Senator Vukmir
Representative Loudenbeck
Representative Nygren
Senator Darling

HEALTH SERVICES

MEDICAID SERVICES
MENTAL HEALTH, PUBLIC HEALTH, AND OTHER PROGRAMS
FOODSHARE

Omnibus Motion

Motion:

Move to adopt the following provisions:

1. *Medical Assistance Cost-to-Continue [Paper #320]*. Adopt Alternative 1, which would reduce funding for MA benefits by $35,436,400 (-$26,416,500 GPR, -$37,093,800 FED, $29,990,600 PR, and -$1,916,700 SEG) in 2017-18 and $98,794,800 (-$69,154,100 GPR, -$67,434,000 FED, $39,463,900 PR, and -$1,670,600 SEG) in 2018-19 to reflect a reestimate of providing MA benefits in the 2017-19 biennium under a cost-to-continue scenario.

In addition, provide $50,000,000 GPR in 2018-19 to increase the Joint Committee on Finance program supplements appropriation.

2. *SeniorCare Cost-to-Continue* [Paper #321]. Adopt the modification, which would reduce funding for SeniorCare benefits by $22,998,000 (-$4,790,600 GPR, -$4,037,100 FED, and -$14,170,300 PR) in 2017-18 and by $30,304,800 (-$4,549,600 GPR, -$3,647,800 FED, and -$22,107,400 PR) in 2018-19 to reflect a reestimate of providing SeniorCare benefits in the 2017-19 biennium under a cost-to-continue scenario.

3. *Nursing Home and ICF-IID Reimbursement [Paper #322]*. Adopt Alternative 1A, which would increase MA reimbursement rates paid to nursing homes by 2% in 2017-18, and by an additional 2% in 2018-19. Modify the Governor's recommendation by reducing funding by $608,500 (-$251,800 GPR and -$356,700 FED) in 2017-18 and $1,332,200 (-$561,900 GPR and -$770,300 FED) in 2018-19. Adopt Alternative 2A, which would approve the Governor's recommendation to increase funding for behavioral and cognitive impairment incentive payments to nursing homes by $10 million in the biennium. (The bill provides $2,064,700 GPR and $2,935,300 FED in 2017-18 and $2,054,700 GPR and $2,945,300 FED in 2018-19 for this purpose.) Adopt Alternative 3A, which would increase MA reimbursement rates paid to intermediate care facilities for individuals with intellectual disabilities by 1% in 2017-18, and by an additional 1% in 2018-19. Modify the Governor's recommendation by reducing funding by $226,600 (-$93,800 GPR and -$132,800 FED) in 2017-18 and $458,900 (-$190,200 GPR and -$268,700 FED) in 2018-19.

4. *Children's Long-Term Support (CLTS) Waiver Program [Paper #323].* Adopt Alternative A1, which would adopt the Governor's recommendation to provide funding to support services for children who are currently on the waiting list for CLTS services. Modify the Governor's recommendation by increasing funding by $94,900 ($191,600 GPR and -$96,700 FED) in 2017-18 and $184,200 ($222,600 GPR and -$38,400 FED) in 2018-19. Adopt Alternative B1, which would adopt the Governor's recommendation to approve all statutory changes in the bill relating to adopting a maintenance of effort requirement, requiring the counties to cooperate with DHS to determine an equitable funding methodology and county contribution mechanism, and authorizing DHS to contract with a county or group of counties to deliver services under the program. Adopt Alternative C1 to repeal Act 55 provisions that specify that any funding the state retains for the provision of school based services that exceed $42.2 million in the 2015-16 and $41.7 million in 2016-17 be transferred to the MA trust fund to fund services for children on the CLTS waiting list, effective December 31, 2017.

5. *Childless Adult Employment and Training Waiver [Paper #324].* Adopt Alternatives A1, A3, B4, and C1, which would do the following:

(a) Approve the Governor's recommendation to direct the Department to request a waiver amendment to include a work and training program for childless adults enrolled in MA;

(b) Require the Department to submit a report to the Joint Committee on Finance no later than three months following the final approval of the proposed waiver amendment by the Centers for Medicare and Medicaid Services. Specify that the report shall include the following: (1) a description of each component of the approved waiver, including any pertinent information on the Department's plan for implementation; and (2) an estimate of the impact on MA enrollment and the MA budget of the waiver provisions in the 2017-19 biennium and beyond;

(c) Specify that the Department may not implement the provisions of the waiver unless the Committee meets under s. 13.10 of the statutes to review the report and approves the waiver. Specify that the Committee may modify the waiver by removing one or more components. Require the Department to implement the waiver as approved, with any modifications adopted by the Committee. Require the Department to submit a subsequent waiver amendment to CMS consistent with the Committee's actions if necessary to implement the waiver as modified;

(d) Delete $1,608,000 GPR, 1.0 GPR position, $1,608,000 FED, and 1.0 FED position in 2017-18 and $8,255,500 GPR, 12.0 GPR positions, $8,255,500 FED, and 12.0 FED positions in 2018-19 to remove funding and positions related to the implementation of the childless adult employment and training program.

