Chapter HFS 108

GENERAL ADMINISTRATION

Note: Chapter HSS 108 was renumbered Chapter HFS 108 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, January, 1997, No. 493.

HFS 108.01 Safeguarded information. (1) Except for purposes directly related to direct program administration, the department may not use or disclose any information concerning past or present applicants and recipients of MA.

(2) In this section, "direct program administration" means:

(a) Determining initial eligibility of the applicant and continuing eligibility of the recipient;

(b) Determining appropriate services to be covered;

(c) Providing services for recipients;

(d) Processing provider claims for reimbursement;

(e) Auditing provider claims for reimbursement;

(f) Investigating or prosecuting criminal or civil proceedings conducted in connection with program administration;

(g) Seeking third−party payment for services provided to a recipient; and

(h) Other activities determined by the department to be necessary for proper and efficient administration of MA.

(3) The department shall request the attorney general to institute appropriate action when necessary to enforce provisions of this section.

(4) Safeguarded information concerning an individual applicant or recipient shall include but not be limited to:

(a) Name and address;

(b) Social data, including but not limited to:

1. Marital status;
2. Age;
3. Race;
4. Names and MA numbers of family members;
5. Paternity status of children; and
6. Unique identifying characteristics;

(c) Economic data, including but not limited to:

1. Assets;
2. Amount of assistance received;
3. Amount of medical expenses incurred;
4. Sources of payment or support;
5. Past or present employment;
6. Income, regardless of source;
7. Social security number; and
8. Income expense deductions;

(d) Agency evaluation information, including but not limited to:

1. Verification of client information; and
2. Identity of verification sources; and

(e) Medical data, including but not limited to:

1. Past history and medical record content;
2. Diagnosis;
3. Drugs prescribed;
4. Course of treatment prescribed; and
5. Name of provider.

(5) For purposes of direct program administration, the department may permit disclosure to, or use of safeguarded information by, legally qualified persons or agency representatives outside the department. Governmental authorities, the courts, and law enforcement officers are persons outside the department who shall comply with sub. (6).

(6) Persons or agency representatives outside the department to whom the department may disclose or permit use of safeguarded information shall meet the following qualifications:

(a) The purpose for use or disclosure shall involve direct program administration; and

(b) The person or the person's agency shall be bound by law or other legally enforceable obligation to observe confidentiality standards comparable to those observed by the department.

(7) Unless it is related to direct program administration, the department shall respond to a subpoena for a case record or for agency representative testimony regarding an applicant or recipient as follows:

(a) The department shall provide the court and all parties to the proceeding with a copy of this section;

(b) The department shall request that the attorney general intervene in the proceeding in a manner which will give effect to this section; and

(c) The department shall notify in writing applicants or recipients affected by a subpoena for safeguarded information.

(8) The department shall publicize this section as follows:

(a) Publication in the Wisconsin administrative code;

(b) Incorporation by reference in certification procedures for all providers; and

(c) Incorporation in information provided to recipients regarding their rights and responsibilities.

(9) The secretary or a designee shall determine the appropriate application of this section to circumstances not covered expressly by this section. Use or disclosure not expressly provided for in this section may not occur prior to this determination.

History: Cr. Register, December, 1979, No. 288, eff. 2−1−80; am. Register, February, 1986, No. 362, eff. 3−1−86.

HFS 108.02 Department rights and responsibilities. (1) DIFFERENT BENEFITS FOR DIFFERENT GROUPS. The department may offer MA benefits to the categorically needy which are different from the benefits offered to the medically needy, subject to ss. 49.46 (2) (a) and 49.47 (6) (a), Stats. For the categorically needy, benefits shall meet federal minimum standards of coverage under 42 CFR 435.100−135. The department need not provide the same benefits that the categorically needy receive to individuals who are determined to be medically needy. The department is not required to provide the same amount, duration and scope of services to all the different groups who make up the medically needy population.

(2) REIMBURSEMENT METHODS AND PAYMENT LEVELS. The department may establish the reimbursement methods and payment levels for program services subject to the requirements of federal and state statutes, regulations and chs. HFS 101 to 107 and this chapter. Notice of specific changes or updates to payment lev-

els shall be communicated to the service providers by the department through periodic publication of provider handbooks.

