LRB-1098

1999 DRAFTING REQUEST

Bill

Received: **12/2/98**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget 7-7980**

By/Representing: **Geisler**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact:

Alt. Drafters:

Subject: **Public Assistance - med. assist.**
Health - miscellaneous

Extra Copies: **TAY**

Topic:

DOA:.....Geisler - Medical assistance services provider fraud and abuse changes

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/1	kenneda 12/19/98	gilfokm 12/26/98	ismith 12/28/98	_____ _____	lrb_docadmin 12/28/98		S&L
/2	kenneda 01/17/99	gilfokm 01/18/99	jfrantze 01/20/99	_____ _____	lrb_docadmin 01/20/99		S&L
/3	kenneda 01/21/99	gilfokm 01/21/99	jfrantze 01/22/99	_____ _____	lrb_docadmin 01/22/99		S&L

FE Sent For:

<END>

1999 DRAFTING REQUEST

Bill

Received: **12/2/98**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget 7-7980**

By/Representing: **Geisler**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact:

Alt. Drafters:

Subject: **Public Assistance - med. assist.**
Health - miscellaneous

Extra Copies: **TAY**

Topic:

DOA:.....Geisler - Medical assistance services provider fraud and abuse changes

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/1	kenneda 12/19/98	gilfokm 12/26/98	ismith 12/28/98	_____ _____	lrb_docadmin 12/28/98		S&L
/2	kenneda 01/17/99	gilfokm 01/18/99	jfrantze 01/20/99	_____ _____	lrb_docadmin 01/20/99		S&L

FE Sent For: /3 1-21-99 kmg 1/22 <END> 1/22

1999 DRAFTING REQUEST

Bill

Received: **12/2/98**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget 7-7980**

By/Representing: **Geisler**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact:

Alt. Drafters:

Subject: **Public Assistance - med. assist.**
Health - miscellaneous

Extra Copies: **TAY**

Topic:

DOA:.....Geisler - Medical assistance services provider fraud and abuse changes

---

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/1	kenneda 12/19/98	gilfokm 12/26/98	ismith 12/28/98	_____ _____	lrb_docadmin 12/28/98		S&L

FE Sent For: 12-1-19-99 kmg 12/20 12/20 lrb

<END>

LRB-1098

1999 DRAFTING REQUEST

Bill

Received: **12/2/98**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget 7-7980**

By/Representing: **Geisler**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact:

Alt. Drafters:

Subject: **Public Assistance - med. assist.**
Health - miscellaneous

Extra Copies: **TAY**

Topic:

DOA:.....Geisler - Medical assistance services provider fraud and abuse changes

---

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kenneda	1-12-26 kmg	IJS 12/28	IJS/CH 12/28			

FE Sent For:

<END>

Kennedy, Debora

From: Geisler, Jeffrey [jeffrey.geisler@doa.state.wi.us]
Sent: Wednesday, December 02, 1998 3:31 PM
To: Miller, Steve
Cc: Kennedy, Debora
Subject: Geisler 1999-01 Statutory Language Drafting Request #6


f&alegis.doc


ma-state-amdmts.doc

Steve,

Attached are two documents.
One describes a proposal to "re-structure the relationship between the [DHFS] Division of Health Care Financing and health care providers to create a relationship that more closely resembles the private insurance model."
The other document is the proposed statutory change as drafted by DHFS attorneys.

<<f&alegis.doc>>

<<ma-stats-amdmts.doc>>

I understand that the LRB has had a problem with opening Microsoft Word 97 files from DOA. If that happens here, please let me know ASAP and our tech support staff will work with your IT people to fix this problem.
Thanks
Jeffrey A. Geisler
267-7980
DOA State Budget Office

DIVISION OF HEALTH CARE FINANCING (DHCF)
BUREAU OF HEALTH CARE PROGRAM INTEGRITY (BHCPI)

ISSUE: Proposed Statute and Rule Changes Regarding Health Care Fraud & Abuse

BACKGROUND: At the recent DHCF briefing for the DHFS Secretary on the Medicaid Audit Program, Secretary Leean expressed interest in forwarding for consideration a package of statutory changes for inclusion in the DHFS 1999-01 Biennial Budget Proposal (and subsequent Administrative Code revisions). In response to that request, the Office of Legal Counsel and BHCPI drafted such revisions. The primary intent of the revisions is to re-structure the relationship between DHCF and providers to create a relationship that more closely resembles the private insurance model.

PROBLEM AREAS: The program currently encounters delays in securing the re-payment of monies identified as overpayments. The current system encourages appeals by delaying the time of collection until all appeals are concluded. In addition, the current administrative code grants rights to the providers that are not required by federal or state law. These rights prevent the Department from taking necessary actions until after the appeals process has been exhausted (admin. hearing , court appeals, judgement, etc...). These proposed changes would reduce the time required to complete the recovery or exclusion process, and would increase the program's authority to include or exclude providers based on the quality of their performance.

PROPOSED REVISIONS:

1. Remove areas of due process not required by federal or state law, by restricting right to hearing.
2. Create state false claims act based on federal model.
3. Increase Department's discretion in selecting and suspending providers, including the right to limit the number of providers in any given benefit area.
4. Require payment of interest on amounts not paid by DHCF deadline.
5. Allow use of surety bonds in areas of potential or actual high fraud or abuse.
6. Require providers to immediately respond to requests for records.
7. Allow withholding of identified overpayments from provider's tax refunds.
8. Permit exclusion of providers upon notice of guilty plea or guilty verdict.
9. Require pre-payments of overpayments prior to transfer of ownership.
10. Allow de-certification for failure to correct identified deficiencies.
11. Revise pre-payment and withholding criteria.
12. Allows Department to suspend provider's ability to submit claims electronically.

The proposed process would create four levels of issue identification:

Level One – Observation of program deficiency, no overpayment identified.

Level Two – Finding of Deficiency, overpayment identified and collected.

Level Three- Finding of Deficiency related to false claim, overpayment and penalty identified, provider has right to hearing on penalty.

Level Four – Finding of Deficiency based on possible fraudulent conduct, provider referred to law enforcement agencies.

PROPOSED MA STATUTORY AMENDMENTS

49.45(2)(a)9, 10, 11, 12, 13 and 14 are amended to read:

9. Periodically set forth conditions of participation and terms of reimbursement of providers ~~in a contract with provider~~ of service under this section.

10. a. Recover ~~After reasonable notice and opportunity for hearing,~~ recover money improperly or erroneously paid, or overpayments to a provider either by offsetting or adjusting amounts owed the provider under the program, crediting against a provider's future claims for reimbursement for other services or items furnished by the provider under the program, or by requiring the provider to make direct payment to the department or its fiscal intermediary.

b. The department shall afford the provider a prompt opportunity to present information and argument to department staff regarding a recovery imposed under this subdivision, but the provider is not entitled to a stay of collection of the amount to be recovered pending that opportunity.

c. If a provider fails to pay any part of a recovery under this subdivision by the deadline set by the department, the provider shall pay interest on any delinquent amount at the rate of one percent per month or fraction of a month from the date of the overpayment.

11. a. Establish criteria for ~~the~~ certification of ~~eligible~~ providers of services under this section ~~Title XIX of the social security act~~ and, except as provided in s. 49.48 , certify ~~such eligible~~ providers who meet those criteria.

b. The department may establish certification criteria that limit the number of providers of particular services, or that limit the amount of resources, including without limitation employes and equipment, a certified

provider may use to provide particular services to medical assistance recipients, if the department finds that existing certified providers and resources provide services that are adequate in quality and amount to meet recipients' need for those particular services, and that there is the potential for program fraud or abuse if additional providers are certified or additional resources are used by certified providers.

12. Decertify ~~or suspend~~ under this subdivision a provider from the medical assistance program, if after giving reasonable notice and opportunity for hearing, the department finds that the provider has violated federal or state law or administrative rule and the ~~such~~ violations are by law, regulation or rule grounds for decertification ~~or suspension~~, and suspend the provider pending hearing if the department includes in its decertification notice findings that the provider's continued participation pending hearing is likely to lead to the irretrievable loss of public funds and is not necessary to provide adequate access to services to recipients. No payment may be made under the medical assistance program with respect to any service or item furnished by the provider subsequent to decertification or during the period of suspension.

13. Impose additional sanctions for noncompliance with the conditions of participation and terms of reimbursement ~~provider agreements~~ under subd. 9. or certification criteria established under subd. 11.

~~14. Assure due process in implementing subds. 12. and 13. by providing written notice, a fair hearing and a written decision.~~

49.45(2)(b)6 is created to read:

By rule require each provider in a provider type that has demonstrated significant potential for fraud or abuse to file with the department a surety bond in a reasonable amount. The bond must be payable to the department to compensate the department for damages resulting from recoveries, forfeitures or fines imposed in connection with a false claim or statement under sub. (3m) or an act of fraud or abuse committed by the provider under the medical assistance program. ***[This is based on a Texas statute that reads almost identically.]***

49.45(3)(f)3. is amended to read:

Contractors under sub. (2) (b) shall maintain records as required by the department for audit purposes. Contractors shall provide the department access to the records immediately upon request of the department, and the department may audit the records.

49.45(3)(g) is amended to read:

(g) The secretary may appoint personnel to audit or investigate and report to the department on any matter involving violations or complaints alleging violations of laws, regulations, or rules applicable to Title XIX of the federal social security act or the medical assistance program and to perform any ~~such~~ investigations or audits as are required to verify the actual provision of services or items available under the medical assistance program and the appropriateness and accuracy of claims for reimbursement submitted by providers participating in the program. Department employes appointed by the secretary under this paragraph shall be issued and shall possess at all times during

which they are performing their investigatory or audit functions under this section identification signed by the secretary which specifically designates the bearer as possessing the authorization to conduct medical assistance investigations or audits. Pursuant to the request of a designated person and upon presentation of that person's authorization, providers and recipients immediately shall accord that ~~such~~ person access to any provider personnel, records, books, recipient medical records, documents or other information needed. Authorized employes shall have authority to hold hearings, administer oaths, take testimony and perform all other duties necessary to bring the ~~such~~ matter before the department for final adjudication and determination.

49.45(3)(h) is amended to read:

~~1. For purposes of any audit, investigation, examination, analysis, review or other function authorized by law with respect to the medical assistance program, the secretary shall have the power to sign and issue subpoenas to any person requiring the production of any pertinent books, records, medical records or other information. Subpoenas so issued shall be served by anyone authorized by the secretary by delivering a copy thereof to the person named therein, or by registered mail or certified mail addressed to such person at his or her last known residence or principal place of business. A verified return by the person so serving the subpoena setting forth the manner of service, or, in the event service is by registered or certified mail, the return post office receipt signed by the person so served shall constitute proof of service.~~

~~2. In the event of contumacy or refusal to obey a subpoena issued under this paragraph and duly served upon any person, any judge in a court of record in the county where the person was served may enforce the subpoena in accordance with s. 885.12.~~

~~3.~~ The failure or refusal of a provider to immediately accord department auditors or investigators access to any provider personnel, records, books, recipient medical records, documents or other information needed ~~person to purge himself or herself of contempt found under s. 885.12 and perform the act as required by law~~ shall constitute grounds for decertification or suspension of that provider ~~person~~ from participation in the medical assistance program and no payment may be made for services rendered by that provider ~~person~~ subsequent to decertification or during the period of suspension.

