CERTIFICATE

STATE OF WISCONSIN)
) SS
DEPARTMENT OF HEALTH AND FAMILY SERVICES)

I, Joseph Leean, Secretary of the Department of Health and Family Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to relating to the Medicaid Purchase Plan were duly approved and adopted by this Department on October 30, 2000.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 30th day of October, 2000.

SEAL:

for Joseph Leean, Secretary
Department of Health and Family Services

00-084

PROPOSED ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING AND CREATING RULES

To amend and create chapters HFS 101 to 103 and 108, relating to the Medicaid Purchase Plan.

Analysis Prepared by the Department of Health and Family Services

This order creates rules that specify the manner in which a new program called the Medicaid Purchase Plan, established under s. 49.472, Stats., as created by 1999 Wisconsin Act 9, will operate. Under the Medicaid Purchase Plan, working adults with disabilities whose family net income is less than 250% of the poverty line are eligible to purchase Medicaid, the name given to Medical Assistance in Wisconsin, on a sliding-fee scale. The order incorporates the rules for operation of the Medicaid Purchase Plan into chs. HFS 101 to 103 and 108, four of the Department's chapters of rules for operation of the Medical Assistance program.

The Medicaid Purchase Plan is projected to provide health care coverage to 1,200 Wisconsin residents with disabilities by the end of Fiscal Year 2001.

Health care coverage under the Medicaid Purchase Plan is identical to the comprehensive package of services provided by Medical Assistance. Persons enrolled in the Medicaid Purchase Plan would also be eligible for Wisconsin's home and community-based waivers under s. 46.27, Stats., provided they meet the functional criteria for these waivers.

The rules created and amended by this order modify the current Medical Assistance rules to accommodate the Medicaid Purchase Plan and in the process provide more specificity than s. 49.472, Stats., as created by Act 9, regarding the non-financial and financial conditions of eligibility for persons under the Medicaid Purchase Plan; define whose income is used when determining eligibility and the monthly premium amount; explain statutory conditions for continuing eligibility; explain how the monthly premium amount is calculated; describe the processes associated with the independence account; and set forth how the Department, in addition to providing Medical Assistance coverage, is to purchase group health coverage offered by the employer of an eligible person or an ineligible family member of an eligible member for the Medicaid Purchase Plan if the Department determines that purchasing that coverage would not cost more than providing Medical Assistance coverage.

The Department, under the authority to amend and create these rules found in ss. 49.45 (10) and 49.472 (3) (h), (4) (a) (intro.) and 2. a., Stats., as created by 1999 Wisconsin Act 9, and s. 227.11 (2) (a), Stats., hereby amends and creates rules interpreting s. 49.472, Stats., as created by 1999 Wisconsin Act 9 as follows:

SECTION 1. HFS 102.04 (3) (d) is amended to read:

HFS 102.04 (3) (d) Within 365 days after the date eligibility was last determined for SSI-related persons and persons eligible for the medicaid purchase plan except that when a person is determined to be permanently 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; and

SECTION 2. HFS 103.01 (1) (a) is amended to read:

HFS 103.03 (1) (a) Eligibility for medical assistance shall be determined pursuant to ss. 49.455, 49.46(1), 49.47(4) and 49.472, 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 3. HFS 101.03 (17x), (34m), (36m), (42m), (51m), (52g), (52r), (52s), (69g), (78u), (80m), (94m), (94p), (94r), (101m), (114q), (115m), (152m), (160m), (160r), (170m), (172m), (180m) and (183) are created to read:

HFS 101.03 (17x) "Benefits counseling" means counseling that describes the effect of earned income on a person's public benefits and other support services, such as food stamps, housing assistance, supplemental security income, social security disability insurance or medical assistance.

(34m) "Cost-effectiveness" means the cost of paying premiums or purchasing health insurance for a medicaid purchase plan recipient through an employer and the associated administrative cost is likely to be less than or equal to the cost of providing medical assistance.

(36m) "Date of account creation" means the date the recipient establishes an independence account with a financial institution.

(42m) "Direct deposit" means an electronic transfer of funds from the recipient's financial institution to the medicaid purchase plan or the department's fiscal agent, initiated by the completion of all registration forms deemed necessary by the department, the recipient's financial institution, or the department's fiscal agent and prepared with evidence of authorized consent from all parties involved in the transaction.

