS 116.02 (2) to (4) are amended to read:

DHS 116.02 (2) A physician who diagnoses a birth defect in a child~~,~~ or treats a child with a reportable condition ~~or identifies a child with a suspected case of a reportable condition~~.

(3) A pediatric specialty clinic that diagnoses a birth defect in a child~~,~~ or treats a child with a reportable condition ~~or identifies a child with a suspected case of a reportable condition~~.

(4) A hospital that diagnoses a birth defect in a child~~,~~ or treats a child with a reportable condition ~~or identifies a child with a suspected case of a reportable condition~~.

SECTION 160. DHS 116.03 (11) and (12) are amended to read:

DHS 116.03 (11) “Registry" means a database ~~comprised of birth defect or suspected birth defect reports submitted by pediatric specialty clinics, physicians, and hospitals~~ required under s. 253.12 (3) (a) 1., Stats.

(12) “Reporter" means a physician, pediatric specialty clinic or hospital that is required or authorized by s. 253.12 (2), Stats., to convey birth defect ~~or suspected birth defect~~ information to the department.

SECTION 161. DHS 116.03 (13) is repealed.

SECTION 162. DHS 116.04 (1), (2) (a) (intro.), 1. and 2., (b), (c), (3) (a) and (Note), are amended to read:

DHS 116.04 (1) BIRTH DEFECTS FOR WHICH REPORTING IS MANDATORY. Reporters shall report to the department a birth defect ~~or suspected birth defect~~ listed in Appendix A for children in whom the condition is diagnosed or treated by age 2.

DHS 116.04 (2) (a) Except as provided in par. (b), the following persons shall report a birth defect ~~or suspected birth defect~~ to the department:

1. A physician who diagnoses a birth defect or treats a child with a birth defect ~~or identifies a suspected birth defect or treats a child with a suspected birth defect~~.

2. A pediatric specialty clinic that diagnoses a birth defect or treats a child with a birth defect or ~~identifies a suspected birth defect or treats a child with a suspected birth defect~~.

(b) No person specified under par. (a) 1. or 2. need report under this subsection if that person knows that another person specified under par. (a) 1. or 2. or par. (c) has already reported to the department the information required under sub. (3) with respect to the same birth defect ~~or suspected birth defect~~ of the same child.

(c) A hospital that diagnoses a birth defect or treats a child with a birth defect ~~or identifies a suspected birth defect or treats a child with a suspected birth defect~~ may report the birth defect ~~or suspected birth defect~~ to the department.

DHS 116.04 (3) (a) Each report of a child with a birth defect ~~or suspected birth defect~~ shall ~~include the core data items for collection listed in Appendix B~~ include the content and format of the report found in the department’s confidential birth registry form, except as provided in sub. (2) (d).

Note: Reports may be mailed to the Wisconsin Children with Special Health Care Needs Program - Attention Birth Defects Registry, 1 West Wilson Street, P.O. Box 2659, Madison, WI 53701-2659. Reports may be faxed to the Birth Defects Registry at 608-267-3824 ~~or~~ , uploaded electronically with approval and assistance by the Program, or submitted electronically to the Wisconsin Birth Defects Registry through a batch upload. A copy of the form to be used for

reporting birth defects ~~or suspected birth defects~~ may be obtained by writing the Birth Defects Registry at the preceding address or ~~by calling 608-267-9184 or by sending a fax to 608-267-3824~~ directing a web browser to https://dhs.wisconsin.gov/forms/f4/f40054.pdf.

SECTION 163. DHS 116.04 (3) (Note 2) is created to read:

DHS 116.04 (3) (Note 2) The Confidential Birth Registry Report Form, DHS F-40054, is available at https://dhs.wisconsin.gov/forms/f4/f40054.pdf.

SECTION 164. DHS 116.04 (4) and (5) (c) and (d) are amended to read:

DHS 116.04 (4) TIMELINESS OF REPORTS. A report shall be submitted to the department ~~within 15~~ on a monthly basis, or within 30 calendar days after a birth defect ~~or suspected birth defect~~ is identified, whichever occurs later.