49.45(3m) is created to read:

[title] *Administrative Remedies for False Claims and Statements.*

(a) Definitions. As used in this subsection:

1. "Knows or has reason to know" means that a provider has actual knowledge that a claim or statement is false, fictitious, or fraudulent, acts in deliberate ignorance of the truth or falsity of the claim or statement or acts in reckless disregard of the truth or falsity of the claim or statement, and no proof of specific intent to defraud is required.

2. "Claim" means any request submitted by a provider of medical assistance for reimbursement for services or items purportedly furnished by the provider under the medical assistance program.

3. "Statement" means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made with respect to a claim or to obtain the approval or payment of a claim.

(b) 1. No provider may submit or cause to be submitted a claim if the provider knows or has reason to know any of the following about the claim:

a. The claim is false, fictitious, or fraudulent.

b. The claim includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent.

c. The claim includes or is supported by any written statement that omits a material fact, is false, fictitious, or fraudulent as a result of the omission and is a statement in which the provider has a duty to include the material fact.

d. The claim is for payment for the provision of services or items which the provider has not provided as claimed.

2. No provider may make or cause to be made a written statement that contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of its contents if the provider knows or has reason to know either of the following:

a. The written statement asserts a material fact which is false, fictitious, or fraudulent.

b. The written statement omits a material fact, is false, fictitious, or fraudulent as a result of that omission and is a statement in which the provider has a duty to include the material fact.

(c) In addition to any recovery under sub. (2)(a)10 and any other remedy that may be provided by law, the department may impose against any provider that violates paragraph (b) either or both of the following:

1. An administrative forfeiture of not more than [$ 5,000] for each statement or claim.

2. In the case of a claim that violates par. (b)1, an assessment, in lieu of damages sustained by the department because of the claim, of not more than twice the amount of the claim, or the portion of the claim, which is determined to be in violation of par. (b)1.

(d) The department shall transmit to the Attorney General a written notice of the intention of the department to impose an administrative forfeiture or assessment under this subsection. The notice shall include the department's reasons for imposing the administrative forfeiture or assessment, a summary of the evidence which supports the action, a description of the claims or statements for which liability is alleged, an estimate of the amount of money claimed in violation of this subsection and a statement of any exculpatory or mitigating circumstances which may relate to the claims or statements. Within [90] days after receipt of a notice under this paragraph the Attorney General either approve or disapprove the imposition of the administrative forfeiture or assessment. In any case in which the action is disapproved, the Attorney General shall give reasons for the disapproval. The department may impose an administrative forfeiture or assessment under this paragraph only if the Attorney General approves the action.

(e) The department shall send a notice to a provider alleged to be liable under this subsection specifying the allegations of liability and the amount of any administrative forfeiture or assessment to be imposed against the provider and giving the provider notice of the right to request a hearing. The provider may request a hearing within 30 days after receiving notice under this paragraph by serving on the department and the division of hearings and

appeals a written request for hearing. The hearing shall be conducted as a class 2 contested case hearing under ch. 227.

(f) The Attorney General shall be responsible for judicial enforcement of any administrative forfeiture or assessment imposed pursuant to the provisions of this subsection. Any administrative forfeiture or assessment which has become final pursuant to this subsection may be recovered in a civil action brought by the Attorney General. In any action, no matter that was raised or that could have been raised in a hearing under paragraph (e) may be raised as a defense, and the determination of liability and the determination of amounts of penalties and assessments shall not be subject to review. In addition to the remedy provided in this paragraph, the amount of any administrative forfeiture or assessment which has become final under this subsection may also be collected by recoupment against future claims submitted by the provider.

(g) For purposes of this subsection, all of the following apply:

1. Each claim form constitutes a separate claim.

2. Each representation, certification, affirmation, document, record, or accounting or bookkeeping entry constitutes a separate statement.

3. A claim is subject to this subsection regardless of whether the claim is actually paid.

4. A claim is considered made when it is received by the fiscal agent.

5. Except as provided in subd. 6, a statement is considered made when it is received by the fiscal agent.

6. Notwithstanding subd. 5, a document, record, accounting or bookkeeping entry or other statement that is not submitted to the fiscal agent but is retained by the provider to support a claim, is considered made when it is entered in the provider's books, files or other records.

49.45(13) is amended to read:

Financial reports. (a) The department may require service providers to prepare and submit cost reports or financial reports for purposes of rate certification under Title XIX, cost verification, fee schedule determination or research and study purposes. These financial reports may include independently audited financial statements which shall include balance sheets and statements of revenues and expenses. The department may withhold reimbursement or may decrease or not increase reimbursement rates if a provider does not submit the reports required under this paragraph within the period specified by the department or if the costs on which the reimbursement rates are based cannot be verified from the provider's cost or financial reports ~~or records from which the reports are derived~~.

(b) In addition to the remedies specified under par. (a), the ~~The~~ department may require any provider who fails to submit a cost report or financial report under par. (a) within the period specified by the department to forfeit not less than $10 nor more than $100 for each day the provider fails to submit the report. If a provider wishes to contest a forfeiture imposed by the department under this paragraph, the provider shall, within 10 days after receipt of notice of the forfeiture, notify the department in writing of its request for hearing under s. 227.44.

49.45(21) is amended to read:

Transfer of business, liability for repayments. (a) If any provider liable for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497 desires to sell or otherwise transfer ~~sells or otherwise transfers~~ ownership of his or her business or all or substantially all of the assets of the business, the transferor and transferee are each liable for the repayment. Prior to final transfer, the transferee and transferor are ~~is~~ responsible for contacting the department and ascertaining the extent of any liability ~~if the transferor is liable~~ under this paragraph.

(b) No ~~If a~~ transfer may occur if ~~occurs and~~ the applicable amount under par. (a) has not been repaid~~, the department may proceed against either the transferor or the transferee. Within 30 days after receiving notice from the department, the transferor or the transferee shall pay the amount in full.~~ Upon failure to comply, the department may bring an action to compel payment~~. If a transferor fails to pay within 90 days after receiving notice from the department, the department may~~ or proceed under sub. (2) (a) 12 or both.

(c) The department may enforce this subsection within 4 years following a transfer.

(d) This subsection supersedes any provision of chs. 180 , 181 and 185 .

49.85(2)(a) is amended to read:

At least annually, the department of health and family services shall certify to the department of revenue the amounts that, based on the notifications received under sub. (1) and on other information received by the department of health and family services, the department of health and family services has determined that it may recover under s. 49.45(2)(a)10 or 49.497 , except

that the department of health and family services may not certify an amount under this subsection unless it has met the notice requirements under sub. (3) and unless its determination has either not been appealed or is no longer under appeal.

49.85(3)(a)1. is amended to read:

Inform the person that the department of health and family services intends to certify to the department of revenue an amount that the department of health and family services has determined to be due under s. 49.45(2)(a)10 or 49.497, for setoff from any state tax refund that may be due the person.

71.93(1)(a)3. is amended to read:

An amount that the department of health and family services may recover under s. 49.45(2)(a)10 or 49.497, if the department of health and family services has certified the amount under s. 49.85.

227.01(13)(zu) and (zv) are created to read:

(zu) Sets forth conditions of participation and terms of reimbursement of providers of service under section 49.45(2)(a)9.

(zv) Establishes guidelines for the medical determination whether to grant prior authorization for medical assistance coverage of services under s. 49.46 or 49.47.

SOON – in editing 12/19

State of Wisconsin
1999 – 2000 LEGISLATURE

D-NOTE

LRB–1098/1
DAK...:.....

DOA:.....Geisler – Medical assistance services provider fraud and abuse changes

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

AN ACT Don't Gen Cat. ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under current law under the medical assistance (MA) program, the department of health and family services (DHFS) certifies persons or facilities that meet certain criteria as providers and pays for services and items that MA recipients receive from the providers. Currently, DHFS is authorized or required to enforce numerous sanctions against providers who fail to comply with requirements under the MA program or to whom MA payments have been improperly or erroneously made or overpayments have been made. Currently, prohibitions exist against fraud in applications for, rights to and conversion of MA benefits or payments. These prohibitions are punishable by fines and imprisonment.

This bill prohibits MA providers from submitting false claims and false statements that accompany the claims for payment of services or items that the provider furnishes under the MA program. The bill permits DHFS to assess forfeitures for violations of the prohibitions and to impose a surcharge on a forfeiture that is assessed. Further, the bill establishes notice and hearing requirements for providers to contest assessment of a forfeiture and forfeiture and surcharge payment requirements, and permits the attorney general to bring an action to collect outstanding forfeitures and surcharges.

The bill authorizes DHFS to require certain MA providers, as a condition of certification, to file with DHFS a surety bond, payable to DHFS, under terms and in an amount specified by DHFS by rule, that would reasonably contribute to DHFS' costs to pursue recovery of overpayments or to investigate and pursue allegations of false claims or statements. Providers who are required to file the surety bonds are those who provide MA services, as specified by DHFS by rule, for which providers have demonstrated significant potential to violate fraud prohibitions, to require recovery of overpayments or to need certain additional sanctions.

The bill authorizes DHFS, if it first makes specified findings, to prescribe MA provider certification criteria that limit the number of providers of particular services or that limit the amount of resources, including employes and equipment, that a certified provider may use to provide MA services and items.

The bill changes numerous provisions relating to procedures for the recovery by DHFS of improper or erroneous MA payments or overpayments, including all of the following:

1. ~~Eliminating~~ reasonable notice and hearing opportunity requirements and, instead, ~~requiring~~ DHFS to promptly afford an opportunity for a provider to present information and argument, but ~~permitting~~ DHFS to collect the amount to be recovered pending that opportunity.

2. ~~Establishing~~ a deadline for payment of recoveries and ~~requiring~~ payment of interest on delinquent amounts.

The bill authorizes DHFS, if certain criteria are met, to suspend certification for a provider pending a hearing on whether the provider has violated federal or state laws.

The bill authorizes DHFS to prescribe conditions of MA participation and reimbursement terms and to impose additional sanctions for noncompliance. Also, the bill requires immediate access, upon request by DHFS, to provider records and specifies that a provider's failure to provide access constitutes grounds for decertification. Lastly, the bill voids a sale of ownership of a business by a MA provider if the provider was liable for repayment of improper or erroneous payments or overpayments.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (2) (a) 9. of the statutes is amended to read:

49.45 **(2)** (a) 9. Periodically ~~set forth~~ prescribe conditions of participation and terms of reimbursement ~~in a contract with provider~~ of service under this section.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120,

176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 2. 49.45 (2) (a) 10. of the statutes is renumbered 49.45 (2) (a) 10. a. and amended to read:

49.45 **(2)** (a) 10. a. ~~After reasonable notice and opportunity for hearing, recover~~ Recover money improperly or erroneously paid, or overpayments to a provider ~~either~~ by offsetting or adjusting amounts owed the provider under the program, crediting against a provider's future claims for reimbursement for other services or items furnished by the provider under the program~~, or by~~ or requiring the provider to make direct payment to the department or its fiscal intermediary.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 3. 49.45 (2) (a) 10. b. of the statutes is created to read:

49.45 **(2)** (a) 10. b. Promptly afford the provider an opportunity to present information and argument regarding a recovery imposed under this subdivision, but need not stay collection of the amount to be recovered pending that opportunity.