(51m) "Electronic funds transfer" means any electronic transfer of a recipient's financial holdings or a portion of these holdings as determined by the recipient to another account, initiated by the completion of all registration forms deemed necessary by the department, the recipient's financial institution, or the department's fiscal agent and prepared with evidence of authorized consent from all parties involved in the transaction.

(52g) "Employed" means the person receives income for ongoing services and as a result of this income has incurred a potential tax liability. Any of the following may be used to verify employment:

(a) Pay stubs.

(b) Wage tax receipts.

(c) State or federal income tax returns.

(d) Self-employment bookkeeping records.

(e) Employer's wage records.

(f) Statements from employers. Employer statements may include those from personnel officers, supervisors or other employes of the company who have direct knowledge of the applicant's or recipient's wages. The person making the statement must provide evidence (such as employment records, business correspondence, etc.) that the applicant or recipient is or was an employe of the company during the calendar month for which the applicant or recipient requests eligibility.

(g) Other agencies who receive reports of the applicant's or recipient's income directly from the employer.

(52r) "Employment barriers assessment" means an analysis that identifies a person's potential employment barriers, such as physical limitations or problems associated with the person's living situation, education or health or long term care coverage, and strategies for overcoming these potential barriers.

(52s) "Employment plan" means a plan developed by a person describing the manner in which a person shall meet the requirements of a health and employment counseling program.

(69g) "Health and employment counseling program" means services provided within a period of eligibility, which assist a person in pursuing and maintaining employment, that are assembled into an employment plan, reviewed by a screening agency, approved by the department and include all of the following:

(a) Benefits counseling.

(b) Employment barriers assessment.

(c) Resource networking.

(78u) "Impairment-related work expense" means a cost paid for by a medicaid purchase plan applicant or recipient to work that is all the following:

(a) Related to the applicant's or recipient's disability.

(b) Not a cost that any similar worker, without a disability, would also have.

(c) Not reimbursable by another source such as medicare, medical assistance, private insurance or an employer.

(d) Representative of the standard charge for the item or service in the applicant's or recipient's community.

(80m) "Independence account" means an account approved by the department that consists solely of savings, dividends and gains derived from savings and income earned from paid employment after the initial date that a person began receiving medical assistance under the medicaid purchase plan.

(94m) "Medicaid purchase plan" means the medical assistance program allowed under 42 USC 1396a (a) (10) (A) (ii) and s. 49.472, Stats.

(94p) "Medicaid review period" is the calendar month of a medical assistance recipient's application plus 11 calendar months or the medicaid eligibility review calendar month plus 11 calendar months.

(94r) "Medical expense" means a cost paid by a medicaid purchase plan recipient 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.

(101m) "Networking of existing resources" means the identification of and referral to an agency in the person's community for any services necessary to overcome the person's barriers to

employment.

(114q) "Participant" means a person who is participating in a health and employment counseling program.

(115m) "Period of eligibility" means nine calendar months from the initial calendar month of participation in a health and employment counseling program.

(152m) "Remedial expense" means a cost paid by a medicaid purchase plan recipient 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.

(160m) "Screener" means a person certified by the department and employed at a screening agency to review employment plans.

(160r) "Screening agency" means an agency certified by the department to review employment plans.

(170m) "Standard maintenance allowance" means a deduction established by the department and adjusted annually in accordance with increases in the cost of living as described in 20 CFR 404.272. The standard maintenance allowance may not be less than the sum of $20, plus the federal supplemental security income payment level described under 42 USC 1382 (b) plus the state supplemental security income payment described under s. 49.77 (2m), Stats.

(172m) "Substantial gainful activity level" means the income standards as described in 20 CFR 404.1572 and the federal social security administration's program operations manual.

(180m) "Income disregard" means earned or unearned income that is not considered when calculating an applicant's or recipient's monthly premium amount.

(183) "Wrap-around coverage" means the supplemental health care coverage necessary to provide any services which would be covered under medical assistance but which are not covered under the group health plan offered by the employer.

