LRB-0193

2001 DRAFTING REQUEST

Bill

Received: **09/08/2000**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget 267-7980**

By/Representing: **Mullikin**

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

Drafter: **kenneda**

May Contact: **DHFS**

Alt. Drafters:

Subject: **Public Assistance - med. assist.**
Health - facility licensure

Extra Copies: **ISR**

Pre Topic:

DOA:.....Mullikin -

Topic:

Health care provider fraud and abuse

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kenneda 11/05/2000	gilfokm 11/16/2000					S&L
/P1			pgreensl 11/17/2000		gretskl 11/17/2000		S&L
/1	kenneda 01/16/2001	wjackson 01/16/2001	kfollet 01/16/2001		lrb_docadmin 01/16/2001		S&L
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/4	kenneda 02/18/2001	jdyer 02/19/2001	jfrantze 02/19/2001	_____ _____	lrb_docadmin 02/19/2001		

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/4 2/9 jld /6 2/19 /6 ch 2/19

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/2 wlj 1/18

1-18-1 1-19-1

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/P1		1 1/16 WLJ	pgreensl 11/17/2000		gretskl 11/17/2000		

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/?	kenneda	/P1 11/15 kmg	11/17 PG	11/17 PG/RS			

FE Sent For:

<END>

DHFS

Department of Health and Family Services
2001-2003 Biennial Budget Statutory Language Request
August 23, 2000

Title: **Limiting Health Care Fraud and Abuse**

Current Language

s. 49.45 (2)(a) 10., s. 49.45 (2)(a) 11., s. 49.45 (2)(a) 12., s. 49.45 (2)(b), s. 49.45 (3)(h), s. 49.45 (21), s. 49.85 (2). S. 49.85 (3), s. 50.03 (13)(a), s. 71.93 (1) (a) 3., Section 19. Initial Applicability.

Proposed Change

1. Require DHFS to stop recovery for a period sufficient to allow providers to present information or argument regarding recoveries. No longer require DHFS to provide reasonable notice or an opportunity for a hearing to a provider before recovery.

2. Allow DHFS to decertify or suspend a provider who does not make the specified business documents available to auditors or investigators.

3. DHFS will establish a deadline for payment of recovery, and allow DHFS to collect 1% interest per month on the amount to be recovered if the provider does not meet the deadline.

4. Allow DHFS to collect $1,000 or 200%, whichever is greater, of the amount of any repeat recovery from providers who have been subject to repeat recoveries.

5. Allow DHFS to suspend a provider if DHFS includes in the decertification notice that the provider's continued participation in medical assistance will lead to irretrievable loss of public funds and is unnecessary to provide MA recipients adequate access to MA services.

6. Allow DHFS to limit the number of providers of particular services, if there are enough currently certified providers to provide for the service needs of MA recipients and that the potential for MA fraud, abuse or overutilization exists if additional providers are certified.

7. Require providers of services that have demonstrated significant potential to violate MA regulations to file a surety bond with DHFS.

8. Require a provider to obtain new certification if that provider takes over an operation of another provider. Also require new licensure of a facility to be transferred between providers if the provider to receive the transfer is not named on the existing license.

9. Require the full amount of monies identified in a recovery of an operation to be paid to DHFS before that operation may be transferred between providers. If full payment is not made, then both the transferee and the transferor are liable for the payment of recovery to DHFS, and DHFS may deny certification to the transferee.

10. Require DHFS to certify to DOR annually the amount of monies received by DHFS through recoveries. DHFS must also inform providers who owe money to a recovery that DHFS will certify to DOR the amount received through recoveries and that DOR may 'setoff' monies from a state tax refund to a provider which are owed to DHFS in a recovery.

Effect of the Change

The proposed changes will strengthen health care fraud and abuse language by expediting the process of decertifying non-compliant providers; by requiring surety bonds for new providers in specific benefit areas that are highly vulnerable to fraud and abuse, and by clarifying transfer of ownership of facilities or practices between providers.

Rationale for the Change

1. Under current regulations governing Department procedures to prevent provider fraud and abuse, the Bureau of Health Care Program Integrity (BHCPI) experiences delays in recovery of MA provider payments which have been identified by BHCPI as improper or erroneous payments. The current system encourages providers to appeal BHCPI's determination of improper or erroneous payments to delay recovery. Recovery cannot begin until the conclusion of all appeals. These proposed changes protect MA from continued fraud by a non-compliant provider.