SECTION 4. 49.45 (2) (a) 10. c. of the statutes is created to read:

49.45 **(2)** (a) 10. c. Establish a deadline for payment of a recovery imposed under this subdivision and, if a provider fails to pay all of the amount to be recovered by the deadline, require payment by the provider of interest on any delinquent amount at the rate of 1% per month or fraction of a month from the date of the overpayment.

SECTION 5. 49.45 (2) (a) 11. of the statutes is amended to read:

49.45 **(2)** (a) 11. Establish criteria for ~~the~~ certification of ~~eligible~~ providers of ~~services under Title XIX of the social security act~~ medical assistance and, except as

provided in par. (b) 6. and 7. and s. 49.48, certify ~~such eligible~~ providers who meet the criteria.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 6. 49.45 (2) (a) 12. of the statutes is amended to read:

49.45 **(2)** (a) 12. Decertify ~~or suspend under this subdivision~~ a provider from the medical assistance program, if after giving reasonable notice and opportunity for hearing, the department finds that the provider has violated a federal statute or regulation or a state ~~law~~ statute or administrative rule and ~~such violations are~~ the violation is by ~~law~~ statute, regulation or rule grounds for decertification or suspension. The department shall suspend the provider pending the hearing under this subdivision if the department includes in its decertification notice findings that the provider's continued participation in the medical assistance program pending hearing is likely to lead to the irretrievable loss of public funds and is unnecessary to provide adequate access to services to medical assistance recipients. No payment may be made under the medical assistance program with respect to any service or item furnished by the provider subsequent to decertification or during the period of suspension.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 7. 49.45 (2) (a) 13. of the statutes is amended to read:

49.45 **(2)** (a) 13. Impose additional sanctions for noncompliance with the conditions of participation and terms of ~~provider agreements~~ reimbursement under

subd. 9. or certification criteria established under subd. 11 and, if prescribed by the department, under par. (b) 6 or 7.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 8. 49.45 (2) (b) 6. of the statutes is created to read:

49.45 **(2)** (b) 6. Prescribe criteria for certification of providers of medical assistance that limit the number of providers of particular services or that limit the amount of resources, including employes and equipment, that a certified provider may use to provide particular services to medical assistance recipients, if the department finds all of the following:

a. That existing certified providers and resources provide services that are adequate in quality and amount to meet the need of medical assistance recipients for the particular services.

b. That the potential for medical assistance fraud or abuse exists if additional providers are certified or additional resources are used by certified providers.

SECTION 9. 49.45 (2) (b) 7. of the statutes is created to read:

49.45 **(2)** (b) 7. Require, as a condition of certification under par. (a) 11., a provider, as specified in this subdivision, to file with the department a surety bond issued by a surety company licensed to do business in this state. Providers subject to this subdivision provide those services under medical assistance for which providers have demonstrated significant potential to violate s. 49.489 (2) or (3), 49.49 (1) (a), (2) (a) or (b), (3), (3m) (a), (3p), (4) (a) or (4m) (a), to require recovery under par. (a) 10. or to need additional sanctions under par. (a) 13. The surety bond shall be payable to the department and in an amount that would reasonably contribute to payment of the department's costs to pursue recovery under par. (a) 10. or to

investigate and pursue allegations of violations of s. 49.489 or 49.49. The department shall promulgate rules under this subdivision that specify all of the following:

a. Services under medical assistance for which providers have demonstrated significant potential to violate s. 49.489 (2) or (3), 49.49 (1) (a), (2) (a) or (b), (3), (3m) (a), (3p), (4) (a) or (4m) (a), to require recovery under par. (a) 10. or to need additional sanctions under par. (a) 13.

b. The amount or amounts of the surety bonds.

c. Terms of the surety bond, including amounts, if any, without interest to be refunded to the provider upon withdrawal or decertification from the medical assistance program.

SECTION 10. 49.45 (3) (f) 3. of the statutes is amended to read:

49.45 **(3)** (f) 3. Contractors under sub. (2) (b) shall maintain records as required by the department for audit purposes. ~~Contractors~~ Upon request of the department, contractors shall immediately provide the department access to the records ~~upon request of the department, and~~, which the department may audit ~~the records~~.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 11. 49.45 (3) (g) of the statutes is amended to read:

49.45 **(3)** (g) The secretary may ~~appoint~~ authorize personnel to audit or investigate and report to the department on any matter involving violations or complaints alleging violations of ~~laws~~ statutes, regulations, or rules applicable to ~~Title XIX of the federal social security act or~~ the medical assistance program and to perform ~~such~~ investigations or audits ~~as~~ that are required to verify the actual provision of services or items available under the medical assistance program and

the appropriateness and accuracy of claims for reimbursement submitted by providers participating in the program. Department employes ~~appointed~~ authorized by the secretary under this paragraph shall be issued and shall possess at all times ~~during which~~ while they are performing their investigatory or audit functions under this section identification signed by the secretary ~~which~~ that specifically designates the bearer as possessing the authorization to conduct medical assistance investigations or audits. ~~Pursuant to~~ Under the request of a designated person and upon presentation of ~~that~~ the person's authorization, providers and medical assistance recipients shall immediately accord ~~such~~ the person access to any provider personnel, records, books~~, recipient medical records,~~ or documents or other information needed. Under the written request of a designated person and upon presentation of the person's authorization, providers and recipients shall immediately accord the person access to any needed patient health care records of a recipient. Authorized employes ~~shall have authority to~~ may hold hearings, administer oaths, take testimony and perform all other duties necessary to bring ~~such~~ the matter before the department for final adjudication and determination.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 12. 49.45 (3) (h) 1. of the statutes is repealed.

SECTION 13. 49.45 (3) (h) 2. of the statutes is repealed.

SECTION 14. 49.45 (3) (h) 3. of the statutes is renumbered 49.45 (3) (h) and amended to read:

49.45 **(3)** (h) The failure or refusal of a ~~person to purge himself or herself of contempt found under s. 885.12 and perform the act as required by law shall constitute~~ provider immediately to accord department auditors under par. (f) 3. or

investigators under par. (g) access to any provider personnel, records, books, patient health care records of medical assistance recipients or documents or other information requested constitutes grounds for decertification or suspension of ~~that person~~ the provider from participation in the medical assistance program and no payment may be made for services rendered by ~~that person subsequent to~~ the provider following decertification or during the period of suspension.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 15. 49.45 (13) (a) of the statutes is amended to read:

49.45 **(13)** (a) The department may require ~~service~~ providers to prepare and submit cost reports or financial reports for purposes of rate certification under Title XIX of the federal social security act, cost verification, fee schedule determination or research and study purposes. These financial reports may include independently audited financial statements ~~which shall include~~, including balance sheets and statements of revenues and expenses. The department may withhold reimbursement or may decrease or not increase reimbursement rates if a provider does not submit the reports required under this paragraph within the period specified by the department or if the costs on which the reimbursement rates are based cannot be verified from the provider's cost or financial reports ~~or records from which the reports are derived~~.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 16. 49.45 (13) (b) of the statutes is amended to read:

49.45 **(13)** (b) ~~The~~ In addition to the remedies specified under par. (a), the department may require any provider who fails to submit a cost report or financial

report under par. (a) within the period specified by the department to forfeit not less than $10 nor more than $100 for each day the provider fails to submit the report. A provider may contest the imposition of a forfeiture under this paragraph by submitting a written request for a hearing under s. 227.44 to the department within 10 days following the date on which the provider received notice of the forfeiture.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 17. 49.45 (21) (a) of the statutes is amended to read:

49.45 **(21)** (a) If any provider liable for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497 sells or otherwise transfers ownership of his or her business or all or substantially all of the assets of the business, the transferor and transferee are each liable for the repayment. Prior to final transfer, the transferee ~~is~~ and transferor are responsible for contacting the department and ascertaining ~~if the transferor is liable~~ the extent of any liability under this paragraph.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 18. 49.45 (21) (b) of the statutes is amended to read:

49.45 **(21)** (b) If a sale or other transfer specified in par. (a) occurs and the applicable amount under par. (a) has not been repaid, the ~~department may proceed against either the transferor or the transferee~~ sale or other transfer is void. ~~Within 30 days after receiving notice from the department, the transferor or the transferee shall pay the amount in full. Upon failure to comply, the~~ The department may bring an action to compel payment. ~~If a transferor fails to pay within 90 days after~~

~~receiving notice from the department, the department~~ or may proceed under sub. (2) (a) 12~~.~~, or both.

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20 ss. 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469; 1995 a. 20; 1995 a. 27 ss. 2947 to 3002r, 7299, 9126 (19), 9130 (4), 9145 (1); 1995 a. 191, 216, 225, 289, 303, 398, 417, 457; 1997 a. 3, 13, 27, 114, 175, 191, 237, 252, 293.

SECTION 19. 49.489 of the statutes is created to read:

49.489 False claims or statements prohibited. (1) In this section:

(a) "Claim" means a request submitted by a provider for payment for services or items furnished by the provider under the medical assistance program.

(b) "Statement" means a representation, certification, affirmation, document, record or accounting or bookkeeping entry made with respect to a claim or to obtain approval or payment of a claim.

(2) No provider may submit a claim or cause a claim to be submitted if the provider knows or should know any of the following:

(a) The claim is false.

(b) The claim includes or is supported by a written statement that asserts a material fact that is false.

(c) The claim includes or is supported by a written statement that omits a material fact that the provider has a duty to include and, by reason of the omission, is false.

(3) No provider may make or cause to be made a written statement that contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the statement if the provider knows or should know any of the following:

(a) The statement asserts a material fact that is false.

(b) The statement omits a material fact that the provider has a duty to include and, by reason of the omission, is false.

(4) For purposes of subs. (2) and (3), all of the following apply:

(a) Each claim form constitutes a separate claim.

(b) Each representation, certification, affirmation, document, record or accounting or bookkeeping entry constitutes a separate statement.

(c) A claim is subject to this section regardless of whether the claim is actually paid.

(d) A claim is considered to be made when it is received by the fiscal agent.

(e) Except as provided in par. (f), a statement is considered to be made when it is received by the fiscal agent.

(f) A statement that is not submitted to a fiscal agent but is retained by the provider to support a claim is considered to be made when it is entered in the provider's books, files or other records.

(5) Any person who violates sub. (2) or (3) may be required to forfeit not more than $5,000 for each offense.