SECTION 4. HFS 103.03 (1) (g) and (h) are created to read:

HFS 103.03 (1) (g) *Medicaid purchase plan non-financial eligibility.* To be non-financially eligible for the medicaid purchase plan a person shall meet the conditions described in par. (c) for SSI-related persons and shall be age 18 or older and the person shall meet any of the following conditions:

1. a. The person shall be employed.

b. The person shall be enrolled in a department-certified health and employment counseling program.

c. The health of the person participating in the medicaid purchase plan for at least 6 months shall have deteriorated to the point that he or she is unable to participate under subpar. a. or b. and the county agency has waived the requirement for a period up to 6 calendar months. The county agency may waive the requirement if the person is hospitalized, injured or suffers any other health

setback. The county agency may waive the requirement as long as it had not granted a waiver of the requirement twice within the 36 months immediately preceding the current waiver request. The waiver periods shall be non-consecutive. The person shall supply proof of health difficulties. In addition to the discretion the county agency has to grant a waiver, the department may grant a temporary waiver of the work requirement upon a showing of good cause.

2. The person meets SSI-related non-financial eligibility requirements under s. HFS 103.03 (1) (c) as verified under s. HFS 103.03 (1) (d) and s. 49.472 (3) (c), Stats.

3. The applicant meets the eligibility requirements described in s. HFS 103.087.

(h) *Medicaid purchase plan health and employment counseling eligibility.* 1. 'Initial eligibility.' To be eligible for the health and employment counseling program within the medicaid purchase plan, a person shall complete an employment plan.

a. The employment plan shall be reviewed by a screening agency and approved by the department before the person receives approval from the department as a participant.

b. The screening agency shall refer the person to community resources as appropriate to meet all employment plan requirements. The screening agency may assist the person in completing the written employment plan or providing any other services required under the plan.

c. A notice of participation status shall be sent by the department to the person, the screener and the appropriate county or tribal economic support office.

2. 'Period of eligibility.' a. A person may participate in a health and employment counseling program for a period of up to nine consecutive calendar months and for any allowable periods of extension described under subpar. (3).

b. Upon completion of a period of eligibility, a person shall be ineligible for a health and employment counseling program for a period of six consecutive calendar months. Following the 6-month period, a person may begin a new period of eligibility, but a given person may only use two periods of eligibility within a period of five consecutive calendar years.

c. Participation in a health and employment counseling program approved by the department meets the eligibility requirement in s. HFS 103.03 (1) (g) (1) b.

3. 'Extending eligibility.' a. If a person is not employed at the end of the period of eligibility, the person may request an extended period of eligibility from the department. The extended period of eligibility shall be valid for a period of three consecutive calendar months.

b. The extended period of eligibility shall be approved by the department.

c. The person may not request more than one extension of eligibility per period of eligibility.

d. After participation in a health and employment counseling ends, a person may continue to receive services from an agency that also provides screening services, in accordance with the agency's rules.

4. 'Retroactive eligibility.' a. A person may request retroactive participation in a health and employment counseling program for a period of up to three months if the person demonstrates he or she met all eligibility requirements of the employment plan during those months.

b. Any retroactive months of eligibility requested by the person shall count toward the period of eligibility as described in this paragraph.

c. The department shall approve requested months of retroactive eligibility.

SECTION 5. HFS 103.04 (8) and (9) are created to read:

HFS 103.04 (8) MEDICAID PURCHASE PLAN FINANCIAL ELIGIBILITY CRITERIA. (a) A person who meets the requirements of ss. HFS 103.03(1) (g) and (2) to (9) and the income and asset limits described in this subsection is eligible for the medicaid purchase plan.

(b) The person's total net family income is less than 250% of the federal poverty line as determined by the person's family size. Net income is calculated using the standard SSI disregards and exemptions. The income disregards are the following:

1. Sixty-five dollars and one-half of the family's remaining earned income. If the family does not have any unearned income, $85 and one-half of the family's remaining earned income.

2. Twenty dollars of any unearned income.

3. Impairment-related work expenses.

(c) The person has non-exempt assets less than the asset limit described under s. 49.472 (3) (b), Stats.

(d) If the person leaves the medicaid purchase plan and subsequently re-enrolls in the program, the person's independence account and any interest, gains, or dividends from that account are disregarded for purposes of subsequent eligibility determinations.

(9) SPECIAL MEDICAID PURCHASE PLAN BUDGETING PROCEDURES. (a) *Medicaid purchase plan group.* Any of the following persons who reside in the home with the applicant or recipient shall be included in determining the family size of the person applying for the medicaid purchase plan, with this family size used in calculating the person's financial eligibility under this section:

1. The applicant.

2. The applicant's spouse.

3. Any dependent child of the applicant as described in s. 49.141, Stats.

(b) *Medicaid purchase plan fiscal test group.* The income of any person listed in par. (a) 1. or 2. shall be included when determining financial eligibility of the applicant.