(e) Apply any legislative directives adopted for FSET contracts under LFB Issue Paper #345 to employment and training contracts for childless adults.

6. *Personal Care Rate Increase [Paper #325].* Adopt Alternative 1, which would approve the Governor's recommendation to increase the MA reimbursement rate for personal care services by 2% in each year of the biennium. Reduce funding in the bill by $78,500 (-$39,400 GPR and -$39,100 FED) in 2017-18 and by $37,900 (-$48,700 GPR and $10,800

FED) in 2018-19 to reflect a reestimate of the costs of Governor's proposal.

7. *Repeal Ambulatory Surgical Center Assessment [Paper #326]*. Adopt Alternative 3, which would delete the repeal of the ambulatory surgical assessment. Increase estimates of ambulatory surgical center revenue by $5,000,000 annually to reflect the retention of the assessment. Increase MA benefits funding by $6,024,100 (-$2,616,300 GPR, $5,000,000 SEG, and $3,640,400 FED) in 2017-18 and $6,024,100 (-$2,623,400 GPR, $5,000,000 SEG, and $3,647,500 FED) in 2018-19 to reflect the increase in MA trust fund revenue and the retention of ambulatory surgical center access payments.

8. *Medical Assistance Purchase Plan and EBD MA Eligibility [Paper #327]*. Adopt Alternative 2, which would modify the Governor's recommendation with respect to the medical assistance purchase plan by deleting the additional DHS position authority and associated funding provided under the bill by: (a) reducing funding by $173,600 (-$86,800 GPR and -$86,800 FED) in 2017-18 and by $278,800 (-$139,400 GPR and -$139,400 FED) in 2018-19; and (b) deleting 3.0 positions (-1.50 GPR positions and -1.50 FED positions) that would be created in the bill, beginning in 2017-18.

9. *Medical Assistance -- Budgeting MA Trust Fund Revenues [Paper #328]*. Adopt Alternative 1, which would modify provisions relating to the treatment of transfers from the hospital assessment and critical access hospital assessment fund to eliminate the double-counting of those funds in SEG appropriations for the MA benefits, and would reduce SEG funding by $161,919,300 in 2017-18 and $163,614,600 in 2018-19 in the hospital assessment SEG appropriation and by $1,605,600 in 2017-18 and $1,463,500 in 2018-19 in the critical access hospital SEG appropriation to reflect the elimination of double-counted funds.

10. *Child Psychiatry Consultation Program [Paper #365]*. Adopt Alternative 1, which would approve the Governor's recommendation to provide $500,000 GPR annually for the child psychiatry consultation program.

11. *Office of Children's Mental Health Travel Reimbursement [Paper #366]*. Adopt Alternative 3, which would delete $10,000 GPR annually for providing travel reimbursement for individuals who have first-hand experience with mental health systems who participate in meetings arranged by the Office. In addition, authorize DHS to fund these travel expenses from its GPR general administration appropriation.

12. *SSI and Caretaker Supplement Reestimate [Paper #367]*. Adopt the modification, which would increase funding by $153,700 GPR in 2017-18 and $174,300 GPR in 2018-19 to fully fund state supplemental payments for SSI recipients, and reduce funding by $1,301,100 PR annually to reflect a reestimate of payments for the caretaker supplement.

13. *Dementia Care Specialists [Paper #368]*. Provide $893,000 ($760,000 GPR and $133,000 FED) in 2017-18 and $2,256,000 ($1,920,000 GPR and $336,000 FED) in 2018-19, to maintain ongoing support for the 19 current dementia care specialist positions through June 30, 2018, and to fund 24 dementia care specialist positions, on an ongoing basis, beginning July 1, 2018.

14. *Family Care Funding*. Provide $12,500,000 GPR in 2017-18 and $12,500,000 GPR in 2018-19 in the Joint Finance's program supplements appropriation. Require DHS to work with the Family Care managed care organizations, and Centers for Medicaid and Medicare Services (CMS) to develop an allowable payment mechanism to increase the direct care and services portion of the capitation rates in recognition of the direct caregiver workforce challenges facing the state. Require DHS to seek the release of these funds under s. 13.10 of the statutes, upon CMS approval of a payment mechanism. Require DHS to seek any federal approvals necessary to implement the plan by December 31, 2017. Increase funding for MA benefits by $17,773,700 FED in 2017-18 and $17,958,100 FED in 2018-19 to reflect MA matching funds that would be available to support these costs.

15. *Graduate Medical Education.* Move to incorporate the provisions of LRB 0129/P2 into the bill, which would: (a) increase funding for grants to establish graduate medical training programs by $750,000 GPR in each year of the biennium; (b) create a continuing appropriation to fund (ongoing) graduate medical training programs, budgeted at $750,000 GPR in 2017-18 and $750,000 GPR in 2018-19, by transferring base funding for grants for current programs ($750,000 GPR) from the MA benefits appropriation to the new appropriation; and (c) provide that, if January 2017 Special Session Assembly Bill 7 is enacted, the one-time funding in that bill to support fellowships in addiction medicine or addiction psychiatry ($63,000 GPR in 2017-18) would be transferred from the medical assistance MA benefits appropriation to the new appropriation.