DHS 116.04 (5) (c) If the department determines there is a discrepancy in any data reported to the department, the department may request that the reporter provide the department with related birth defect ~~or suspected birth defect~~ information contained in the child's medical records. The reporter shall provide the information to the department within 10 working days after the date the department transmits the request.

(d) With informed consent, the department shall refer a child with a birth defect ~~or suspected birth defect~~ to a local health officer, a local birth to 3 program or an agency under contract with the department to administer the children with special health care needs program for information, referral or follow-up services.

SECTION 165. DHS 118.02 (2) (a) is amended to read:

DHS 118.02 (2) (a) An ~~EMT – basic or EMT – basic IV~~ emergency medical services practitioner.

SECTION 166. DHS 118.02 (2) (b) and (c) are repealed.

SECTION 167. DHS 118.02 (2) (e) is amended to read:

DHS 118.02 (2) (e) ~~A first~~ An emergency medical responder.

SECTION 168. DHS 118.03 (10d) and (10j) are created to read:

DHS 118.03 (10d) “Emergency medical responder” " has the meaning given in s. 256.01 (4p), Stats.

DHS 118.03 (10j) “Emergency medical responder service” means a group of persons licensed by the department under s. 256.15 (8), Stats., who are employed or organized to provide emergency care to sick, disabled, or injured individuals as a response for aid requested through a public service access point in conjunction with the dispatch of an ambulance, but who do not provide ambulance transportation of a patient.

SECTION 169. DHS 118.03 (11) is repealed and recreated to read:

DHS 118.03 (11) “Emergency medical services practitioner” has the meaning given in s. 256.01 (5), Stats.

SECTION 170. DHS 118.03 (13) and (14) are repealed.

SECTION 171. DHS 118.03 (16) (g) and (h), (25) (intro.) and (a) and (b), and (28) to (30) are amended to read:

DHS 118.03 (16) (g) An emergency medical ~~technician~~ services practitioner.

(h) ~~A first~~ An emergency medical responder.

DHS 118.03 (25) "Medical director" means the physician who is designated in an ~~EMT~~ operational plan to be responsible for all of the following off-line medical direction activities:

(a) Controlling, directing and supervising all phases of the emergency medical services program operated under the plan and the ~~EMT's~~ emergency medical services practitioners performing under the plan.

(b) Establishing standard operating protocols for ~~EMTs~~ emergency medical services practitioners performing under the plan.

DHS 118.03 (28) "Off-line medical direction" means medical direction that does not involve voice communication provided to ~~EMTs~~ emergency medical services practitioners and ~~first responders~~ emergency medical responders providing direct patient care.

(29) "On-line medical direction" means medical direction of the activities of an ~~EMT~~ emergency medical services practitioner that involves voice communication provided to the ~~EMTs~~ emergency medical services practitioners by the medical director or by a physician designated by the medical director.

(30) "On-line medical control physician" means a physician who is designated by the medical director to provide voice communicated medical direction to ~~emergency medical technician~~ emergency medical services practitioner and ~~first~~ emergency medical responder personnel and to assume responsibility for the care provided by emergency medical technician and first responder personnel in response to that direction.

SECTION 172. 118.06 (3) (b) 1. a. (Note), 118.07 (1) (a) to (c), and 118.09 (2) (title) and (b), and (3) (intro.) are amended to read:

DHS 118.06 (3) (b) 1. a. (Note) Out-of-hospital trauma care providers include ~~EMTs, first responders~~ emergency medical services practitioners, emergency medical responders, or air medical personnel.

DHS 118.07 (1) (a) All ambulance service providers and ~~first~~ emergency medical responder services shall select one regional trauma advisory council for primary membership by July 30, 2005.

(b) Notwithstanding par. (a), an ~~EMT, first responder~~ emergency medical services practitioner, emergency medical responder, or ambulance service provider may participate in any regional trauma advisory council.

(c) An ambulance service provider or ~~first~~ emergency medical responder service shall notify the department if the service changes membership in an RTAC.

DHS 118.09 (2) DEPARTMENT COORDINATION OF DATA COLLECTED BY TRAUMA CARE FACILITIES, AMBULANCE SERVICE PROVIDERS AND ~~FIRST~~ EMERGENCY MEDICAL RESPONDER SERVICES.