(c) *Medicaid purchase plan coverage.* 1. Medical assistance under the medicaid purchase plan applies to the applicant or recipient only.

2. The monthly premium for the medicaid purchase plan is calculated using only the income of the applicant or recipient.

SECTION 6. HFS 103.06 (15) is created to read:

HFS 103.06 (15) INDEPENDENCE ACCOUNTS. (a) *Account provisions.* 1. Contributions to any of the recipient's registered independence accounts are subject to the rules described in this section and to any policies of the respective financial institution governing the account.

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.

3. The purpose of an independence account is to allow the recipient to purchase any items or services that may aid in his or her pursuit of personal or financial independence.

4. The medicaid purchase plan recipient shall be the sole owner of any account registered as an independence account.

5. Retirement or pension accounts registered as independence accounts are not required to remain as separate holdings from the recipient's other non-exempt retirement or pension assets.

6. The county agency shall monitor the recipient's independence account as described in the medicaid review period for the medicaid purchase plan. The review process shall include verifying all contributions to the recipient's independence account with the financial institution holding the recipient's account.

7. The sum total a medical assistance recipient deposits in all independence accounts may not exceed an amount equal to 50% of the recipient's gross earned income for the medicaid review period. If a recipient's contributions to his or her independence accounts total more than an amount equal to 50% of his or her gross earned income within the medicaid review period, an amount equal to one-twelfth of the contributions greater than an amount equal to 50% of gross earned income shall be added to the recipient's monthly premium payment under s. HFS 103.087 for the next 12 months of eligibility.

(b) *Independence account registration.* 1. A person shall register each independence account with the county agency. A person shall re-register the independence account with the county agency if the financial institution or other information for the independence account changes.

2. A medicaid purchase plan recipient shall complete an account registration form to register the account as an independence account.

3. The applicant or recipient shall report any changes in personal or financial status that may affect his or her eligibility for medical assistance to the county agency as described in s. HFS 104.02 (6).

4. For all registered independence accounts that are not retirement or pension accounts, the date of account creation may be no earlier than the date a medicaid purchase plan recipient is determined eligible for medical assistance under this section. For all registered independence accounts that are not retirement or pension accounts, the funds in the independence account shall be held separate from a recipient's non-exempt assets.

SECTION 7. HFS 103.087 is created to read:

HFS 103.087 Conditions for continuation of eligibility. (1) PREMIUMS. (a) *Authority.* Subject to this section and s. 49.472, Stats., a person eligible for the medicaid purchase plan shall

pay a monthly premium.

(b) *Applicability.* 1. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is at or above 150% 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 below 150% of the poverty line for the applicable household size need not pay a monthly premium.

3. An applicant or recipient eligible for the medicaid purchase plan whose premium, calculated as described in par. (c), is greater than $10.00 shall pay a premium for the cost of the health care coverage offered under the medicaid purchase plan.

(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.

2. The county agency shall determine the amount of the premium an applicant shall pay according to the guidelines described in this subsection at the time of application.

3. All earned and unearned sources of income available to the applicant or recipient, except for the interest, dividends or other gains accrued from a recipient's independence account, shall be used in the premium determination.

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.

(d) *Calculating the monthly adjusted unearned income.* An applicant's or recipient's monthly adjusted unearned income shall be calculated by subtracting the monthly income disregards in subdivs. 1. to 3. from 100% of the applicant's or recipient's gross monthly countable unearned income.

1. The standard maintenance allowance. The allowance shall be equal to the sum of the monthly federal supplemental security income cash benefit, the monthly state supplemental cash benefit, and 20 dollars, rounded to the nearest dollar.

2. Monthly impairment-related work expenses for an applicant or recipient. To be claimed as a monthly income disregard, the cost may not have been claimed by the applicant or recipient under any other medicaid purchase plan income disregard.

3. Monthly medical and remedial expenses for an applicant or recipient. To be claimed as a monthly income disregard, the cost may not have been claimed by the applicant or recipient under any other medicaid purchase plan income disregard.

4. If the applicant or recipient has monthly unearned income equal to $0, the monthly income disregards described in subdivs. 1. to 3. apply to the applicant's or recipient's gross monthly earned income. If the applicant or recipient has monthly income disregards greater than his or her monthly unearned income, the difference shall be applied as a deduction to the applicant's or recipient's monthly earned income.