2. BHCPI also encounters difficulty in controlling what have been identified as problem practices areas in terms of prevalent fraud. The proposed statutory change would allow BHCPI to restrict certification of new providers in practice areas which BHCPI has identified as problematic. The proposed statutory language will also allow BHCPI more control over the transfer of practices between providers to limit a provider from divesting assets to avoid recovery.

3. In the 1999-2001 biennial budget, the Department also proposed a change to strengthen health care fraud and abuse language. The 99-01 proposal was opposed by the State Medical Society and some legislators and was deleted from the budget by Joint Finance. The statutory language changes being proposed for the 2001-2003 budget respond to the concerns of the State Medical Society and legislators who opposed the original changes. These proposed changes represent a compromise relative to last budget's language changes.

   Please see attached statutory language draft.

Desired Effective Date:	Upon Passage of the Budget Bill
Agency:	DHFS
Agency Contact:	Anne Miller
Phone:	266-5422

PROPOSED MA FRAUD AMENDMENTS -- 2000

SECTION 1. 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 2. 49.45 (2) (a) 10. b. of the statutes is created to read:

49.45 (2) (a) 10. b. Stay collection of the amount to be recovered for a period sufficient to afford the provider a reasonable opportunity to present information and argument regarding a recovery imposed under this subdivision.

SECTION 3. 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 4. 49.45 (2) (a) 10m. of the statutes is created to read:

49.45 (2) (a) 10m. After reasonable notice and opportunity for hearing, charge a fee to a provider that has been subject to repeated recoveries under subd. 10 due to failure to follow the same or similar billing procedures or other

program requirements. The fee may not exceed $1,000 or 200% of the amount of any repeat recovery, whichever is greater. Fees shall be paid to the department within 10 days after receipt of notice of the fee or the final decision after administrative hearing, whichever is later. The department may recover any part of a fee not timely paid by offset against any medical assistance payment owed to the provider, and may refer any fees not collected in this manner to the attorney general for collection. Failure to pay a fee timely is grounds for decertification under subd. 12. Payment of a fee does not relieve the provider of any other legal liability incurred in connection with the recovery for which the fee is charged, but does not constitute evidence of violation of any law. The department shall credit all fees received to the account under s. 20.435 (1) (kx). The purpose of fees under this subdivision is to help defray the costs of audits and investigations by the department relative to overpayments to providers.

mostly same ✓ 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. through 8. s. 49.48, certify ~~such eligible~~ providers who meet the criteria.

same ✓ 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 or restrict a provider's participation in 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~~ restriction. 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. As soon as practicable after the hearing, the department shall issue a written decision. 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) (b) 6. of the statutes is created to read:

49.45 (2) (b) 6. Limit the number of providers of particular services that may be certified under par. (a) 11. or 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, abuse or overutilization exists if additional providers are certified or additional resources are used by certified providers.

SECTION 8. 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., all providers of a specific service that is among those enumerated under s. 49.46 (2) or 49.47 (6) (a), 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 specified under s. 49.46 (2) or 49.47 (6) (a) for which providers have demonstrated significant potential to violate s. 49.489 (2) or (3) or 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 in an amount the department determines is reasonable in view of amounts of past recoveries against other providers of the specific service and the department's costs to pursue those recoveries. 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) or 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.

✓ new SECTION 9. 49.45 (2) (b) 8. of the statutes is created to read:

49.45 (2) (b) 8. Require that a new certification under par. (a)11. be obtained before any person takes over the operation of a provider, within the meaning of sub. (21), and withhold a new certification under these circumstances until any repayment required under sub. (21) has been made.

SECTION 10. 49.45 (3) (h) 1. of the statutes is repealed.

SECTION 11. 49.45 (3) (h) 2. of the statutes is repealed.

SECTION 12. 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 to accord department auditors or investigators access in accordance with par. (g) 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~~ No payment may be made for services rendered by ~~that person subsequent to~~ the provider following decertification or during the period of suspension or the period the provider's failure or refusal to accord access to information in accordance with par. (g) persists.