(3) ADVISORY COMMITTEES. The department may appoint and make use of professional advisory committees on an ad hoc basis to provide expertise for development of service or reimbursement policies.

(4) PROVIDER HANDBOOKS AND BULLETINS. The department shall publish provider handbooks, bulletins and periodic updates to inform providers of changes in state or federal law, policy, reimbursement rates and formulas, departmental interpretation, and procedural directives such as billing and prior authorization procedures, specific reimbursement changes and items of general information. The department shall inform providers in a handbook, bulletin or other publication of specific services requiring collection of benefits from medicare or other health care plans under s. HFS 106.03 (7) before benefits are claimed from the MA program. Information regarding eligibility for medicare or for another health care plan as identified on the recipient's MA identification card shall also be included in these publications.

(5) NOTIFICATION OF RECIPIENTS. The department shall publish periodic notification to eligible recipients, as necessary, to provide general information regarding MA program benefits and procedural requirements, and to notify recipients of any benefit or eligibility changes.

(6) NOTICE OF CHANGE IN METHOD OR LEVEL OF REIMBURSEMENT. (a) Except as provided in par. (b), the department shall publish a public notice in the Wisconsin administrative register of any significant proposed change in the statewide method or level of reimbursement for a service, in compliance with 42 CFR 447.205. This notice shall include information on the procedure for obtaining details of the proposed change, why the change is proposed and how to provide public comment to the department.

(b) Changes for which no public notice is required include the following:

1. Changes to conform with medicare methods and federally−invoked upper limits on reimbursement;

2. Changes required of the department by court order; and

3. Changes in wholesalers' or manufacturers' prices of drugs or materials, if the department's method of reimbursement is based on direct or wholesale prices as reported in a national standard such as the American druggist blue book, plus a pharmacy dispensing fee.

(c) Notice in the Wisconsin administrative register shall constitute official notice by the department to its contracted health service providers of a contractual change.

(7) MAILINGS AND DISTRIBUTIONS. The department shall mail or distribute materials to applicants, recipients or medical providers, as follows:

(a) All materials shall be limited to purposes directly related to program administration.

(b) Materials which may not be mailed or distributed include:

1. "Holiday" greetings;

2. General public announcements;

3. Voting information;

4. Alien registration notices;

5. Names of individuals, unless:

a. The named individual is connected with direct program administration; or

b. The named individual is identified only in an official agency capacity; and

6. Any material with political implications.

(c) Materials which may be mailed or distributed include:

1. Information of immediate interest to applicants' or recipients' health and welfare;

2. Information regarding the deletion or reduction of covered services; and

3. Consumer protection information.

(8) THIRD PARTY LIABILITY FOR COST OF SERVICES. (a) The department shall make reasonable efforts to identify any third party insurer, including medicare, legally liable to contribute in whole or in part to the cost of services provided to a recipient under the MA program.

(b) When the department has determined that medicare or any other health care plan provides health care coverage to the recipient which is primary to MA, as stated in s. 632.755 (2), Stats., the medicare or other insurance coverage shall be identified on the recipient's MA identification card by specific codes.

(c) In the event payment for services otherwise covered by medicare or by another health care plan is unavailable, the provider may bill the department's MA fiscal agent, identifying the efforts to seek reimbursement from medicare or the other health care plan, on condition that the provider complies with the instructions issued by the department under sub. (4).

(9) DEPARTMENTAL RECOUPMENT OF OVERPAYMENTS. (a) *Recoupment methods.* If the department finds that a provider has received an overpayment, including but not limited to erroneous, excess, duplicative and improper payments regardless of cause, under the program, the department may recover the amount of the overpayment by any of the following methods, at its discretion:

1. Offsetting or making an appropriate adjustment against other amounts owed the provider for covered services;

2. Offsetting or crediting against amounts determined to be owed the provider for subsequent services provided under the program if:

a. The amount owed the provider at the time of the department's finding is insufficient to recover in whole the amount of the overpayment; and

b. The provider is claiming and receiving MA reimbursement in amounts sufficient to reasonably ensure full recovery of the overpayment within a reasonable period of time; or

3. Requiring the provider to pay directly to the department the amount of the overpayment.

(b) *Written notice.* No recovery by offset, adjustment or demand for payment may be made by the department under par. (a), except as provided under par. (c), unless the department gives the provider prior written notice of the department's intention to recover the amount determined to have been overpaid. The notice shall set forth the amount of the intended recovery, identify the claim or claims in question or other basis for recovery, summarize the basis for the department's finding that the provider has received amounts to which the provider is not entitled or in excess of that to which the provider is entitled, and inform the provider of a right to appeal the intended action under par. (e). Payment due the department shall be made by the provider within 30 days after the date of service of the notice of intent to recover. Final notices of intent to recover shall be sent by certified mail.