(6) If the department assesses a forfeiture under sub. (5) for a violation of sub. (2), the department may impose on the violator, in addition to the forfeiture assessment, a false claim surcharge in an amount that is not more than 200% of the amount of the claim in regard to which sub. (2) was found to have been violated.

(7) The department may directly assess a forfeiture provided for in sub. (5). If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the alleged violator. The notice shall specify the amount of the forfeiture assessed, the violation, the

statute alleged to have been violated and shall inform the alleged violator of the right to a hearing under sub. (8).

(8) An alleged violator may contest an assessment of forfeiture by sending, within 30 days after receipt of the notice under sub. (7), a written request for hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days of receipt of the request for hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

(9) All forfeitures and false claim surcharges, if any, shall be paid to the department within 10 days of receipt of notice of assessment or, if the forfeiture is contested under sub. (8), within 10 days of receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund. The department shall credit all false claims surcharges to the appropriation account under s. 20.435 (1) (kx).

(10) The attorney general may bring an action in the name of the state to collect any forfeiture or false claim surcharge imposed under this section if the forfeiture or false claim surcharge has not been paid following the exhaustion of all administrative and judicial reviews. The only issue to be contested in any such action is whether the forfeiture or false claim surcharge has been paid.

SECTION 20. 49.85 (2) (a) of the statutes is amended to read:

49.85 **(2)** (a) At least annually, the department of health and family services shall certify to the department of revenue the amounts that, based on the notifications received under sub. (1) and on other information received by the department of health and family services, the department of health and family services has determined that it may recover under s. 49.45 (2) (a) 10. or 49.497, except that the department of health and family services may not certify an amount under this subsection unless it has met the notice requirements under sub. (3) and unless its determination has either not been appealed or is no longer under appeal.

History: 1993 a. 437, 1995 a. 27 ss. 2143 to 2157, 3212, 9126 (19), 9130 (4); Stats. 1995 s. 49.85; 1995 a. 289; 1997 a. 3.

SECTION 21. 49.85 (3) (a) 1. of the statutes is amended to read:

49.85 **(3)** (a) 1. Inform the person that the department of health and family services intends to certify to the department of revenue an amount that the department of health and family services has determined to be due under s. 49.45 (2) (a) 10. or 49.497, for setoff from any state tax refund that may be due the person.

History: 1993 a. 437, 1995 a. 27 ss. 2143 to 2157, 3212, 9126 (19), 9130 (4); Stats. 1995 s. 49.85; 1995 a. 289; 1997 a. 3.

SECTION 22. 50.03 (13) (a) of the statutes is amended to read:

50.03 **(13)** (a) *New license.* Whenever ownership of a facility is transferred from the person or persons named in the license to any other person or persons, the transferee must obtain a new license. The license may be a probationary license. Penalties under sub. (1) shall apply to violations of this subsection. The transferee shall notify the department of the transfer, file an application under sub. (3) (b) and apply for a new license at least 30 days prior to final transfer. Retention of any interest required to be disclosed under sub. (3) (b) after transfer by any person who held such an interest prior to transfer may constitute grounds for denial of a license where violations of this subchapter for which notice had been given to the transferor

are outstanding and uncorrected, if the department determines that effective control over operation of the facility has not been transferred. If the transferor was a provider under s. 49.43 (10), the transferee and transferor shall comply with s. 49.45 (21).

History: 1975 c. 413; 1977 c. 29, 170, 205, 272, 418, 447; 1979 c. 221; 1981 c. 20, 72, 121; 1981 c. 314 s. 146; 1985 a. 29 ss. 1058, 3202 (56) (a); 1985 a. 176; 1985 a. 182 s. 57; 1985 a. 332 s. 251 (1), (3); 1987 a. 27, 127, 399; 1989 a. 31, 359; 1991 a. 39, 221; 1993 a. 27, 112, 375, 491; 1995 a. 27 ss. 3227 to 3232, 9126 (19), 1997 a. 27, 114.

SECTION 23. 71.93 (1) (a) 3. of the statutes is amended to read:

71.93 **(1)** (a) 3. An amount that the department of health and family services may recover under s. 49.45 (2) (a) 10. or 49.497, if the department of health and family services has certified the amount under s. 49.85.

History: 1987 a. 312; 1989 a. 31; 1993 a. 437; 1995 a. 27 ss. 3427 to 3429, 9126 (19), 9130 (4); 1995 a. 404; 1997 a. 3, 27. History: 1987 a. 312; 1989 a. 31; 1993 a. 437; 1995 a. 27 ss. 3427 to 3429, 9126 (19), 9130 (4); 1995 a. 404; 1997 a. 3, 27.

SECTION 24. 227.01 (13) (zL) of the statutes is created to read:

227.01 **(13)** (zL) Prescribes conditions of participation and terms of reimbursement of providers under s. 49.45 (2) (a) 9.

SECTION 9323. Initial applicability; health and family services.

(1) TRANSFERS BY LIABLE PROVIDERS OF MEDICAL ASSISTANCE. The treatment of sections 49.45 (21) (a) and (b) and 50.03 (13) (a) of the statutes first applies to sales or other transfers completed on the effective date of this subsection.

(2) FALSE CLAIMS OR STATEMENTS BY PROVIDERS OF MEDICAL ASSISTANCE. The treatment of section 49.489 of the statutes first applies to violations of section 49.489 (2) or (3) of the statutes, as created by this act, that occur on the effective date of this subsection.

(3) DECERTIFICATION OR SUSPENSION OF PROVIDERS OF MEDICAL ASSISTANCE. The treatment of section 49.45 (2) (a) 12. of the statutes first applies to violations of federal statutes or regulations or state statutes or rules committed on the effective date of this subsection.

(4) SANCTIONS FOR NONCOMPLIANCE BY PROVIDERS OF MEDICAL ASSISTANCE. The treatment of section 49.45 (2) (a) 13. of the statutes first applies to instances of noncompliance with conditions of participation or terms of reimbursement or certification criteria that occur on the effective date of this subsection.

(END)

D-NOTE

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1098/1dn
DAK...

To Jeff Geisler:

1. Please review my change to the language proposed for s. 49.45 (2) (a) 9. The term "set forth" seemed vague, if it is no longer being used in the context of terms of a specific contract.

2. Note that I substituted "medical assistance" (a defined term) for "services under this section" proposed for s. 49.45 (2) (a) 11., stats. If the intent here was for "this section" to modify "certification", it would appear to be redundant and therefore unnecessary; if, however, the intent was to modify "services", the language would be inaccurate, since medical assistance services are provided under several sections in addition to s. 49.45, stats. I deleted "services", since the definition of "medical assistance" under s. 49.43 (8), stats., makes it clear that items also are provided.

3. Note that I created material proposed as s. 49.45 (2) (a) 11. b. instead as s. 49.45 (2) (b) 6. The material is proposed as a power, rather than a duty, of the department and therefore is appropriate for location in s. 49.45 (2) (b), stats.

4. Because it is likely that certification as a provider of medical assistance confers on the holder of the certification a property right, elimination of the due process rights of written notice, a fair hearing and a written decision in s. 49.45 (2) (a) 14., stats., is likely to be vulnerable to a challenge under article I, section 1, of the Wisconsin Constitution and the Fifth and Fourteenth Amendments of the United States Constitution. I, therefore, have not repealed the subdivision in this version of the draft. I do not have time to research this issue. Please let me know what you want to do here.

5. Currently, s. 49.45 (3) (g), stats., requires that providers accord the department's investigator access to records, books, recipient medical records, documents or other information needed "[P]ursuant to the request of a designated person and upon presentation of that person's authorization." The requested language change adds access to provider personnel to this paragraph and uses the same list in amending s. 49.45 (3) (h) 3., stats., to establish grounds for decertification or suspension of a provider who fails or refuses to accord access. I have updated the term "recipient medical records" to "patient health care records of medical assistance recipients" (see s. 146.81 (4), stats.). However, I note that under s. 146.82, stats., personnel such as those described in s. 49.45 (3) (g), stats., appear to be able to have access, without informed consent, only under s. 146.82 (2) (a) 5., stats. This subdivision requires a *written* request by a state governmental agency. It is unclear if s. 49.45 (3) (g), stats.,

requires written or oral requests. I have therefore amended s. 49.45 (3) (g), stats., to require a written request for access to patient health care records, to avoid putting a provider in a double bind of being unable to comply with s. 49.45 (3) (g), stats., because of the requirement of s. 146.82 (2) (a) 5., stats., and thus being subject to s. 49.45 (3) (h), stats. Okay?

6. With respect to the amendment to s. 49.45 (13) (b), stats., when must DHFS hold a hearing? Should mention of judicial review be made? (Please see, for example, ss. 48.72 and 49.498 (16) (f), stats.)

7. I did not draft the proposed amendment to the first sentence of s. 49.45 (21) (a), stats.; liability does not attach upon the feeling of a desire to sell or transfer.

8. I did not draft the language proposed as s. 227.01 (13) (zv) (an exception to rule–making requirements). The proposal is not explained in the materials accompanying the request; it appears to relate to subject matter that is different from the other parts of the request. Is the department making the medical determination? Please let me know what is intended here.

9. Please read s. 49.45 (2) (b) 7. very carefully. Should the surety bond be a condition of certification, as drafted? Is it essential to have only certain providers and not others provide the bond? If this is a condition of certification, because a property interest is involved, requiring of some providers but not all may involve an equal protection problem. Note that I have made some provision about withdrawal or decertification of a provider. Okay?

10. In drafting s. 49.489, I have eliminated approval by the attorney general of imposition of forfeitures; this type of review, for each forfeiture, has no precedent and seems to serve no particularly useful purpose—it would seem that the department need not have the attorney general determine if their allegations are frivolous. Perhaps this is a requirement in Texas (the origin of the language is not specified), but in Wisconsin, for DHFS, the only review by the attorney general is for "fifth standard" cases and is done to ensure that the standard, as administered, would meet constitutional requirements. Here there seem to be no constitutional questions. For s. 49.489 I have, in large part, used language from s. 50.04 (4), stats., and, on the advice of the drafters for civil procedure and criminal law, have used the term "knows or should know" and have eliminated the term and definition of "knows or has reason to know", which, in any event, was circular. I drafted the "assessment as a false claims surcharge", but I did not draft the provision that permitted collection of the amount by recoupment against future claims submitted by the provider, because I have required deposit of the surcharge in s. 20.435 (1) (kx), stats.,which permits expenditure by DHFS for the MA program. Please review.

Debora A. Kennedy
Assistant Chief Counsel
266–0137

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1098/1dn
DAK:kmg:ijs

December 28, 1998

To Jeff Geisler:

1. Please review my change to the language proposed for s. 49.45 (2) (a) 9. The term "set forth" seemed vague, if it is no longer being used in the context of terms of a specific contract.

2. Note that I substituted "medical assistance" (a defined term) for "services under this section" proposed for s. 49.45 (2) (a) 11., stats. If the intent here was for "this section" to modify "certification", it would appear to be redundant and therefore unnecessary; if, however, the intent was to modify "services", the language would be inaccurate, since medical assistance services are provided under several sections in addition to s. 49.45, stats. I deleted "services", since the definition of "medical assistance" under s. 49.43 (8), stats., makes it clear that items also are provided.