(e) *Calculating monthly adjusted earned income.* An applicant's or recipient's monthly adjusted earned income shall be 3 percent of the applicant's or recipient's gross monthly earned income after the amount of any monthly income disregards greater than the applicant's or recipient's total unearned income have been subtracted.

(f) *Calculating the total monthly premium.* 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.

Table 103.087: Medicaid Purchase Plan Premium Schedule

PREMIUM SCHEDULE					
Sum of Monthly Adjusted Earned and Adjusted Unearned Income		The premium is:	Sum of Monthly Adjusted Earned and Adjusted Unearned Income		The premium is:
FROM	TO	**PREMIUM**	FROM	TO	**PREMIUM**
$0	$10.00	$0.00	500.01	525.00	500.00
10.01	25.00	10.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.00	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
425.01	450.00	425.00	950.01	975.00	950.00
450.01	475.00	450.00	975.01	1000.00	975.00
475.01	500.00	475.00	1000.01	1025.00	1000.00

2. The monthly premium shall be recalculated by the county agency to reflect any changes in earned or unearned income as reported by the recipient. A recipient's premium amount may change for any of the following reasons:

a. Termination of the recipient from the medicaid purchase plan.

b. A change in the poverty line or SSI federal or state benefit payment rate.

c. Changes in income, impairment-related work expense costs or medical and remedial expense costs.

d. Contributions to a recipient's independence account greater than an amount equal to 50% of earned income as described in s. HFS 103.06 (15).

e. Other changes in personal or financial status that alter medical assistance eligibility.

(g) *Monthly payments.* 1. Before the county agency may certify an applicant as eligible for the medicaid purchase plan, the applicant who owes a premium under this subsection shall pay the premium amount. The premium amount owed shall include the premiums for all retroactive and current months in which the applicant owes a premium as of the date eligibility is determined.

2. An applicant may claim retroactive medicaid purchase plan eligibility for a period of up to 3 months prior to the month of application, but not prior to January 1, 2000. To be eligible for retroactive eligibility, an applicant shall pay the retroactive premium amount for each month claimed, in full, to the state's fiscal agent via the county agency, prior to the county agency certifying the applicant's eligibility for the medicaid purchase plan.

3. Based on arrangements made by the applicant or recipient, entities other than the applicant or recipient may pay monthly premiums on behalf of the applicant or recipient. The applicant or recipient shall be ultimately responsible for his or her monthly premium payment.

4. If the county agency does not receive payment by the last day of the calendar month for which the premium is owed, the department shall terminate the recipient's eligibility for the medicaid purchase plan, effective the last calendar day of the month.

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

6. If no premium is required and the applicant meets all other eligibility factors, the county agency shall approve the applicant for the medicaid purchase plan.

(h) *Non-payment of medicaid purchase plan premiums.* 1. An applicant or recipient required to pay a monthly premium shall be ineligible for re-enrollment for the period specified in par. (i) 2. when the applicant or recipient fails to pay his or her monthly premium within the time specified in par. (g) 4. resulting in a finding of premium non-payment.

2. Premium non-payment shall include attempted payment with an instrument such as a check or direct deposit, that has been returned, refused or dishonored. A guaranteed form of payment such as a cashier's check or money order shall be required to replace a returned, refused or dishonored payment.

3. Failure to pay premiums due to circumstances beyond the recipient's control may not be considered non-payment, provided that all past due premiums are paid in full. Circumstances beyond the recipient's control are any of the following:

a. Problems with an electronic funds transfer or direct deposit from a financial institution to the medicaid purchase plan program.

b. Problems with an employer's wage withholding.

c. Administrative error in processing the premium.

d. Any other circumstances that may be found to be good cause as determined by the department on a case-by-case basis.

4. At the time of application or anytime thereafter, an applicant or recipient may sign a release statement identifying an emergency contact to receive copies of the person's notice of decision letters.

(i) *Consequences of premium non-payment.* 1. A person eligible for the medicaid purchase plan who fails to pay his or her monthly premium shall be terminated from the medicaid purchase plan and subject to restrictive re-enrollment as described under subdiv. 2.

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 consecutive calendar months following the date that the medicaid purchase plan eligibility ends. After 6 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.