(c) *Exception.* The department need not provide prior written notice under par. (b) when the overpayment was made as a result of a computer processing or clerical error, for a recoupment of a manual partial payment, or when the provider requested or authorized the recovery to be made. In any of these cases the department or its fiscal agent shall provide written notice of any payment adjustments made on the next remittance issued the provider. This notice shall specify the amount of the adjustment made and the claim or claims which were the subject of the adjustments.

(d) *Withholding of payment involving fraud or willful misrepresentation.* 1. The department may withhold 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. 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. The department may with-

hold payments without first notifying the provider of its intention to withhold the payments. A provider is entitled to a hearing under s. HFS 106.12.

2. The department shall send written notice to the provider of the department's withholding of MA program payments within 5 days after taking that action. 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:

a. State that payments are being withheld in accordance with this paragraph;

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

c. Specify, when appropriate, to which type or types of MA claims withholding is effective; and

d. Inform the provider 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.

3. Withholding of the provider's payments shall be temporary. Withholding of payment may not continue after:

a. The department determines after a preliminary investigation that 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;

b. Any law enforcement agency or prosecuting authority which has investigated or commenced prosecution of the matter determines that there is insufficient evidence of fraud or misrepresentation by the provider to pursue criminal charges or civil forfeitures; or

c. 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.

(e) *Request for hearing on recovery action.* If a provider chooses to contest the propriety of a proposed recovery under par. (a), the provider shall, within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. The request shall be in writing and shall briefly identify the basis for contesting the proposed recovery. Receipt of a timely request for hearing shall prevent the department from making the proposed recovery while the hearing proceeding is pending. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the provider the amount specified in the notice of intent to recover and may take such other legal action as it deems appropriate to collect the amount specified. All hearings on recovery actions by the department shall be held in accordance with the provisions of ch. 227, Stats. The date of service of a provider's request for a hearing shall be the date on which the department of administration division of hearings and appeals receives the request.

(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 867.035, 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. HFS 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 following home health services:

a. Skilled nursing services specified in s. HFS 107.11 (2) (a);

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

c. Therapy and speech pathology services specified in s. HFS 107.11 (2) (c);

2. Private duty nursing services specified in s. HFS 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. HFS 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. HFS 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. HFS 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.

(11) ESTATE RECOVERY ADJUSTMENTS. (a) The department may make adjustments to and settle estate claims and liens filed under s. 46.27 (7g), 49.496 or 867.035, Stats., to obtain the fullest amount practicable.

(b) The department shall take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if either of the following apply:

1. A child of the recipient or client, regardless of age, resides in the decedent's home and that child resided in the home for at least 24 months before:

a. The date the recipient was admitted to a nursing home, the expenses for which are subject to recovery under sub. (10) (a), and that child provided care to the recipient that delayed the recipient's admission to the nursing home;

b. The date the recipient was admitted to a hospital, the expenses of which are subject to recovery under sub. (10) (b), and that child provided care to the recipient that delayed the recipient's admission to the hospital; or

c. The date the recipient or client began receiving services which are subject to recovery under sub. (10) (c) 3. or (d), and that child provided care to the recipient or client that delayed the recipient's or client's receipt of the services.

2. A sibling of the recipient or client resides in the decedent's home and that sibling resided in the home for at least 12 months before:

a. The date the recipient was admitted to a nursing home, the expenses for which are subject to recovery under sub. (10) (a);

b. The date the recipient was admitted to a hospital, the expenses for which are subject to recovery under sub. (10) (b); or

c. The date the recipient or client began receiving services which are subject to recovery under sub. (10) (c) 3. or (d).