3. Note that I created material proposed as s. 49.45 (2) (a) 11. b. instead as s. 49.45 (2) (b) 6. The material is proposed as a power, rather than a duty, of the department and therefore is appropriate for location in s. 49.45 (2) (b), stats.

4. Because it is likely that certification as a provider of medical assistance confers on the holder of the certification a property right, elimination of the due process rights of written notice, a fair hearing and a written decision in s. 49.45 (2) (a) 14., stats., is likely to be vulnerable to a challenge under article I, section 1, of the Wisconsin Constitution and the Fifth and Fourteenth Amendments of the United States Constitution. I, therefore, have not repealed the subdivision in this version of the draft. I do not have time to research this issue. Please let me know what you want to do here.

5. Currently, s. 49.45 (3) (g), stats., requires that providers accord the department's investigator access to records, books, recipient medical records, documents or other information needed "[P]ursuant to the request of a designated person and upon presentation of that person's authorization...." The requested language change adds access to provider personnel to this paragraph and uses the same list in amending s. 49.45 (3) (h) 3., stats., to establish grounds for decertification or suspension of a provider who fails or refuses to accord access. I have updated the term "recipient medical records" to "patient health care records of medical assistance recipients" (see s. 146.81 (4), stats.). However, I note that under s. 146.82, stats., personnel such as those described in s. 49.45 (3) (g), stats., appear to be able to have access, without informed consent, only under s. 146.82 (2) (a) 5., stats. This subdivision requires a *written* request by a state governmental agency. It is unclear if s. 49.45 (3) (g), stats.,

requires written or oral requests. I have therefore amended s. 49.45 (3) (g), stats., to require a written request for access to patient health care records, to avoid putting a provider in a double bind of being unable to comply with s. 49.45 (3) (g), stats., because of the requirement of s. 146.82 (2) (a) 5., stats., and thus being subject to s. 49.45 (3) (h), stats. Okay?

6. With respect to the amendment to s. 49.45 (13) (b), stats., when must DHFS hold a hearing? Should mention of judicial review be made? (Please see, for example, ss. 48.72 and 49.498 (16) (f), stats.)

7. I did not draft the proposed amendment to the first sentence of s. 49.45 (21) (a), stats.; liability does not attach upon the feeling of a desire to sell or transfer.

8. I did not draft the language proposed as s. 227.01 (13) (zv) (an exception to rule–making requirements). The proposal is not explained in the materials accompanying the request; it appears to relate to subject matter that is different from the other parts of the request. Is the department making the medical determination? Please let me know what is intended here.

9. Please read s. 49.45 (2) (b) 7. very carefully. Should the surety bond be a condition of certification, as drafted? Is it essential to have only certain providers and not others provide the bond? If this is a condition of certification, because a property interest is involved, requiring of some providers, but not all, may involve an equal protection problem. Note that I have made some provision about withdrawal or decertification of a provider. Okay?

10. In drafting s. 49.489, I have eliminated approval by the attorney general of imposition of forfeitures; this type of review, for each forfeiture, has no precedent and seems to serve no particularly useful purpose — it would seem that the department need not have the attorney general determine if their allegations are frivolous. Perhaps this is a requirement in Texas (the origin of the language is not specified), but in Wisconsin, for DHFS, the only review by the attorney general is for "fifth standard" cases and is done to ensure that the standard, as administered, would meet constitutional requirements. Here there seem to be no constitutional questions. For s. 49.489 I have, in large part, used language from s. 50.04 (4), stats., and, on the advice of the drafters for civil procedure and criminal law, have used the term "knows or should know" and have eliminated the term and definition of "knows or has reason to know", which, in any event, was circular. I drafted the "assessment as a false claims surcharge", but I did not draft the provision that permitted collection of the amount by recoupment against future claims submitted by the provider, because I have required deposit of the surcharge in s. 20.435 (1) (kx), stats.,which permits expenditure by DHFS for the MA program. Please review.

Debora A. Kennedy
Assistant Chief Counsel
266–0137

Kennedy, Debora

From: Geisler, Jeffrey [jeffrey.geisler@doa.state.wi.us]
Sent: Thursday, January 14, 1999 1:46 PM
To: Kennedy, Debora
Subject: FW: LRB 1098/1dn-Provider Fraud and Abuse Statutory Language Requ est.


DOAcomments.doc


MA-fraud-amndmts.doc


legis.doc

Debora,
Here are answers to your drafter's note questions on LRB-1098/1dn.

<<DOAcomments.doc>>

Jeffrey A. Geisler
267-7980
DOA State Budget Office

> -----Original Message-----
> From: Chao, Richard
> Sent: Wednesday, January 13, 1999 3:00 PM
> To: Geisler, Jeffrey
> Cc: Vavra, James; Johnston, James
> Subject: Provider Fraud and Abuse Statutory Language Request.
>
> Dear Jeff:
> Greetings. Attached are the Department's comments to the statutory
> language
> draft for the Provider Fraud and Abuse Initiative. Thank you for a
> providing us
> the opportunity to comment.
>
> Please reply acknowledgment of having received this transmission. Our
> "transparent and seamless" transition to GroupWise 5.5 has caused turmoil
> in our
> email system.
>
> Richard T. Chao
> Budget Section
> Department of Health and Family Services
> (608) 267-0356
> <<MA-fraud-amndmts.doc>> <<legis.doc>>

Response to Drafter's Note #1:

The Drafter is correct that the word "prescribe" is clearer than the current statutory language "set forth."
JG - "Prescribe" is good, keep it.

Response to Drafter's Note #2:

Agree with all changes suggested by Drafter.
JG - Debora, your draft is fine here.

Response to Drafter's Note #3:

The Drafter is correct that this proposed provision should be incorporated into (2)(b) rather than (2)(a).
JG - Debora, your draft is fine here.

Response to Drafter's Note #4:

Rather than repealing the "due process" provision as proposed in the Department's original draft or retaining it as currently worded as proposed by the Drafter, we propose amending it as follows:

SECTION 7m. 49.45 (2) (a) 14. of the statutes is amended to read:

14. Provide ~~Assure due process in implementing subds. 12. and 13. by providing~~ written notice, a fair hearing and a written decision in implementing subds. 12. and 13. to the extent due process is required by federal law or the state or federal constitution.

JG - Debora, do not make this change.

Response to Drafter's Note #5:

Agree with changes suggested by Drafter.
JG - Debora, your draft is fine here.

Response to Drafter's Note #6:

A number of statutes require hearings without specifying deadlines by which they must be held. If current drafting rules call for creating statutory hearing deadlines, please consult with DOA Division of Hearings and Appeals, which will hold the hearings. As to the question on judicial review, it is our view that ch. 227 provides for judicial review and so no explicit provision for judicial review need be made here.
JG - Debora, make no mention of judicial review.

Response to Drafter's Note #7:

see change

The Drafter is correct that the amendment to the first sentence of s. 49.45(21)(a) was poorly worded. To capture the Department's original intent, we suggest amending that paragraph as follows:

SECTION 17. 49.45 (21) (a) of the statutes is amended to read:

49.45(21) is amended to read:

Transfer of business, liability for repayments. (a) Any ~~If any~~ provider that intends to sell ~~liable for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497 sells~~ or otherwise transfer ~~transfers~~ ownership of the provider's ~~his or her~~ business or all or substantially all of the assets of the business must first contact the department. The department will inform the provider of the extent of the provider's liability, if any, for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497. ~~, the transferor~~ The provider and the proposed transferee are ~~each~~ jointly and severally liable for the repayment. ~~Prior to final transfer, the transferee is responsible for contacting the department and ascertaining if the transferor is liable under this paragraph~~.

JG - Debora, please make this change.

Response to Drafter's Note #8:

The provision requested by the Department would exempt from rule-making any department policy that "[e]stablishes guidelines for the medical determination whether to grant prior authorization for medical assistance coverage of services under s. 49.46 or 49.47." The Drafter is correct that this proposal was not explained in the materials accompanying the request and that it relates to a subject matter different from other parts of the request. This was due to an oversight. The explanatory materials should have included this provision as a separate subject. The Drafter is also correct that the department makes a medical determination in prior authorization reviews. MA rules governing covered services call for the Department to determine medical necessity and appropriateness of certain services under certain circumstances before MA coverage is authorized. Physicians and other medical professionals employed by and under contract to the Department make these

medical determinations under medical criteria developed by the Department. The purpose of this proposed provision is to exempt these criteria from rule-making.
JG - Debora, please make this change or tell me what more is required by why of explanation or clairification of intent..

Response to Drafter's Note #9:

The Drafter is correct that the surety bond should be a condition of certification and that provision should be made for decertification if the surety bond is not maintained. The Drafter is also correct that requiring some but not all providers to obtain a surety bond could create equal protection problems. However, the Drafter has avoided those problems by limiting the Department's authority to require surety bonds to provider groups more likely to engage in fraud or require recoveries or sanctions. The Department requests one change in the draft language on surety bonds to achieve the Department's original intent:

... The surety bond shall be payable to the department and in an amount that would reasonably ~~contribute to payment of~~ pay the amount of a recovery and the department's costs to pursue recovery under par. (a) 10. or to investigate and pursue allegations of violations of s. 49.489 or 49.49. ...

JG - Debora, please make this change

Response to Drafter's Note #10:

The Department agrees with all of the Drafter's suggested changes. They better capture the Department's intent than the language originally proposed by the Department.
JG - Debora, nice to hear, no?

1/14/99: Questions for J. Geisler:

49.45(21)(a)

✓ ① Dept's change makes proposed transferee liable; but no transaction has taken place

From JG – delete proposed

✓ ② Dept's orig. request required the transferor + the transferee to contact the dept – now only the transferor has to do so — what's to prevent a transferor from handing transferee debt + skipping town?

From JG – Require transferor to inform proposed transferee of amt. of liab.

✓ ③ ok to draft ch. 227 rule-making exemption

From JG: ok

49.45(21)(b)

Further problem: Dept. wants to void the sale – so that means the buyer (transferee) doesn't really even become a buyer but, under par. (b), is still liable

From JG – Buyer isn't liable if seller fails to inform.