(2) COOPERATION WITH BUY-IN TO EMPLOYER-PROVIDED HEALTH CARE COVERAGE. (a) The applicant eligible for the medicaid purchase plan and the applicant's parent, if the applicant is a dependent child aged 18 or 19, shall cooperate when the department determines whether it is cost-effective to purchase coverage under the employer-provided health plan for the person under s. HFS 108.02 (14). In this subsection, "cooperate" means provide necessary information in order to determine cost-effectiveness, sign up with the health plan when requested by the department and comply with any other requirements of the health plan.

(b) 1. Except as provided in subd. 2., a person who fails or refuses to cooperate with the department's buy-in to employer-provided health care coverage is not eligible for the medicaid purchase plan.

2. An exception to subd. 1. shall be made in cases where a person who is otherwise eligible for medical assistance is unable to enroll in the group health plan on his or her own behalf. An example of a person who is otherwise eligible for medical assistance but unable to enroll in the group health plan on his or her own behalf may be a child whose parent refuses to enroll the child or a spouse unable to enroll on his or her own behalf.

SECTION 8. HFS 108.02 (14) is created to read:

HFS 108.02 (14) MEDICAID PURCHASE PLAN BUY-IN TO EMPLOYER-PROVIDED HEALTH CARE COVERAGE. (a) *Authority.* The department may purchase a group health plan offered by the employer of an eligible person or non-eligible family member if the department determines that purchasing that coverage and the associated administrative expense would not be more costly than providing the medical assistance coverage described under this chapter.

(b) Buy-in to employer-provided coverage. 1. The department shall pay on behalf of the recipient all deductibles, coinsurance and other cost sharing obligations under the group health plan that are for services covered under the state plan, except for the nominal cost

sharing amounts otherwise permitted under section 1916 of the social security act that are the responsibility of the recipient.

2. The department shall purchase coverage by making payment to one of the following:

a. The employer of the recipient.

b. The insurance company that provides the health care coverage offered by the employer.

c. The employe.

3. If a non-medical assistance eligible family member is enrolled in the group health plan in order to obtain coverage for the medical assistance eligible family member, the department shall pay for premiums only and not other cost sharing expenses for the non-medical assistance eligible family member. Premium payments for non-eligible members shall be included in the determination of cost-effectiveness under par. (c).

4. If a person's group health plan offers more services than are covered under the state plan, the department may not pay any deductibles, coinsurance or other cost sharing obligations for non-covered services.

5. Medicaid purchase plan eligible persons enrolled in a group health plan under this section shall be eligible for wrap-around coverage as described in ch. HFS 101.

(c) *Cost-effectiveness determination.* A person's enrollment in a group health plan shall be cost-effective when the amount the department pays for premiums, coinsurance, deductibles, other cost sharing obligations, wrap-around costs and additional administrative cost is likely to be less than or equal to the medical assistance expenditures for an equivalent set of services.

SECTION 9. HFS 108.02 (15) is created to read:

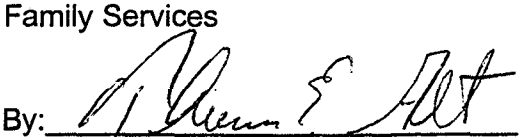
HFS 108.02 (15) ESTATE RECOVERY FOR MEDICAID PURCHASE PLAN. (a) Except as provided in par. (b), estate recovery requirements of sub. (11) and ss. 46.27 (7g), 49.496, and 867.035, Stats., apply to recipients of the medicaid purchase plan.

(b) Amounts recovered in estate recovery from a recipient of the medicaid purchase plan shall be reduced by the total amount of monthly premiums paid by the recipient as a condition of eligibility for the medicaid purchase plan.

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22 (2), Stats.

Wisconsin Department of Health and Family Services

Dated: 10-30-00

By: 
for Joseph Leean
Secretary

SEAL:

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

October 30, 2000

Mr. Bruce E. Munson
Revisor of Statutes
131 W. Wilson St., Suite 800
Madison, WI 53703

Dear Mr. Munson:

As provided in s. 227.20, Stats., there is hereby submitted a certified copy of amendments to chs. HFS 101 to103 and 108, relating to the Medicaid Purchase Plan. **The rulemaking order submitted to you on October 16th contained a small error in a sentence in s. HFS 103.03 (1) (g) 1. c. This version contains the correct, intended language.**

These rules are also being submitted to the Secretary of State as required by s. 227.20, Stats.

The rule changes will not affect small businesses as defined in s. 227.114 (1) (a), Stats.

Sincerely,

for Joseph Leean
Secretary

Enclosure