(c) Except as provided in par. (d), the lien shall be payable upon the death of the child or sibling or upon the transfer of the property, whichever comes first.

(d) If the child or sibling sells the home against which the department has taken a lien under par. (b) and uses the proceeds of that sale to buy another home which will be used as the child's or sibling's primary residence, then the following apply:

1. If the amount of the child's or sibling's payment for or down payment on the second home is equivalent to or greater than the amount received as the proceeds from the sale of the first home, the department shall transfer the lien to the second home.

2. If the amount of the child's or sibling's payment for or down payment on the second home is less than the amount received as the proceeds from the sale of the first home, the department may recover the amount of the lien to the extent that the proceeds from the sale of the first home exceed the amount of the child's or sibling's payment or down payment on the second home. The department shall transfer any remaining portion of the lien to the second home.

(12) HARDSHIP WAIVERS UNDER ESTATE RECOVERY. (a) *Definitions.* In this subsection:

1. "Beneficiary" means any person nominated in a will to receive an interest in property other than in a fiduciary capacity.

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 867.035, Stats.

3. "Heir" means any person who is entitled under the statutes of intestate succession, ch. 852, Stats., to an interest in property of a decedent.

4. "Recipient" means a person who received services funded by medical assistance or the long−term community support program under s. 46.27 (7), 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 867.035, Stats.

(b) *Hardship waiver criteria.* 1. A beneficiary or heir of a decedent may apply to the department for a waiver of an estate claim filed by the department. The department shall review an application for a waiver under this subsection and shall determine whether the applicant meets the criterion under subd. 2. a., b. or c. If the department determines that the criterion under subd. 2. a., b. or c.. is met, the department shall waive its claim as to that applicant.

2. Any of the following situations constitutes an undue hardship on the waiver applicant:

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. 45.351 (1), Stats.

(c) *Notice.* 1. The department shall provide written notice of the hardship waiver provisions to the person handling the decedent's estate, if that person can be ascertained from the probate information provided to the department, or, if that person cannot be ascertained, the department shall include the notice with the copy of the claim it files with the probate court.

2. The person handling the decedent's estate shall be responsible for notifying the decedent's beneficiaries and heirs of the hardship waiver provisions.

3. The department's notice shall include the following information:

a. The individuals who are eligible to apply for a waiver;

b. The criteria for granting a waiver as specified in par. (b) 2. a., b. or c.,

c. The application and review process as specified in par. (d); and

d. The waiver applicant's right to a hearing as specified in par. (e).

(d) *Application and review process.* 1. A waiver applicant shall mail his or her application for a waiver in writing to the department within 45 days after the date the department mailed its claim or affidavit pursuant to s. 49.496 or 867.035, Stats., or its notice under par. (c), whichever is later. The application shall include the following information:

a. The relationship of the waiver applicant to the decedent and copies of documents establishing that relationship; and

b. The criterion under par. (b) 2. a., b., or c.. which is the basis for the application and documentation supporting the waiver applicant's position.

2. The department shall review each application and issue a written decision within 90 days after the application was received by the department. The department shall consider all information received within 60 days following receipt of the application. The department's decision shall be based on information received within that time−period. The department's written decision shall include information regarding the waiver applicant's right to a hearing under par. (e).

(e) *Hearing rights.* 1. If a waiver applicant wishes to contest the department's decision denying a waiver, the waiver applicant shall serve the department with a request for a hearing within 45 days of the date the department's decision was mailed. The hearing request shall be in writing and shall identify the basis for contesting the decision. The request shall be submitted to the department of administration's division of hearings and appeals. The date on which the division of hearings and appeals receives the request shall be the date of service.

Note: The mailing address of the division of hearings and appeals is P.O. Box 7875, Madison, Wisconsin 53707.

2. If a waiver applicant wishes to introduce information at the hearing that he or she did not submit to the department under par. (d), the applicant shall provide the department with that information by mailing it to the department with a postmark of at least 7 working days prior to the hearing date.

3. The issue for hearing shall be whether the department's decision was correct based on the information submitted to the department by the waiver applicant within the time periods specified in par. (d) 2. and subd. 2. No other information may be considered by the hearing examiner unless the hearing examiner finds that the applicant did not timely provide the information to the department for good cause. The hearing decision shall be the final decision of the department. The hearing shall be held in accordance with the provisions of ch. 227, Stats.