16. *Disproportionate Share Hospital Payments and Rural Critical Care Supplements.* Increase payments to disproportionate share hospitals (DSH) under the medical assistance (MA) program, and create a new supplemental payment for hospitals that would otherwise qualify for DSH payments but for the fact that they do not provide obstetric services.

Increase MA benefits funding by $30,879,200 ($12,500,000 GPR and $18,129,200 FED) in 2017-18 and $31,067,300 ($12,500,000 GPR and $18,317,300 FED) in 2018-19, to increase DSH payments to hospitals. Modify statutory provisions relating to the program by: (a) increasing, from $15,000,000 to $27,500,000 per year, the state share of payments, in addition to the federal matching funds, that the Department of Health Services (DHS) is required to pay to hospitals that serve a disproportionate share of low-income patients; and (b) increasing, from $2,500,000 (all funds) to $4,600,000 (all funds) the maximum amount any single hospital can receive.

Increase MA benefits funding by $605,500 ($250,000 GPR and $355,500 FED) in 2017-18 and by $609,200 ($250,000 GPR and $359,200 FED) in 2018-19 to create a "rural critical care supplement" payment to hospitals that would meet all of the criteria for disproportionate share hospitals, but do not provide obstetric services. Provide that the state's share of these payments would be $250,000, and that DHS would annually make supplemental payments totaling this amount, in addition to federal MA matching funds, to these hospitals.

Specify that the DHS may make a payment to a hospital under a calculation method determined by the Department that provides a fee-for-service supplemental payment that increases as the hospital's percentage of inpatient days for MA recipients at the hospital increases. Require DHS to ensure that the total amount of moneys available to pay hospitals the rural critical care

supplement is distributed in each fiscal year.

Require DHS to limit the maximum payment to hospitals such that the amount of payment is in accordance with federal rules concerning any hospital specific limit. Direct DHS to seek any necessary approval from the federal Department of Health and Human Services (DHHS) to implement the rural critical care supplement and, if approval is necessary and approval from DHHS is received, direct DHS to implement the payment methodology. Provide that, if approval is necessary and DHHS does not approve, DHS may not implement the hospital payment supplement.

17. *Grants for Training Allied Health Professionals.* Move to incorporate the statutory provisions of 2017 Assembly Bill 224 into the bill, and provide $500,000 GPR annually, beginning in 2018-19 for the Department of Health Services (DHS) to distribute as grants for training allied health professionals, as follows.

Direct the Department to distribute grants to hospitals, health systems, and educational entities that form health care education and training consortia for allied health professionals. Define an "allied health professional" as any individual who is a health care provider other than a physician, registered nurse, dentist, pharmacist, chiropractor, or podiatrist and who provides diagnostic, technical, therapeutic, or direct patient care and support services to the patient.

Specify that DHS may distribute up to $125,000 per fiscal year per consortium to be used for any of the following: (a) curriculum and faculty development; (b) tuition reimbursement; and (c) clinical site or simulation expenses. Specify that each grant recipient must match, through its own funding sources, the amount of the grant distributed by the Department for the purposes of operating an allied health professional training consortium. Require DHS to determine the requirements for the formation of health care education and training consortia for allied health professionals, and that in distributing grants under this section, the Department give preference to rural hospitals, health systems with a rural hospital or rural clinic, and rural educational entities.

Create a biennial appropriation, budgeted in $500,000 GPR annually, beginning in 2018-19, for the Division of Public Health to fund grants.

18. *Grants for Advanced Practice Clinicians.* Move to incorporate the statutory provisions of 2017 Assembly Bill 227 into the bill, and provide $500,000 GPR annually, beginning in 2018-19, to establish a grant program for training of advanced practice clinicians, as follows.

Direct the Department of Health Services to distribute grants to hospitals and clinics that provide new training opportunities for advanced practice clinicians. For these purposes, define an "advanced practice clinician" as a physician assistant or an advanced practice nurse, including a nurse practitioner, certified nurse midwife, clinical nurse specialist, or certified registered nurse anesthesiologist.

Create a biennial GPR appropriation for the Division of Public Health to distribute $500,000 GPR annually in grants, beginning in 2018-19. Specify that of this total, DHS could distribute up to $50,000 per fiscal year per hospital or clinic. Specify that DHS must require the hospital or clinic to

use the grant to pay for the costs of operating a clinical training program for advanced practice clinicians, which may include any of the following: (a) required books and materials; (b) tuition and fees; (c) stipends for reasonable living expenses; (d) preceptor costs, including preceptor compensation attributable to training, certification requirements, travel, and advanced practice clinician training. Provide that if a hospital or clinic awarded a grant has not previously received such a grant, it may also use the grant to create the education and infrastructure for training advanced practice clinicians.

Require grant recipients to provide a match to the state grant amount for the purposes of operating an advanced practice clinician rotation. Provide that a hospital or clinic supported by these grants may determine what, if any, post-education requirements must be fulfilled by participants in the training program.