(SOON In edit 1/17)

State of Wisconsin
1999 – 2000 LEGISLATURE

LRB–1098/~~1~~2
DAK:kmg:~~jfs~~

DOA:.....Geisler – Medical assistance services provider fraud and abuse changes

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

AN ACT (Don't Gen Cat.); **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

PUBLIC ASSISTANCE

Under current law under the medical assistance (MA) program, the department of health and family services (DHFS) certifies persons or facilities that meet certain criteria as providers and pays for services and items that MA recipients receive from the providers. Currently, DHFS is authorized or required to enforce numerous sanctions against providers who fail to comply with requirements under the MA program or to whom MA payments have been improperly or erroneously made or overpayments have been made. Currently, prohibitions exist against fraud in applications for, rights to and conversion of MA benefits or payments. These prohibitions are punishable by fines and imprisonment. (INSERT A-1) ✓

This bill prohibits MA providers from submitting false claims and false statements that accompany the claims for payment of services or items that the provider furnishes under the MA program. The bill permits DHFS to assess forfeitures for violations of the prohibitions and to impose a surcharge on a forfeiture that is assessed. Further, the bill establishes notice and hearing requirements for providers to contest assessment of a forfeiture; establishes forfeiture and surcharge payment requirements; and permits the attorney general to bring an action to collect outstanding forfeitures and surcharges.

pay the amount of a recovery and

The bill authorizes DHFS to require certain MA providers, as a condition of certification, to file with DHFS a surety bond, payable to DHFS, under terms and in an amount specified by DHFS by rule, that would reasonably ~~contribute to~~ DHFS' costs to pursue recovery of overpayments or to investigate and pursue allegations of false claims or statements. Providers who are required to file the surety bonds are those who provide MA services, as specified by DHFS by rule, for which providers have demonstrated significant potential to violate fraud prohibitions, to require recovery of overpayments or to need certain additional sanctions.

The bill authorizes DHFS, if it first makes specified findings, to prescribe MA provider certification criteria that limit the number of providers of particular services or that limit the amount of resources, including employes and equipment, that a certified provider may use to provide MA services and items.

The bill changes numerous provisions relating to procedures for the recovery by DHFS of improper or erroneous MA payments or overpayments, including all of the following:

1. Reasonable notice and hearing opportunity requirements are eliminated and, instead, DHFS must promptly afford an opportunity for a provider to present information and argument, but DHFS may collect the amount to be recovered pending that opportunity.

2. A deadline for payment of recoveries is established and payment of interest on delinquent amounts is required.

The bill authorizes DHFS, if certain criteria are met, to suspend certification for a provider pending a hearing on whether the provider has violated federal or state laws.

The bill authorizes DHFS to prescribe conditions of MA participation and reimbursement terms and to impose additional sanctions for noncompliance. ~~Also,~~ the bill requires immediate access, upon request by DHFS, to provider records and specifies that a provider's failure to provide access constitutes grounds for decertification. Lastly, the bill voids a sale of ownership of a business by a MA provider if the ~~provider was liable for repayment of improper or erroneous payments~~ or overpayments.

INSERT A-2

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (2) (a) 9. of the statutes is amended to read:

49.45 **(2)** (a) 9. Periodically ~~set forth~~ prescribe conditions of participation and terms of reimbursement ~~in a contract with provider~~ of service under this section.

SECTION 2. 49.45 (2) (a) 10. of the statutes is renumbered 49.45 (2) (a) 10. a. and amended to read:

49.45 **(2)** (a) 10. a. ~~After reasonable notice and opportunity for hearing, recover~~ Recover money improperly or erroneously paid~~,~~ or overpayments to a provider ~~either~~ by offsetting or adjusting amounts owed the provider under the program, crediting against a provider's future claims for reimbursement for other services or items furnished by the provider under the program~~, or by~~ or requiring the provider to make direct payment to the department or its fiscal intermediary.

SECTION 3. 49.45 (2) (a) 10. b. of the statutes is created to read:

49.45 **(2)** (a) 10. b. Promptly afford the provider an opportunity to present information and argument regarding a recovery imposed under this subdivision, but the department need not stay collection of the amount to be recovered pending that opportunity.

SECTION 4. 49.45 (2) (a) 10. c. of the statutes is created to read:

49.45 **(2)** (a) 10. c. Establish a deadline for payment of a recovery imposed under this subdivision and, if a provider fails to pay all of the amount to be recovered by the deadline, require payment by the provider of interest on any delinquent amount at the rate of 1% per month or fraction of a month from the date of the overpayment.

SECTION 5. 49.45 (2) (a) 11. of the statutes is amended to read:

49.45 **(2)** (a) 11. Establish criteria for ~~the~~ certification of ~~eligible~~ providers of ~~services under Title XIX of the social security act~~ medical assistance and, except as provided in par. (b) 6. and 7. and s. 49.48, certify ~~such eligible~~ providers who meet the criteria.

SECTION 6. 49.45 (2) (a) 12. of the statutes is amended to read:

49.45 **(2)** (a) 12. Decertify ~~or suspend under this subdivision~~ a provider from the medical assistance program, if after giving reasonable notice and opportunity for hearing, the department finds that the provider has violated a federal statute or regulation or a state ~~law~~ statute or administrative rule and ~~such violations are~~ the violation is by ~~law~~ statute, regulation or rule grounds for decertification or suspension. The department shall suspend the provider pending the hearing under this subdivision if the department includes in its decertification notice findings that the provider's continued participation in the medical assistance program pending hearing is likely to lead to the irretrievable loss of public funds and is unnecessary to provide adequate access to services to medical assistance recipients. No payment may be made under the medical assistance program with respect to any service or item furnished by the provider subsequent to decertification or during the period of suspension.

SECTION 7. 49.45 (2) (a) 13. of the statutes is amended to read:

49.45 **(2)** (a) 13. Impose additional sanctions for noncompliance with the conditions of participation and terms of ~~provider agreements~~ reimbursement under subd. 9. or certification criteria established under subd. 11. and, if prescribed by the department, under par. (b) 6. or 7.

SECTION 8. 49.45 (2) (b) 6. of the statutes is created to read:

49.45 **(2)** (b) 6. Prescribe criteria for certification of providers of medical assistance that limit the number of providers of particular services or that limit the amount of resources, including employes and equipment, that a certified provider may use to provide particular services to medical assistance recipients, if the department finds all of the following:

a. That existing certified providers and resources provide services that are adequate in quality and amount to meet the need of medical assistance recipients for the particular services.

b. That the potential for medical assistance fraud or abuse exists if additional providers are certified or additional resources are used by certified providers.

SECTION 9. 49.45 (2) (b) 7. of the statutes is created to read:

49.45 **(2)** (b) 7. Require, as a condition of certification under par. (a) 11., a provider, as specified in this subdivision, to file with the department a surety bond issued by a surety company licensed to do business in this state. Providers subject to this subdivision provide those services under medical assistance for which providers have demonstrated significant potential to violate s. 49.489 (2) or (3), 49.49 (1) (a), (2) (a) or (b), (3), (3m) (a), (3p), (4) (a) or (4m) (a), to require recovery under par. (a) 10. or to need additional sanctions under par. (a) 13. The surety bond shall be payable to the department and in an amount that would reasonably ~~contribute to payment of~~ the department's costs to pursue recovery under par. (a) 10. or to investigate and pursue allegations of violations of s. 49.489 or 49.49. The department shall promulgate rules under this subdivision that specify all of the following:

a. Services under medical assistance for which providers have demonstrated significant potential to violate s. 49.489 (2) or (3), 49.49 (1) (a), (2) (a) or (b), (3), (3m) (a), (3p), (4) (a) or (4m) (a), to require recovery under par. (a) 10. or to need additional sanctions under par. (a) 13.

b. The amount or amounts of the surety bonds.

pay the amount of a recovery and

c. Terms of the surety bond, including amounts, if any, without interest to be refunded to the provider upon withdrawal or decertification from the medical assistance program.

SECTION 10. 49.45 (3) (f) 3. of the statutes is amended to read:

49.45 **(3)** (f) 3. Contractors under sub. (2) (b) shall maintain records as required by the department for audit purposes. ~~Contractors~~ Upon request of the department, contractors shall immediately provide the department access to the records ~~upon request of the department, and~~, which the department may audit ~~the records~~.

SECTION 11. 49.45 (3) (g) of the statutes is amended to read:

49.45 **(3)** (g) The secretary may ~~appoint~~ authorize personnel to audit or investigate and report to the department on any matter involving violations or complaints alleging violations of ~~laws~~ statutes, regulations, or rules applicable to ~~Title XIX of the federal social security act or~~ the medical assistance program and to perform such investigations or audits as are required to verify the actual provision of services or items available under the medical assistance program and the appropriateness and accuracy of claims for reimbursement submitted by providers participating in the program. Department employes ~~appointed~~ authorized by the secretary under this paragraph shall be issued, and shall possess at all times ~~during which~~ while they are performing their investigatory or audit functions under this section, identification, signed by the secretary ~~which~~, that specifically designates the bearer as possessing the authorization to conduct medical assistance investigations or audits. ~~Pursuant to~~ Under the request of a designated person and upon presentation of ~~that~~ the person's authorization, providers and medical assistance recipients shall immediately accord ~~such~~ the person access to any provider personnel, records, books~~, recipient medical records,~~ or documents or other

information needed. Under the written request of a designated person and upon presentation of the person's authorization, providers and recipients shall immediately accord the person access to any needed patient health care records of a recipient. Authorized employes ~~shall have authority to~~ may hold hearings, administer oaths, take testimony and perform all other duties necessary to bring ~~such~~ the matter before the department for final adjudication and determination.

SECTION 12. 49.45 (3) (h) 1. of the statutes is repealed.

SECTION 13. 49.45 (3) (h) 2. of the statutes is repealed.

SECTION 14. 49.45 (3) (h) 3. of the statutes is renumbered 49.45 (3) (h) and amended to read:

49.45 **(3)** (h) The failure or refusal of a ~~person to purge himself or herself of contempt found under s. 885.12 and perform the act as required by law shall constitute~~ provider immediately to accord department auditors under par. (f) 3. or investigators under par. (g) access to any provider personnel, records, books, patient health care records of medical assistance recipients or documents or other information requested constitutes grounds for decertification or suspension of ~~that person~~ the provider from participation in the medical assistance program and no payment may be made for services rendered by ~~that person subsequent to~~ the provider following decertification or during the period of suspension.

SECTION 15. 49.45 (13) (a) of the statutes is amended to read:

49.45 **(13)** (a) The department may require ~~service~~ providers to prepare and submit cost reports or financial reports for purposes of rate certification under Title XIX of the federal Social Security Act, cost verification, fee schedule determination or research and study purposes. These financial reports may include independently audited financial statements ~~which shall include~~, including balance sheets and

statements of revenues and expenses. The department may withhold reimbursement or may decrease or not increase reimbursement rates if a provider does not submit the reports required under this paragraph within the period specified by the department or if the costs on which the reimbursement rates are based cannot be verified from the provider's cost or financial reports ~~or records from which the reports are derived~~.