(f) *Applicability.* 1. Heirs and beneficiaries may apply for a hardship waiver under this subsection from estate claims filed by the department pursuant to s. 49.496 or 867.035, Stats., in the estates of persons who die on or after April 1, 1995.

2. Heirs and beneficiaries may apply for a hardship waiver under this subsection from estate claims filed by the department pursuant to s. 46.27 (7g) or 867.035, Stats., for services received pursuant to s. 46.27(7), Stats., with respect to a client who died after February 15, 1996.

(13) BADGERCARE BUY−IN TO EMPLOYER−PROVIDED HEALTH CARE COVERAGE. (a) *Authority.* The department may purchase coverage under a group health insurance plan offered by the

employer of a member of an eligible family if the department determines that purchasing that coverage would not be more costly than providing coverage under BadgerCare.

(b) *General*. 1. The department may not buy in to a group health insurance plan when any member of a family has been covered by a group health insurance plan offered by the employer of a member of an eligible family in the 6 months prior to the buy−in decision.

2. Children in a family are not eligible for buy−in to a group health insurance plan if the family had health care coverage through the employer of a member of the family for these children within the previous 6 months.

3. The employer shall pay at least 60% of the cost of the premiums for the group health insurance plan, but not more than 80% of the cost, for the department to purchase coverage under a group health insurance plan.

(c) *Buy−in method*. The department shall purchase coverage by making payment to one of the following:

1. The employer of the recipient.

2. The insurance company that provides the group health insurance plan offered by the employer.

3. If it is not practical or feasible for the department to purchase coverage by making payment to those specified in subd. 1. or 2., and if requested by the employer or the insurance company offering the group health insurance plan, directly to the employee as reimbursement for premiums paid by the employee.

(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 employee.

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.

(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.

History: Cr. Register, February, 1986, No. 362, eff. 3−1−86; emerg. am. (4), cr. (8) and (9), eff. 7−1−92; am. (4), cr. (8) and (9), Register, February, 1993, No. 446, eff. 3−1−93; correction in (6) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, June, 1994, No. 462**;** cr. (10) to (12), Register, June, 1995, No. 474, eff. 7−1−95; am. (10) (intro.), (b), (c) (intro.), 3. to 6., (11) (a), (b) 1. (intro.), c., 2. (intro.), c., (12) (a) 2., 4. and 5., cr. (10) (d) and (12) (f) 2., renum. (12) (f) to be (12) (f) 1., Register, April, 1996, No. 484, eff. 5−1−96; correction in (9) (e) made under s. 13.93 (2m) (b) 6., Stats., Register, April, 1999, No. 520**;** emerg. cr. (13), eff. 7−1−99; emerg. cr. (9) (f), eff. 12−23−99; cr**.** (13), Register, March, 2000, No. 531, eff. 4−1−00; cr. (14) and (15), Register, November, 2000, No. 539, eff. 12−1−00.

HFS 108.03 County responsibilities. (1) DETERMINATION OF ELIGIBILITY. Agencies shall be responsible for determination of eligibility for MA. These determinations shall comply with standards for eligibility found in ss. 49.46 (1), 49.47 (4) and 49.665 (4) Stats., and ch. HFS 103.

(2) INFORMING RECIPIENTS OF RIGHTS AND DUTIES. Agencies shall inform recipients of the recipients' rights and duties under the program, including those rights enumerated in s. HFS 106.04 (3).

(3) RECOVERY OF INCORRECT PAYMENTS. (a) Agencies shall begin recovery action, as provided by statute for civil liabilities, on behalf of the department against any MA recipient to whom or on whose behalf an incorrect payment was made.

(b) The incorrect payment shall have resulted from a misstatement or omission of fact by the person supplying information during an application for MA benefits, or failure by the recipient, or any other person responsible for giving information on the recipient's behalf, to report income or assets in an amount which would affect the recipient's eligibility for benefits.

(c) The amount of recovery may not exceed the amount of the MA benefits incorrectly provided.

(d) Records of payment for the period of ineligibility, provided to the agency by the MA fiscal agent, shall be evidence of the amounts paid on behalf of the recipient.