Specify that in distributing these grants, DHS must give preference to advanced practice clinician clinical training programs that include rural hospitals and rural clinics as clinical training locations.

19. *Communicable Disease Control and Prevention Grants.* Move to incorporate the statutory provisions of 2017 Assembly Bill 293 into the bill, and provide $500,000 GPR annually for DHS to provide as grants to local public health departments to control and prevent communicable diseases, as follows.

Provide $500,000 GPR annually, in a continuing appropriation, for DHS to distribute as grants to control and prevent communicable diseases. Permit local health departments to use grant funds for disease surveillance, contact tracing, staff development and training, improving communication among healthcare professionals, public education and outreach, and other infection control activities which local health departments are required to undertake in accordance with Chapter 252.

Specify criteria the Department must consider when determining the amount of grant funding to distribute to each local health department. These criteria would include: (a) base funding amount, with each local health department guaranteed at least some level of base funding; (b) general population; (c) target populations; (d) risk factors; and (e) geographic area, including consideration of the size of the geographic area served by the local health department or the density of the population. Provide DHS discretion in how these criteria are applied, including in determining what level of base funding to provide to each local health department.

Require local health departments receiving funding under this program to submit biennial financial statements to the Department on their use of the funds, with the first such statement due January 1, 2019.

20. *Intensive Care Coordination Pilot Program.* Provide one-time funding of $750,000 ($309,700 GPR and $440,300 FED) in 2017-18 and $1,500,000 ($616,400 GPR and $883,600 FED) in 2018-19 for DHS to fund an intensive care coordination pilot project, as described in LRB draft 3521/P4, as follows.

Create a program to reimburse hospitals and health care systems for intensive care

coordination services provided to MA recipients. Require DHS to select eligible hospitals and health care systems to receive reimbursement under the program that submit a description of their programs to the Department that meet criteria including:

(a) The hospital or health care system must use emergency department utilization data to identify MA recipients to receive intensive care coordination to reduce use of the emergency department by those MA recipients by providing a connection to a primary care physician and other primary care services;

(b) The hospital or health care system identifies for intensive care coordination a MA recipient who uses the emergency department frequently such that he or she visits the emergency room three or more times within 30 days, six or more times within 90 days, or seven or more times within 12 months;

(c) The hospital or health care system has an intensive care coordination team that includes health care providers other than solely physicians, such as nurses; social workers, case managers, or care coordinators; behavioral health specialists; and schedulers;

(d) The hospital or health care system provides to a MA recipient enrolled in intensive care coordination through the hospital or health care system all of the following, as appropriate to his or her care: (1) discharge instructions and contacts for following up on care and treatment; (2) referral information; (3) appointment scheduling; and (4) intensive care coordination by a social worker, case manager, or care coordinator to connect the MA recipient to a primary care provider or to a managed care organization.

(e) The intensive care coordination by the hospital or health care system is designed to result in outcomes for a MA recipient during the six-month or 12-month period including successful connection to primary care or the managed care organization as evidenced by two or three primary care appointments, successful connection to behavioral health resources and alcohol and other drug abuse resources, as needed, and a decrease in use of the emergency room.

Require DHS to do all of the following:

(a) Respond to the hospital or health care system indicating if additional information is required to determine eligibility for reimbursement under this subsection.

(b) If the hospital or health care system is eligible for intensive care coordination reimbursement under this subsection, provide a description of the process for enrolling MA recipients in intensive care coordination for reimbursement.

Require DHS to provide as reimbursement for intensive care coordination to eligible hospitals and health care systems participating in the program under the program $500 for each MA recipient the hospital or health care system enrolls in intensive care coordination. Provide that the initial enrollment for each recipient would last for six months and the health care provider may enroll the MA recipient in one additional six-month period for an additional $500 reimbursement payment.

Require each hospital and health care system that is eligible for reimbursement under this

program to a report, for each of the two years of the pilot program, to DHS all of the following:

(a) The number of MA recipients served by intensive care coordination.

(b) For each MA recipient, the number of emergency department visits for a time period before enrollment of that recipient in intensive care coordination and the number of emergency department visits for the same recipient during the same period after enrollment in intensive care coordination.

(c) Any demonstrated outcomes.

Provide that, for each hospital or health care system receiving a reimbursement under the program, DHS must calculate the costs saved to the MA program by avoiding emergency department visits by subtracting the sum of reimbursements made under this subsection to the hospital or health care systems from the sum of costs of visits to the emergency department that were expected to occur without intensive care coordination. If the result of the calculation is positive, require DHS to distribute half of the amount saved to the hospital or health care system.

Provide that, no later than 24 months after the date on which the first hospital or health care system is able to enroll individuals in the intensive care coordination program under the program, DHS must submit a report to the Joint Committee on Finance, including the costs saved by avoiding emergency department visits.

Require DHS to obtain any necessary approval from the federal Department of Health and Human Services (DHHS) to implement the program, and provide that if DHHS disapproves the request for approval, DHS may implement the reimbursement, the savings distribution, or both, or any part of the program.