SECTION 16. 49.45 (13) (b) of the statutes is amended to read:

49.45 **(13)** (b) ~~The~~ In addition to the remedies specified under par. (a), the department may require any provider who fails to submit a cost report or financial report under par. (a) within the period specified by the department to forfeit not less than $10 nor more than $100 for each day the provider fails to submit the report. A provider may contest the imposition of a forfeiture under this paragraph by submitting a written request for a hearing under s. 227.44 to the department within 10 days following the date on which the provider received notice of the forfeiture.

fix component

SECTION 17. 49.45 (21) (a) of the statutes is renumbered 49.45 (21) (a) (intro.) and amended to read:

49.45 **(21)** (a) (intro.) ~~If any~~ Before a provider ~~liable for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497~~ sells or otherwise transfers ownership of his or her business or all or substantially all of the assets of the business, ~~the transferor and transferee are each liable for the repayment. Prior to final transfer, the transferee is and transferor are responsible for contacting the department and ascertaining if the transferor is liable to the extent of any liability under this paragraph.~~ all of the following shall take place:

Ins. 8-19

SECTION 18. 49.45 (21) (b) of the statutes is amended to read:

49.45 **(21)** (b) If a sale or other transfer specified in par. (a) occurs and the applicable amount under par. (a) has not been repaid, the ~~department may proceed~~

~~against either the transferor or the transferee. Within 30 days after receiving notice from the department, the transferor or the transferee shall pay the amount in full. Upon failure to comply, the~~ sale or other transfer is void. The department may bring an action to compel payment. ~~If a transferor fails to pay within 90 days after receiving notice from the department, the department~~ or may proceed under sub. (2) (a) 12., or both.

SECTION 19. 49.489 of the statutes is created to read:

49.489 False claims or statements prohibited. (1) In this section:

(a) "Claim" means a request submitted by a provider for payment for services or items furnished by the provider under the medical assistance program.

(b) "Statement" means a representation, certification, affirmation, document, record or accounting or bookkeeping entry made with respect to a claim or to obtain approval or payment of a claim.

(2) No provider may submit a claim or cause a claim to be submitted if the provider knows or should know any of the following:

(a) That the claim is false.

(b) That the claim includes or is supported by a written statement that asserts a material fact that is false.

(c) That the claim includes or is supported by a written statement that omits a material fact that the provider has a duty to include and, by reason of the omission, is false.

(3) No provider may make or cause to be made a written statement that contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the statement if the provider knows or should know any of the following:

(a) That the statement asserts a material fact that is false.

(b) That the statement omits a material fact that the provider has a duty to include and, by reason of the omission, is false.

(4) For purposes of subs. (2) and (3), all of the following apply:

(a) Each claim form constitutes a separate claim.

(b) Each representation, certification, affirmation, document, record or accounting or bookkeeping entry constitutes a separate statement.

(c) A claim is subject to this section regardless of whether the claim is actually paid.

(d) A claim is considered to be made when it is received by the fiscal agent.

(e) Except as provided in par. (f), a statement is considered to be made when it is received by the fiscal agent.

(f) A statement that is not submitted to a fiscal agent but is retained by the provider to support a claim is considered to be made when it is entered in the provider's books, files or other records.

(5) Any person who violates sub. (2) or (3) may be required to forfeit not more than $5,000 for each offense.

(6) If the department assesses a forfeiture under sub. (5) for a violation of sub. (2), the department may impose on the violator, in addition to the forfeiture, a false claim surcharge in an amount that is not more than 200% of the amount of the claim in regard to which sub. (2) was found to have been violated.

(7) The department may directly assess a forfeiture provided for in sub. (5). If the department determines that a forfeiture should be assessed for a particular violation, the department shall send a notice of assessment to the alleged violator. The notice shall specify the amount of the forfeiture assessed, the violation and the

statute alleged to have been violated and shall inform the alleged violator of the right to a hearing under sub. (8).

(8) An alleged violator may contest an assessment of a forfeiture by sending, within 30 days after receipt of the notice under sub. (7), a written request for hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator of the division may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator of the division shall be the final administrative decision. The division shall commence the hearing within 30 days after receipt of the request for hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the party, other than the petitioner, who was in the proceeding before the division shall be the named respondent.

(9) All forfeitures and false claim surcharges, if any, shall be paid to the department within 10 days after receipt of notice of assessment or, if the forfeiture is contested under sub. (8), within 10 days after receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed. The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund. The department shall credit all false claims surcharges to the appropriation account under s. 20.435 (1) (kx).

(10) The attorney general may bring an action in the name of the state to collect any forfeiture or false claim surcharge imposed under this section if the forfeiture or false claim surcharge has not been paid following the exhaustion of all administrative and judicial reviews. The only issue to be contested in any such action is whether the forfeiture or false claim surcharge has been paid.

SECTION 20. 49.85 (2) (a) of the statutes is amended to read:

49.85 **(2)** (a) At least annually, the department of health and family services shall certify to the department of revenue the amounts that, based on the notifications received under sub. (1) and on other information received by the department of health and family services, the department of health and family services has determined that it may recover under s. 49.45 (2) (a) 10. or 49.497, except that the department of health and family services may not certify an amount under this subsection unless it has met the notice requirements under sub. (3) and unless its determination has either not been appealed or is no longer under appeal.

SECTION 21. 49.85 (3) (a) 1. of the statutes is amended to read:

49.85 **(3)** (a) 1. Inform the person that the department of health and family services intends to certify to the department of revenue an amount that the department of health and family services has determined to be due under s. 49.45 (2) (a) 10. or 49.497, for setoff from any state tax refund that may be due the person.

SECTION 22. 50.03 (13) (a) of the statutes is amended to read:

50.03 **(13)** (a) *New license.* Whenever ownership of a facility is transferred from the person or persons named in the license to any other person or persons, the transferee must obtain a new license. The license may be a probationary license. Penalties under sub. (1) shall apply to violations of this subsection. The transferee shall notify the department of the transfer, file an application under sub. (3) (b) and apply for a new license at least 30 days prior to final transfer. Retention of any interest required to be disclosed under sub. (3) (b) after transfer by any person who held such an interest prior to transfer may constitute grounds for denial of a license where violations of this subchapter for which notice had been given to the transferor are outstanding and uncorrected, if the department determines that effective control

over operation of the facility has not been transferred. If the transferor was a provider under s. 49.43 (10), the transferee and transferor shall comply with s. 49.45 (21).

SECTION 23. 71.93 (1) (a) 3. of the statutes is amended to read:

71.93 **(1)** (a) 3. An amount that the department of health and family services may recover under s. 49.45 (2) (a) 10. or 49.497, if the department of health and family services has certified the amount under s. 49.85.

SECTION 24. 227.01 (13) (zL) of the statutes is created to read:

227.01 **(13)** (zL) Prescribes conditions of participation and terms of reimbursement of providers under s. 49.45 (2) (a) 9.

INSERT 13-10

SECTION 9323. Initial applicability; health and family services.

(1) TRANSFERS BY LIABLE PROVIDERS OF MEDICAL ASSISTANCE. The treatment of sections 49.45 (21) (a) and (b) and 50.03 (13) (a) of the statutes first applies to sales or other transfers completed on the effective date of this subsection.

(2) FALSE CLAIMS OR STATEMENTS BY PROVIDERS OF MEDICAL ASSISTANCE. The treatment of section 49.489 of the statutes first applies to violations of section 49.489 (2) or (3) of the statutes, as created by this act, that occur on the effective date of this subsection.

(3) DECERTIFICATION OR SUSPENSION OF PROVIDERS OF MEDICAL ASSISTANCE. The treatment of section 49.45 (2) (a) 12. of the statutes first applies to violations of federal statutes or regulations or state statutes or rules committed on the effective date of this subsection.

(4) SANCTIONS FOR NONCOMPLIANCE BY PROVIDERS OF MEDICAL ASSISTANCE. The treatment of section 49.45 (2) (a) 13. of the statutes first applies to instances of

noncompliance with conditions of participation or terms of reimbursement or certification criteria that occur on the effective date of this subsection.

(END)

INSERT A-1 ✓

p. 1081

STATE OF WISCONSIN – **LEGISLATIVE REFERENCE BUREAU** – LEGAL SECTION
(608–266–3561)

No. 9

Lastly, under current law, if a provider who is liable for repayment of improper or erroneous payments or overpayments sells or otherwise transfers ownership of his or her business, the seller and transferee are each liable for the repayment. The ~~buyer~~ must contact DHFS and ascertain if the seller has an outstanding amount owing. DHFS may bring an action to compel payment against either the buyer or transferee if a sale or other transfer occurs and the amount has not been repaid.

End INSERT

INSERT A-2

p. 102

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608–266–3561)

4 The bill changes provisions concerning liability for repayment of improper or erroneous payments or overpayments of a provider who sells or transfers ownership of his or her business. Under the bill, before such a sale or transfer may take place, the provider must notify DHFS of the impending sale and DHFS must inform the provider of the extent of liability, if any. If liability exists, the provider must (so) inform the prospective buyer or transferee of the extent of the liability and, if done, the liability attaches to both the provider and the buyer or transferee, with the sale or other transfer conditioned upon repayment. If the provider fails to inform the buyer or other transferee, liability does not attach to the buyer. Repayment must be made prior to the sale or transfer and, if not done, the sale or transfer is void.

(INSERT A-2)

Lastly, the bill excepts from the definition of a rule actions by DHFS in prescribing conditions of participation and terms of reimbursement for MA providers of services and in establishing guidelines for determining medical necessity and appropriateness for granting prior authorization for MA coverage of services.

SECTION . CR; 49.45 (21) (a) 1. to 6.

49.45(21)(a) 1. The provider shall notify the department of the proposed sale or other transfer.

2. Upon notification under subd. 1., the department shall inform the provider of the extent of the provider's liability, if any, for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497.

3. If the department informs the provider under subd. 2. that the provider has liability, the provider shall so inform the prospective buyer or other transferee.

4. If the provider informs the prospective buyer or other transferee under subd. 3., joint and several liability for the repayment attaches to the provider and to the prospective buyer or other transferee and the sale or

other transfer is conditioned upon repayment.

5. If the provider fails to notify the prospective buyer or other transferee under subd. 3., no ~~[illegible]~~ liability for the repayment ~~does not~~ attaches to the prospective buyer or other transferee.

6. The provider and, if subd. 4. applies, the prospective buyer or other transferee shall repay the amount of improper or erroneous payments or overpayments under ss. 49.43 to 49.497 for which the provider and, if subd. 4. applies, the prospective buyer or other transferee have liability.

End of INS 8-19

[INSERT 13-10]

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608–266–3561)

SECTION . CR; 227.01(13)(zm)

227.01(13)(zm) Establishes guidelines for the determination of medical necessity and appropriateness for the granting of prior authorization for medical assistance coverage of services under s. 49.46 or 49.47.

1/20/99 From J. Geisler, following mtg. w/ DHFS (Neil Gebhart, Peggy Bartell, etc.).

Add written decision requirement to 49.45(2)(b)12.

Add requirement to s. 49.45(2)(b)12. that notice, hearing & written decision also apply to restriction of a provider's participation

Repeal s. 49.45(2)(a)14.

Change 49.45(2)(b)7. to apply to all providers of a specific service under 49.46(2)(b) or 49.47(6)(a).

ments to preserve continuity of care and for the protection of the recipient.

(2) ALTERNATIVE SANCTIONS. (a) In the event the department finds it more appropriate to take alternative action to termination of certification under sub. (1) to ensure compliance with program requirements, it may impose one or more sanctions under par. (b) for no more than 6 months following the last day of the department's review of the provider. If, at the end of the 6 month period, the provider continues to not comply with the MA program requirement or requirements, the provider shall be terminated from MA program participation under sub. (1).