SECTION 13. 49.45 (21) (a) and (b) of the statutes are amended to read:

49.45 (21)(a) ~~If any~~ Before any person takes over the operation of 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~~ full repayment must be made. ~~Prior to final transfer, the transferee is responsible for contacting~~ Upon request, the department ~~and ascertaining if the transferor~~ shall notify the provider or person intending to take over the provider's operation whether the provider is liable under this paragraph.

49.45(21)(b) If a person takes over the operation of a provider ~~transfer occurs~~ and the applicable amount under par. (a) has not been repaid, in addition to denying new certification under sub. (2)(b)8., the department may proceed against any liable party ~~either the transferor or the transferee~~. Within 30 days after receiving notice from the department, the ~~transferor or the transferee shall pay the~~ amount shall be paid 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 proceed under sub. (2) (a) 12, or both.

SECTION 14. 49.45 (21) (e) of the statutes is created to read:

49.45 (21)(e) As used in this subsection, a person "takes over the operation of a provider" if the person obtains any of the following, relative to any aspect of the provider's business for which the provider has filed claims for medical assistance reimbursement:

1. Ownership of the provider's business or all or substantially all of the assets of the business.

2. Majority control over decisions.

3. The right to any profits or income.

4. The right to contact and offer services to patients or clients served by the provider.

5. An agreement that the provider will not compete with the person, either at all or as to certain patients, clients, services, geographical areas or other parts of the provider's business.

6. The right to perform services substantially similar to services performed by the provider at the same location they were performed by the provider.

7. The right to use any distinctive name or symbol by which the provider is known in connection with services to be provided by the person.

same ✓ SECTION 15. 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.

same ✓ SECTION 16. 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.

same ✓ SECTION 17. 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).

same SECTION 18. 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 19. Initial Applicability.

(a) TRANSFERS BY LIABLE PROVIDERS OF MEDICAL ASSISTANCE. The treatment of sections 49.45 (21) of the statutes first applies to transfers completed on the effective date of this subsection.

(b) 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.

(c) 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.

Kennedy, Debora

From: Miller, Anne
Sent: Friday, November 03, 2000 8:15 AM
To: Kennedy, Debora
Cc: Bove, Fredi-Ellen; Gebhart, Neil; Thornton, Lori; White, Alan; Mullikin, Melissa
Subject: RE: Statutory Language for Limiting Health Care Fraaud and Abuse

Debora Kennedy:

Thank you clarifying your question.

Following is Neil Gebhart's response to your question:
Certification of providers is site and/or services-specific. Therefore, "new" means that a currently certified person who takes over the operation of another provider must obtain a new certification only with respect to the operation of that specific provider.

Please feel free to contact me with any additional questions.

Anne Miller
DHFS/OSF
6-5422

>>> Kennedy, Debora 11/02/00 05:17PM >>>
Dear Anne:

The specific question that I asked you was for a clarification of what the adjective "new" means, as proposed to modify "certification" in s. 49.45 (2) (b) 8. of the proposed material: does it mean that a currently-certified person who takes over the operation of a provider must obtain a new certification only with respect to the operation of the provider or that the person must be completely newly certified for any services that the person provides? If the latter, it would seem that the person's current certification must be terminated, so that the person would not concurrently possess two certifications. I asked the question because I lack knowledge about whether certifications are general or are site-specific or service-specific.

I have no doubt that the Department will consider onerousness when implementing the statutory language, but that is not the point of my inquiry; I am trying to ascertain the Department's intent so that I may unambiguously fit the language to that intent.

I'd appreciate your obtaining the information I am requesting, if possible. Thank you.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
debora.kennedy@legis.state.wi.us

-----Original Message-----
From: Miller, Anne
Sent: Thursday, November 02, 2000 11:51 AM
To: Kennedy, Debora
Cc: Bove, Fredi-Ellen; Gebhart, Neil; Thornton, Lori; Mullikin, Melissa
Subject: Statutory Language for Limiting Health Care Fraaud and Abuse

Dear Debora Kennedy:

Regarding your question on whether or not the statutory language draft submitted on Limiting Health Care Fraud and Abuse should be changed to further specify certification procedures for providers who purchase an operation owned by a provider liable for fraud and abuse as defined in the statutes:

The Department does not want to change the statutory language as submitted, but does believe that you have a good point, and that certification for some providers could become onerous. The Department will make every consideration of this when implementing the statutory language.