DHS 118.09 (2) (b) Notify trauma care facilities, ambulance service providers and ~~first~~ emergency medical responder services of the required registry data sets and update the facilities and providers, as necessary, when the registry data set changes.

DHS 118.09 (3) SUBMISSION OF DATA. All hospitals, ambulance service providers and ~~first~~ emergency medical responder services shall submit to the department on a quarterly basis trauma data determined by the department to be required for the department's operation of the state trauma registry. The department shall prescribe all of the following:

SECTION 173. DHS 124.09 (6) (b) and DHS 124.39 (3) (b) are amended to read:

DHS 124.09 (6) (b) Communicate these policies to the local emergency medical services system to ensure appropriate routing of emergency cases by emergency medical ~~technicians~~ services practitioners.

DHS 124.39 (3) (b) Upon receipt of a completed application from a hospital for designation as a critical access hospital, the department shall review the application and shall determine if the applicant meets the federal conditions of participation in medicare for critical access hospitals under 42 CFR 485.601 to 485.645, and, if applicable, 42 CFR 412.103(a)(1). If the applicant hospital meets those federal regulations and all requirements under s~~s~~. ~~DHS 124.40 and~~ 124.41, the department shall, within 90 days after receipt of a completed application, recommend certification of the hospital as a critical access hospital to the federal centers for medicare and medicaid services.

SECTION 174. DHS 132.13 (4) (intro.) is amended to read:

DHS 132.13 (4) “Developmental disability" means intellectual disability or a related condition, such as cerebral palsy, epilepsy or autism, but excluding mental illness and ~~infirmities of aging~~ degenerative brain disorder, which is:

SECTION 175. DHS 134.13 (9) (intro.), DHS 134.52 (2) (c), and DHS 134.68 (2) are amended to read:

DHS 134.13 (9) “Developmental disability" means intellectual disability or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and ~~infirmities of aging~~ degenerative brain disorder ~~infirmities of aging~~ degenerative brain disorder, which is:

DHS 134.52 (2) (c) If the individual's medical condition and diagnosis require on-going monitoring and physician supervision, the facility has obtained the concurrence of a physician in the admission decision and information about the person's current medical condition and diagnosis, ~~a physician's plan of care as required by s. 50.04 (2m), Stats.,~~ and any orders from a physician for immediate care have been received by the facility before or on the day of admission;

DHS 134.68 (2) BLOOD AND BLOOD PRODUCTS. Any blood-handling and storage facilities at an FDD shall be safe, adequate and properly supervised~~. If a facility maintains and transfers blood and blood products or only provides transfusion services, it shall meet the requirements of s. DHS 124.17 (3).~~

SECTION 176. DHS 150 is repealed.

SECTION 177. DHS 153.02 (17) is amended to read:

DHS 153.02 (17) “Resident” means any person who is living in Wisconsin with the intention of remaining permanently in the state. ~~A person under the age of 18 is a resident if he or she is determined to be a resident in accordance with s. DWD 11.15.~~

SECTION 178. DHS 163.03 (61) is amended to read:

DHS 163.03 (61) “Lead-based paint" or “lead-bearing paint" means paint or any other surface coating material containing more than 0.06% lead by weight, calculated as lead metal, in the total nonvolatile content of liquid paint, more than 0.5% lead by weight in the dried film of applied paint, or equal to or more than 1 milligram of lead per square centimeter in the dried film of applied paint.

SECTION 179. DHS 163 Appendices A to I are repealed.

SECTION 180. DHS 182.03 (8) is repealed.

SECTION 181. DHS 182.03 (10) is amended to read:

DHS 182.03 (10) “Lead poisoning or lead exposure" ~~means, in reference to children under the age of 6, a level of lead in the blood of 10 or more micrograms per 100 milliliters of blood~~ has the meaning given in s. 254.11 (9), Stats.

SECTION 182. DHS 251.03 (6) is repealed.

SECTION 183. EFFECTIVE DATE. This rule shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22 (2) (intro.), Stats.