21. *IMD Exclusion.* Modify provisions in state law that prohibit MA coverage of services provided in an institution for mental disease for persons ages of 21 through 64 to permit DHS to provide MA coverage for these services to the extent permitted under federal law or under waiver agreement, if federal financial participation is available to support these services.

22. *Clinical Consultations.* Direct the Department of Health Services to provide reimbursement for clinical consultations under the medical assistance program, subject to federal approval. Repeal this provision effective June 30, 2019. Require DHS to report to the Joint Committee on Finance by March 31, 2019, on utilization of these services.

Define "clinical consultation" as, for a student up to age 21, communication from a mental health professional, or a qualified treatment trainee working under the supervision of a mental health professional, to another individual who is working with the client to inform, inquire, and instruct regarding all of the following and to direct and coordinate clinical service components: (a) the client's symptoms; (b) strategies for effective engagement, care, and intervention for the client; and (c) treatment expectations for the client across service settings.

23. *Enhanced MA Reimbursement Rates for Dental Services Provided by Certain*

Facilities that Serve Individuals with Disabilities. Authorize the Department of Health Services (DHS) to provide enhanced medical assistance (MA) reimbursement payment rates for dental services rendered by facilities that provide at least 90% of their dental services to individuals with cognitive and physical disabilities, as determined by the Department. Specify that these enhanced reimbursement rates for dental services would equal 200% of the MA reimbursement rates that would otherwise be paid for these dental services.

Require DHS to request any waiver from, and submit any amendments to, the state MA plan to the federal Department of Health and Human Services to implement these provisions.

24. *Emergency Physician Services and Reimbursement Workgroup.* Establish a workgroup to examine medical services provided in hospital emergency departments (EDs) to medical assistance (MA) recipients, and to make recommendations regarding potential savings in these services and increases to MA reimbursement for emergency physician services. Specify that the workgroup may examine aspects of the healthcare system involving emergency care, including patient care practices, medication use and prescribing practices, billing and coding administration, organization of health care delivery systems, care coordination, patient financial incentives and other aspects, as the workgroup sees appropriate.

Specify that the workgroup would include: (a) two physicians practicing in Wisconsin representing a statewide physician-member organization of emergency physicians; (b) two representatives of the DHS Division of Medicaid Services, with experience in emergency physician services, codes and payment; (c) one representative who is a hospital emergency department administrator employed by a Wisconsin hospital or hospital-based health system; (d) one coding/billing specialist from an organization with expertise and in the business of emergency medicine that contracts emergency physicians practicing in Wisconsin.

Authorize the workgroup to solicit input from others as it deems necessary and appropriate.

Specify that the workgroup must first convene no later than 60 days after the effective date of the bill, and meet at least every 45 days until arriving at a set of recommendations. Require the workgroup to report its findings and recommendations to the Joint Finance Committee no later than September 1, 2018. Provide that all recommendations of the workgroup must be made on the basis of a consensus of the workgroup.

25. *DHS Study on the Use of Physical Medicine and Proposal for Physical Medicine Pilot Program.* Require the Department of Health Services (DHS) to study best practices for physical medicine and how physical medicine affects the use, and frequency of use, of prescription and over-the-counter medication.

In addition, require DHS to develop a proposal for a physical medicine pilot program to minimize prescription of addictive drugs for individuals who receive benefits under the medical assistance (MA) program by treating pilot participants using chiropractic and physical and occupational therapy services that are reimbursed under the MA program.

Define "physical medicine" as rehabilitation techniques that aim to enhance and restore functional ability and quality of life to persons with physical impairments, injuries or disabilities.

Require DHS to solicit input from persons that are interested in physical medicine, including those interested in chiropractic care and physical therapy, in completing the study and developing the pilot proposal. Require DHS to submit a report of the study and the proposal for the pilot program to the Legislature by April 1, 2018. Prohibit DHS from implementing the pilot program unless the Legislature directs or explicitly authorizes the DHS to implement the pilot program.

26. *IRIS Waiver to Allow Adults with Intellectual Disabilities to Use Medicaid Funding at Accredited Institutions of Higher Education.* Direct DHS to request a waiver, or a modification to a current waiver, from the federal Centers for Medicare and Medicaid Services in order to receive the federal MA percentage for home–based and community–based services provided to individuals who are developmentally disabled and who received post–secondary education on the grounds of health care institutions. Provide that, if the waiver is approved, DHS must operate a waiver program to provide these services to no more than 100 individuals per month per year.

Specify that only individuals who are receiving post–secondary education in a setting that is distinguishable from the health care institution are eligible for services under the waiver. Require that individuals eligible for these waiver services meet the same financial eligibility requirements and functional eligibility requirements as those established for the IRIS (Include, Respect, I Self-Direct) program, except that the individual must also be an individual who is developmentally disabled and who is receiving post–secondary education on the grounds of a health care institution. Require that DHS provide the same services under this waiver program as it provides under IRIS. Require DHS to determine the funding amount for a waiver program participant under this section based on what the individual would have received if enrolled in IRIS.

27. *HIV/AIDS Services -- Mike Johnson Life Care Grants.* Increase funding for Mike Johnson life care and early intervention service grants by $323,000 GPR annually, beginning in 2017-18. Increase, from $3,677,000 to $4,000,000, the maximum amount DHS may award in grants to applying organizations.