(b) The department may apply one or several of the following sanctions:

1. Suspension of payment for new admissions;

2. Suspension of payments for new admissions who require particular types of services;

3. Suspension of payments for any MA recipient requiring a particular type of service;

4. A plan of correction prescribed by the department;

5. Provider monitoring by the department;

6. Appointment of a temporary manager; or

7. Any of the sanctions described in s. HFS 106.07 (4).

(c) In determining the most effective sanctions to be applied to a non–compliant provider, the department shall consider:

1. The severity and scope of noncompliance;

2. The relationship of several areas of the deficiencies or noncompliance;

3. The provider's previous compliance history, particularly as it relates to the insufficiencies under consideration;

4. Immediate or potential jeopardy to patient health and safety;

5. The direct relationship to patient care; and

6. The provider's financial condition.

(d) The department may revisit the provider during the sanction period. Termination procedures may be initiated as a result of the review conducted during the revisit if substantial noncompliance is found to persist, or if recipient safety is potentially or actually compromised.

History: Cr. Register, February, 1993, No. 446, eff. 3–1–93.

HFS 106.07 Effects of suspension or involuntary termination. (1) LENGTH OF SUSPENSION OR INVOLUNTARY TERMINATION. In determining the period for which a party identified in this chapter is to be disqualified from participation in the program, the department shall consider the following factors:

(a) The number and nature of the program violations and other related offenses;

(b) The nature and extent of any adverse impact on recipients caused by the violations;

(c) The amount of any damages;

(d) Any mitigating circumstances; and

(e) Any other pertinent facts which have direct bearing on the nature and seriousness of the program violations or related offenses.

(2) FEDERAL EXCLUSIONS Notwithstanding any other provision in this chapter, a party who is excluded from participation in the MA program under s. HFS 106.06 (28) (e), (f) or (g) as the result of a directive from the secretary of the federal department of health and human services under the authority of s. 1128 or 1128A of the social security act of 1935, as amended, shall be excluded from participation in the MA program for the period of time specified by the secretary of that federal agency.

(3) REFERRAL TO LICENSING AGENCIES The secretary shall notify the appropriate state licensing agency of the suspension or termination by MA of any provider licensed by the agency and of the act or acts which served as the basis for the provider's suspension or termination.

(4) OTHER POSSIBLE SANCTIONS. In addition or as an alternative to the suspension or termination of a provider's certification, the secretary may impose any or all of the following sanctions against a provider who has been found to have engaged in the conduct described in s. HFS 106.06:

(a) Referral to the appropriate state regulatory agency;

(b) Referral to the appropriate peer review mechanism;

(c) Transfer to a provider agreement of limited duration not to exceed 12 months; or

(d) Transfer to a provider agreement which stipulates specific conditions of participation.

History: Cr. Register, December, 1979, No. 288, eff. 2–1–80; am. Register, February, 1986, No. 362, eff. 3–1–86; emerg. r. and recr. (2), eff. 2–19–88; am. (2), Register, February, 1988, No. 386, eff. 3–1–88; r. and recr. (2), Register, August, 1988, No. 392, eff. 9–1–88.

HFS 106.08 Intermediate sanctions. (1) To enforce compliance with MA program requirements, the department may impose on a provider for a violation listed under sub. (2) one or more of the sanctions under sub. (3) unless the requirements of s. HFS 106.065 apply. Any sanction imposed by the department pursuant to this section may be appealed by the provider under s. HFS 106.12. Prior to imposing any alternative sanction under this section the department shall issue a written notice to the provider in accordance with s. HFS 106.12 (3). Nothing in this chapter shall be construed to compel the department, through a fair hearing or otherwise, to impose an intermediate sanction in lieu of suspension or termination of certification, a different intermediate sanction, monetary recoveries, auditing, withholding of claims or pre–payment review, nor may imposition of an intermediate sanction on a provider be construed to limit the department's authority under s. HFS 106.06, 106.065, 106.07, 106.10 or 106.11, under this section, or under the applicable provider agreement, concluded pursuant to s. 49.45 (2) (a) 9., Stats.

(2) The department may impose an intermediate sanction under sub. (3) for any of the following violations of this chapter:

(a) For conduct specified in s. HFS 106.06;

(b) For refusal to grant the department access to records under s. HFS 106.02 (9) (e);

(c) For conduct resulting in repeated recoveries under s. HFS 108.02 (9);

(d) For non–compliance with one or more certification requirement applicable to the type of provider under ch. HFS 105;

(e) For interference with recipient rights specified under ch. HFS 104; or

(f) For refusal or repeated failure to comply with one or more requirement specified under this chapter.

(3) The department may impose one or more of the following intermediate sanctions for a violation listed under sub. (2):

(a) Referral to the appropriate peer review organization, licensing authority or accreditation organization;

(b) Transfer to a provider agreement of limited duration, which also may stipulate specific conditions of participation;

(c) Requiring prior authorization of some or all of the provider's services;

(d) Review of the provider's claims before payment;

(e) Restricting the provider's participation in the MA program;

(f) Requiring an independent audit of the provider's practices and records, with the findings and recommendations to be provided to the department;

(g) Requiring the provider to perform a self–audit following instructions provided by the department; and

(h) Requiring the provider, in a manner and time specified by the department, to correct deficiencies identified in a department audit, independent audit or department survey or inspection.

(4) In determining the appropriate sanction or sanctions to be applied to a non–compliant provider and the duration of the sanction or sanctions, the department shall consider:

(a) The seriousness and extent of the offense or offenses;

(b) History of prior offenses;

(c) Prior sanctions;

(d) Provider willingness and ability to comply with MA program requirements;

(e) Whether a lesser sanction will be sufficient to remedy the problem in a timely manner;

(f) Actions taken or recommended by peer review organizations, licensing authorities and accreditation organizations;

(g) Potential jeopardy to recipient health and safety and the relationship of the offense to patient care; and

(h) Potential jeopardy to the rights of recipients under federal or state statutes or regulations.

History: Cr. Register, February, 1993, No. 446, eff. 3–1–93.

HFS 106.09 Departmental discretion to pursue monetary recovery. (1) Nothing in this chapter shall preclude the department from pursuing monetary recovery from a provider at the same time action is initiated to impose sanctions provided for under this chapter.

(2) The department may pursue monetary recovery from a provider of case management services or community support program services when an audit adjustment or disallowance has been attributed to the provider by the federal health care financing administration or the department. The provider shall be liable for the entire amount. However, no fiscal sanction under this subsection shall be taken against a provider unless it is based on a specific policy which was:

(a) In effect during the time period being audited; and

(b) Communicated to the provider in writing by the department or the federal health care financing administration prior to the time period audited.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; r. and recr. Register, February, 1988, No. 386, eff. 3–1–88; emerg. am. (2) (intro.), eff. 1–1–90; am. (2) (intro.), Register, September, 1990, No. 417, eff. 10–1–90; renum. from HSS 106.075, Register, February, 1993, No. 446, eff. 3–1–93.

HFS 106.10 Withholding payment of claims. (1) Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under MA, except for health care provided prior to the suspension or termination.

(2) No clinic, group, corporation or other association which is a provider of services may submit any claim for payment for any health care provided by an individual provider within that organization who has been suspended or terminated from participation in MA, except for health care provided prior to the suspension or termination.

(3) The department may recover any payments made in violation of this subsection. Knowing submission of these claims shall be a grounds for administrative sanctions against the submitting provider.

History: Cr. Register, December, 1979, No. 288, eff. 2–1–80; am. Register, February, 1986, No. 362, eff. 3–1–86; r. (1), renum. (2) (a) to (c) to be (1) to (3), Register, February, 1988, No. 386, eff. 3–1–88; renum. from HSS 106.08, Register, February, 1993, No. 446, eff. 3–1–93.

HFS 106.11 Pre–payment review of claims. (1) HEALTH CARE REVIEW COMMITTEES. The department shall establish committees of qualified health care professionals to evaluate and review the appropriateness, quality and quantity of services furnished recipients.

(2) REFERRAL OF ABERRANT PRACTICES. If the department has cause to suspect that a provider is prescribing or providing services which are not necessary for recipients, are in excess of the medical needs of recipients, or do not conform to applicable professional practice standards, the department shall, before issuing payment for the claims, refer the claims to the appropriate health care review committee established under sub. (1). The committee shall review and evaluate the medical necessity, appropriateness and propriety of the services for which payment is claimed. The decision to deny or issue the payment for the claims shall take into consideration the findings and recommendation of the committee.

(3) WITHDRAWAL OF REVIEW COMMITTEE MEMBERS FOR CONFLICT OF INTEREST. No individual member of a health care review committee established under sub. (1) may participate in a review and evaluation contemplated in sub. (2) if the individual has been directly involved in the treatment of recipients who are the subject of the claims under review or if the individual is financially or contractually related to the provider under review or if the individual is employed by the provider under review.

(4) PROVIDER NOTIFICATION OF PREPAYMENT REVIEW. A provider shall be notified by the department of the institution of the pre–payment review process under sub. (2). Payment shall be issued or denied, following review by a health care review committee, within 60 days of the date on which the claims were submitted to the fiscal agent by the provider.

(5) APPLICATION OF SANCTION. If a health care review committee established under sub. (1) finds that a provider has delivered services that are inappropriate or not medically necessary, the department may require the provider to request and receive from the department authorization prior to the delivery of any service under the program.

History: Cr. Register, December, 1979, No. 288, eff. 2–1–80; am. Register, February, 1986, No. 362, eff. 3–1–86; renum. from HSS 106.09, Register, February, 1993, No. 446, eff. 3–1–93.

HFS 106.12 Procedure, pleadings and practice. (1) SCOPE. The provisions of this section shall govern the following administrative actions by the department:

(a) Decertification or suspension of a provider from the medical assistance program pursuant to s. 49.45 (2) (a) 12., Stats.;

(b) Imposition of additional sanctions for non–compliance with the terms of provider agreements under s. 49.45 (2) (a) 9., Stats., or certification criteria established under s. 49.45 (2) (a) 11., Stats., pursuant to s. 49.45 (2) (a) 13., Stats.; and

(c) Any action or inaction for which due process is otherwise required under s. 227.42, Stats.

(1m) APPLICATION. The provisions of this section do not apply to either of the following:

(a) Hearings to contest recoveries by the department of overpayments to providers. Requests for hearings and hearings under these circumstances are governed exclusively by s. HFS 108.02 (9) (e); or

(b) Contests by providers of the propriety of the amount of payment received from the department, including contests of claim payment denials. The exclusive procedure for these contests is as provided in s. HFS 106.03 (3) (b) 5, except as may be provided under the terms of the applicable provider agreement, pursuant to s. 49.45 (2) (a) 9., Stats.

(2) DUE PROCESS. The department shall assure due process in implementing any action described in sub. (1) by providing written notice, a fair hearing and written decision pursuant to s. 49.45 (2) (a) 14., Stats., or as otherwise required by law. In addition to any provisions of this section, the procedures implementing a fair hearing and a written decision shall comply with the provisions of ch. 227, Stats.