(e) The agency shall notify the recipient or the recipient's representative of the period of ineligibility and the amounts incorrectly paid, and shall request arrangement of repayment within a specified period of time.

(f) If the effort to recover incorrect payments under par. (e) is not successful, the agency shall refer cases of possible recovery to the district attorney or corporation counsel for investigation and the district attorney or corporation counsel may bring whatever action may be appropriate for prosecution for fraud or collection under civil liability statutes. Judgments obtained in these actions shall be filed as liens against property in any county in which the recipient is known to possess assets, if not satisfied at the time the judgment or order for restitution is rendered. Execution may be taken on the judgments as otherwise provided in statute.

(g) The agency may seek recovery through an order for restitution by the court of jurisdiction in which the recipient or former recipient is being prosecuted for fraud.

(h) The agency's decision concerning ineligibility and amounts owed may be appealed pursuant to ch. HSS 225. During the appeal process the agency may take no further recovery actions pending a decision. Benefits shall be continued pending the decision on the appeal. When the hearing decision is subsequently adverse to the client the benefits paid pending a decision on the appeal shall be collectable as incorrect payments.

(i) The agency shall immediately deposit monies collected under this subsection to a designated bank account. The collection shall be reported to the department in the manner and on forms

designated by the department within 30 days following the end of the month in which the collection is made, and shall be transmitted to the state in accordance with departmental instructions.

(4) ESTABLISHING A PROGRAM OF MEDICAL SUPPORT LIABILITY. Pursuant to s. 59.53 (5), Stats., counties shall contract with the department to implement and administer the child support collection program under Title IV−D of the Social Security Act of 1935, as amended. One of the responsibilities of a county's child support agency defined in s. HSS 215.02 (1) is to establish a program of medical support liability along with the child and spousal support and paternity establishment program.

(5) INCENTIVE PAYMENTS FOR INSURANCE REPORTING. (a) Pursuant to approval by the federal health care financing administration, the department shall make payments under s. 49.45 (3) (am), Stats., to county and tribal agencies under this subsection, including agencies subject to the requirements under sub. (4), to encourage identification and reporting by these agencies of MA applicants and recipients who are covered by other medical insurance. Unless par. (b) applies, an agency shall receive an incentive payment if:

1. The agency identifies an MA applicant or recipient who is medically insured, identifies the person's insurance carrier providing the medical insurance coverage, and supplies information describing the person's insurance plan. The department's requirement for reporting specific information necessary to receive payment is further described in the *Medical Assistance Eligibility Handbook:* and

2. The department makes a reasonable effort to verify with the insurance carrier that the person's medical insurance was in effect during a coverage period corresponding to a period of MA eligibility occurring within the period of 12 months prior to the month in which the department received the county agency's information report for any MA applicant or recipient.

(b) Insurance policies which do not qualify for payment under this subsection shall be identified by the department based on factors that include cost effectiveness and the limitation of coverage. Policies which do not qualify under this subsection include the following:

1. A policy with coverage limited to specific diagnoses unless the policyholder has a diagnosis covered by the policy;

2. A policy limiting benefits to specific circumstances such as accidental injury;

3. A policy limiting benefits to the extent that coordinating benefits is administratively unfeasible; and

4. A policy not primarily intended as providing medical insurance coverage, such as a policy providing periodic benefits for disability or hospitalization, a policy providing liability insurance with payment for medical benefits or a policy which does not specifically cover medical services.

History: Cr. Register, December, 1979, No. 288, eff. 2−1−80; renum. from HSS 108.02 and am. Register, February, 1986, No. 362, eff. 3−1−86; cr. (6), Register, December, 1988, No. 396, eff. 1−1−89; r. (4), renum. (5) and (6) to be (4) and (5), Register, September, 1991, No. 429, eff. 10−1−91; correction in (5) made under s. 13.93 (am) (b) 7., Stats., Register, September, 1991, No. 429; correction in (3) (h) made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1995, No. 473**;** emerg. am. (1), eff. 7−1−99**;** am. (1), Register, March, 2000, No. 531, eff. 4−1−00; **correction in (4) made under s. 13.93 (2m) (b) 7., Stats**.