28. *Family Care Partnership Program.* Direct DHS to submit a request for a waiver from the Centers for Medicare and Medicaid Services to expand the Family Care Partnership program statewide by December 31, 2017. Within 60 days of receiving approval from CMS, DHS shall submit a plan to expand Partnership statewide to JFC for approval following the guidelines issued in the waiver. If CMS denies the waiver request, DHS shall submit a report to JFC outlining the reasons why the request was denied.

29. *Nursing Home Bed Licenses.* Require DHS to increase by 18 the number of licensed beds for a nursing facility that meets the following criteria: (a) has a licensed bed capacity of no more than 30 on the effective date of the bill; (b) is located in a county with a population of at least 27,000, with the population of the county seat of no more than 9,200 and the home county is adjacent to a county with a population of at least 20,000, on the effective date of the bill; and (c) the

facility has requested the increase in the number of its licensed beds through a notice to DHS that includes the applicant's per diem and operating and capital rates.

Specify that DHS must approve an application from a nursing home under this provision, within one month after DHS receives the application

In addition, require DHS to develop a policy that specifies the procedures nursing homes may use to apply for, and receive, approval of, the transfer of available, licensed nursing home beds. Require the Department to report to the Joint Committee on Finance no later than July 1, 2018.

30. *Grant for Hospital-Based Behavior Health Crisis Management and Videoconferencing for Court Hearings in Civil Commitment Proceedings.* Provide one-time funding of $250,000 GPR in 2017-18 in the DHS appropriation for grants for community programs and require DHS to make a grant of $250,000 in the 2017-18 to a critical access hospital to support the cost of a behavioral health crisis management system. Specify that the Department must award the grant to a hospital that presents a proposal that does the following: (a) provides in-person triage, assessment, and brief intervention services to persons presenting in the hospital emergency department for reasons related to a behavioral health crisis; (b) provides the same services to persons presenting in the hospital emergency department of hospitals within the same region via video telemedicine consultation; and (c) coordinates the transfer of persons who require care for a behavioral health condition in another facility, as appropriate. Specify that the grant shall be made to a critical access hospital that meets the following criteria: (a) is located in the northwestern part of the state in a county that borders Minnesota and that has immediate access to I-94; (b) provides alcohol and drug abuse assessment and treatment services; and (c) provides inpatient psychiatric services.

In addition, modify provisions relating to court hearings conducted under Chapter 51 of the statutes (Mental Health Act) to specify that if a person who is the subject of a hearing is detained in a facility that is more than 100 miles away from the courthouse where the hearing is held, the court may conduct the hearing by videoconference if the detention facility has videoconferencing capabilities that meet the current law technical and operational standards used for circuit courts, except that the hearing may not be held by videoconference if both the corporation counsel and the counsel representing the subject object to holding the hearing by videoconference. Specify that this provision does not preclude a court from holding a hearing by videoconferencing in other circumstances.

31. *FoodShare Employment and Training Program -- Cost to Continue [Paper #345].* Adopt Alternative 2, which would reduce funding in the bill by $24,935,800 (-$6,131,300 GPR and -$18,804,500 FED) in 2017-18 and by $23,933,900 (-$5,129,400 GPR and -$18,804,500 FED) in 2018-19, by budgeting funding for the FSET program based on an average monthly enrollee cost of $283 including all administrative expenses, with no funding budgeted for a pay-for-performance incentives. Require the Department to provide an outcome report before February 1, 2018, and include in the report any proposed program improvements and contract modifications necessary based on the reported outcomes.

32. *FoodShare Employment and Training Program -- Universal Referrals [Paper #346].* Adopt Alternative 4, which would delete the Governor's recommendation to increase funding for the FSET program to fund estimated costs of referring all eligible able-bodied adults to the FSET program, including those with children up to the age of 18, and those who care for incapacitated persons, who are not required to meet the work requirement. Reduce funding in the bill by $470,400 (-$235,200 GPR and -$235,200 FED) in 2017-18 and $29,573,200 (-$14,786,600 GPR and -$14,786,600 FED) in 2018-19. Require income maintenance workers to provide all Foodshare applicants and participants information about the FSET program at least two times per year, in addition to maintaining current practice of referring all ABAWDs to FSET regardless of whether they need to meet the work requirement.

33. *FSET Pilot for Able-Bodied Adults with Dependents [Paper #347].* Modify the Governor's recommendation by only approving the pilot portion of the work requirement to operate from April, 2019, through the end of June 30, 2020. Require that the pilot region selected by the Department be composed of no more than two FSET vendor regions. Require an evaluation of the pilot program and make statewide expansion contingent on the evaluation. Reduce funding in the bill by $58,000 (-$29,000 GPR and -$29,000 FED) in 2017-18 and increase funding in the bill by $84,600 ($42,300 GPR and $42,300 FED) in 2018-19. Transfer the GPR funding that would be provided under this item from DHS to the Joint Committee on Finance program supplements appropriation. Require DHS to submit a detailed plan for implementation of the pilot to the Joint Committee on Finance, in order to seek the release of funds for this provision under s. 13.10.

34. *FoodShare Eligibility -- Asset Limit [Paper #348].* Adopt the Governor's statutory changes to prohibit individuals who are not elderly, blind, or disabled, from participating in the FoodShare program in any month in which the household of which the individual is a member has liquid assets that exceed $25,000. Modify the bill to specify that the asset requirements would first apply to initial applications and redeterminations for FoodShare benefits that occur after July 1, 2018, or the date FNS approves the state's waiver request, whichever is later. Expand current statutory authority for DHS to use the financial record matching program for the FoodShare program, in addition to current authorization for Medical Assistance.

Delete all funding and positions in the bill relating to this item by reducing funding by $118,200 (-$59,100 GPR and -$59,100 FED) and deleting 1.50 positions (-0.75 GPR position and -0.75 FED position) in 2017-18 and by $3,589,800 (-$1,794,900 GPR and -$1,794,900 FED) and deleting 10.20 positions (-5.10 GPR positions and -5.10 FED positions) in 2018-19.

35. FoodShare Eligibility -- Child Support and Paternity Compliance [Paper #349]. Adopt Alternative 2, which would: (a) adopt all statutory changes related to cooperation in establishing child support orders, not falling delinquent on child support, and paternity establishment as eligibility requirements for the FoodShare program; (b) modify the Governor's recommendation by placing the reestimated GPR funding amounts ($527,600 in 2017-18 and $76,300 in 2018-19) into the Joint Finance Committee's program supplements appropriation and specify that these funds could be released upon request of DCF or DHS under a 14-day passive review process for the purpose of implementing the proposed FoodShare eligibility provisions; (c) specify that the statutory changes in the bill would not take effect unless DCF determines that the new provision related to FoodShare eligibility, as it pertains to child support and paternity order establishment and

compliance, can be implemented in a manner that is substantially state budget-neutral in regard to child support fees; (d) require DHS and DCF to request any applicable waivers or other federal authorization necessary to allow for budget-neutral implementation with respect to these fees; and (e) require DCF and DHS to notify the Governor and the Committee, upon making such a determination, and specify that the new provisions would take effect on the first day of the sixth month beginning after the date of DCF's notification.

36. *Expunging Unused FoodShare Balances.* Require DHS to remove all FoodShare benefits electronically and store the benefits offline for accounts that are inactive for a minimum of six months. Provide that accounts would be considered inactive if, for a period of six months or longer, an individual or household that is receiving FoodShare benefits through an electronic benefit transfer system uses no benefits that have been posted to the individual's or household's account. Require that benefits stored offline must be made available to the individual or household again within 48 hours after a request by the individual or a household member to restore the benefits or upon reapplication for FoodShare. Require that DHS attempt to notify the affected individual or household before benefits are removed and describe the steps the individual or household must take to get the benefits returned to the account. Require DHS to permanently expunge any benefits that have not been used after a period of one year. Allow the implementation of this provision only if DHS seeks and obtains any necessary approvals from the U.S. Department of Agriculture to implement this provision.

37. *Exemption from Nursing Home Bed Assessment.* Exempt county owned institutions for mental diseases and state licensed nursing homes that are not certified to participate in Medicaid and Medicare from the state nursing home bed assessment. Require the Department of Health Services to seek approval from the U.S. Department of Health and Human Services to ensure that, by exempting these facilities from the assessment, the state would remain compliant with federal rules relating to health provider taxes. Provide that the exemption would take effect only if the state received federal approval for the exemption, and that the exemption would take effect on July 1, 2017, or the date on which the state receives approval to exempt these facilities, whichever is later.

Reduce estimated revenue to the Medical Assistance trust fund by $387,600 SEG-REV in 2017-18 and $387,600 SEG-REV in 2018-19 to reflect the loss of assessment revenue. Reduce funding for Medical Assistance benefits from the Medical Assistance trust fund by $387,600 SEG in 2017-18 and $387,600 SEG in 2018-19. Increase funding for Medical Assistance benefits by $387,600 GPR in 2017-18 and $387,600 GPR in 2018-19 to replace the loss of SEG funding to support MA benefits costs.

Funding Change to Bill

	2017-18				2018-19				2017-19 Biennium			
	GPR	FED	PR	SEG	GPR	FED	PR	SEG	GPR	FED	PR	SEG
MA Cost-to-Continue/JFC Reserve	-$26,416,500	-$37,093,800	$29,990,600	-$1,916,700	-$19,154,100	-$67,434,000	$39,463,900	-$1,670,600	-$45,570,600	-$104,527,800	$69,454,500	-$3,587,300
SeniorCare Cost-to-Continue	-4,790,600	-4,037,100	-14,170,300	0	-4,549,600	-3,647,800	-22,107,400	0	-9,340,200	-7,684,900	-36,277,700	0
Nursing Home and ICF-IID Reimbursement	-345,600	-489,500	0	0	-752,100	-1,039,000	0	0	-1,097,700	-1,528,500	0	0
Children's Long-Term Support Waiver Program	191,500	-96,700	0	0	222,600	-38,400	0	0	414,200	-135,100	0	0
Childless Adult Employment and Training Waiver	-1,608,000	-1,608,000	0	0	-8,255,500	-8,255,500	0	0	-9,863,500	-9,863,500	0	0
Personal Care Rate Increase	-39,400	-39,100	0	0	-48,700	10,800	0	0	-88,100	-28,300	0	0
Retain Ambulatory Surgical Center Assessment	-2,616,300	3,640,400	0	5,000,000	-2,623,400	3,647,500	0	5,000,000	-5,239,700	7,287,900	0	10,000,000
Medical Assistance Purchase Plan and EBD MA Eligibility	-86,800	-86,800	0	0	-139,400	-139,400	0	0	-226,200	-226,200	0	0
Medical Assistance -- Budgeting MA Trust Fund Revenues	0	0	0	-163,524,900	0	0	0	-165,078,100	0	0	0	-328,603,000
Child Psychiatry Consultation Program	0	0	0	0	0	0	0	0	0	0	0	0
Office of Children's Mental Health Travel Reimbursement	-10,000	0	0	0	-10,000	0	0	0	-20,000	0	0	0
SSI and Caretaker Supplement Reestimate	153,700	0	-1,301,100	0	174,300	0	-1,301,100	0	328,000	0	-2,602,200	0
Dementia Care Specialists	760,000	133,000	0	0	1,920,000	336,000	0	0	2,680,000	469,000	0	0
Family Care Funding	12,500,000	17,773,700	0	0	12,500,000	17,958,100	0	0	25,000,000	35,731,800	0	0
Graduate Medical Education	750,000	0	0	0	750,000	0	0	0	1,500,000	0	0	0
DSH Payments and Rural Critical Care Supplements	12,750,000	18,484,700	0	0	12,750,000	18,676,500	0	0	25,500,000	37,161,200	0	0
Grants for Training Allied Health Professionals	500,000	0	0	0	500,000	0	0	0	1,000,000	0	0	0
Grants for Advance Practice Clinicians	500,000	0	0	0	500,000	0	0	0	1,000,000	0	0	0
Communicable Disease Control and Prevention Grants	500,000	0	0	0	500,000	0	0	0	1,000,000	0	0	0
Care Coordination Pilot Program	309,700	440,300	0	0	616,400	883,600	0	0	926,100	1,323,900	0	0
IMD Exclusion	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Consultations	0	0	0	0	0	0	0	0	0	0	0	0
Enhanced MA Reimbursement Rates	0	0	0	0	0	0	0	0	0	0	0	0
Emergency Physician Services and Reimbursement Workgroup	0	0	0	0	0	0	0	0	0	0	0	0
DHS Study of the Use of Physical Medicine	0	0	0	0	0	0	0	0	0	0	0	0
IRIS Waiver	0	0	0	0	0	0	0	0	0	0	0	0
HIV/AIDS Services	323,000	0	0	0	323,000	0	0	0	646,000	0	0	0
Family Care Partnership Program	0	0	0	0	0	0	0	0	0	0	0	0
Nursing Home Bed Licenses	0	0	0	0	0	0	0	0	0	0	0	0
Grant for Hospital-Based Crisis Management	250,000	0	0	0	0	0	0	0	250,000	0	0	0
FoodShare Employment and Training--Cost-to-Continue	-6,131,300	-18,804,500	0	0	-5,129,400	-18,804,500	0	0	-11,260,700	-37,609,000	0	0
FoodShare Employment and Training--Universal Referrals	-235,200	-235,200	0	0	-14,786,600	-14,786,600	0	0	-15,021,800	-15,021,800	0	0
FSET Pilot for Able-Bodied Adults with Dependents	-29,000	-29,000	0	0	42,300	42,300	0	0	13,300	13,300	0	0
FoodShare Eligibility -- Asset Limit	-59,100	-59,100	0	0	-1,794,900	-1,794,900	0	0	-1,854,000	-1,854,000	0	0
FoodShare Eligibility -- Child Support and Paternity Compliance	7,400	7,400	0	0	-16,600	-16,600	0	0	-9,200	-9,200	0	0
Expunging Unused FoodShare Balances	0	0	0	0	0	0	0	0	0	0	0	0
Exemption from Nursing Home Bed Assessment	387,600	0	0	-387,600	387,600	0	0	0	775,200	0	0	-775,200
Total	-$12,484,800	-$22,099,300	$14,519,200	-$160,829,200	-$26,074,100	-$74,401,900	$16,055,400	-$162,136,300	-$38,558,900	-$96,501,200	$30,574,600	-$322,965,500

Non-Appropriation Changes

	GPR	FED
Positions		
Childless Adult Waiver	-12.00	-12.00
Medical Assistance Purchase Plan and EBD MA Eligibility	-1.50	-1.50
FoodShare Eligibility -- Asset Limit	-5.10	-5.10
Total	-18.60	-18.60
Revenue		
Retain Ambulatory Surgical Assessment	10,000,000	SEG-REV
Exemption from Nursing Home Bed Assessment	-775,200	SEG-REV