Please feel free to contact me with any additional questions.

Anne Miller
DHFS/OSF
6-5422

SOON; in edit 11/5

State of Wisconsin
1999 - 2000 LEGISLATURE

0193/P1

LRB-~~1098/3~~

DAK:~~kmg:~~

D-NOTE

DOA-BUD

K9

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

FOR 1999-01 BUDGET — NOT READY FOR INTRODUCTION

Due the 11/10

LPS: Proof all amended stats! w/ FOLIO.

Don't GEN. CAT

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

~~PUBLIC ASSISTANCE~~ MEDICAL 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, including decertification or suspension from the medical assistance program, 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. To implement these sanctions, DHFS must provide written notice, a fair hearing and a written decision. 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. 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 transferee 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 ~~be~~ been repaid.

MA

MA

whether

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.

INSERT A1

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 pay the amount of a recovery and 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.

that may receive MA certification

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.~~ stay collection of the recoverable amount for a time period sufficient to

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

The bill eliminates DHFS' general authority to suspend a provider, but instead authorizes DHFS, if certain criteria are met, to suspend certification for a provider pending a hearing on whether the provider must be decertified for violation of federal or state laws. The bill eliminates the right of notice, a fair hearing and a written decision for most sanctions against providers that DHFS may enforce, except for decertification from or restriction of a provider's participation in the MA program.

~~The bill authorizes DHFS to prescribe conditions of MA participation and reimbursement terms and to impose additional sanctions for noncompliance.~~ 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.

With respect to

INSERT A2

~~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~~

The bill eliminates provisions that confer liability on both the transferor and the transferee

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.

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.

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:

INSERT 3-3

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:

restore to plain text

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~~ plain 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 the recovery ~~imposed under this subdivision, but~~ Stay collection of the amount to be recovered under this subdivision for a period of time sufficient to

~~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.

INSERT 4-7

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~~, and s. 49.48, certify ~~such eligible~~ providers who meet the criteria.

to 8.

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 or restrict a provider's participation in 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~~ restriction. 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. As soon as practicable after the hearing, the department shall issue a written decision. 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) (a) 14. of the statutes is repealed.

SECTION 9. 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 10. 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., all providers of a specific service that is among those enumerated under s. 49.46 (2) or 49.47 (6) (a), 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 specified under s. 49.46 (2) or

SECTION 10

49.47 (6) (a) for which providers have demonstrated significant potential to violate s. ~~49.489 (2) or (3) or~~ 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 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.~~ 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) or~~ 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.

INSERT 6-16

SECTION 11. 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 12. 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 13. 49.45 (3) (h) 1. of the statutes is repealed.

SECTION 14. 49.45 (3) (h) 2. of the statutes is repealed.

SECTION 15. 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~~

access as required

~~constitute~~ provider ~~immediately~~ to accord department auditors ~~under par. (a)~~ 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. INSERT 8-7

SECTION 16. 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 17. 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.

SECTION 18. 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 responsible for contacting the department and ascertaining if the transferor is liable under this paragraph.~~ all of the following shall take place:

SECTION 19. 49.45 (21) (a) 1. to 6. of the statutes are created to read:

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 liability for the repayment 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.

SECTION 20. 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 21. 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.

INSERT 13-10

SECTION 22. 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 23. 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 24. 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 25. 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 26. 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 27. 227.01 (13) (zm) of the statutes is created to read:

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.

SECTION 9323. Initial applicability; health and family services.

(1) TRANSFERS BY CERTAIN 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)

This bill requires DHFS, after providing reasonable notice and the opportunity for a hearing, to charge a fee to a MA provider that has repeatedly been subject to recoveries of MA payments because of the provider's failure to follow identical or similar billing procedures or to follow other identical or similar MA requirements. The fee may not exceed $1,000 or 200% of the amount of the repeated recovery, whichever is greater. The bill permits DHFS to recover any part of such a fee that is not timely paid by offsetting the fee against any MA payment owed to the provider and also authorizes fee collection by the attorney general. Further, failure to pay a fee is grounds for MA decertification. The bill creates an appropriation of program revenue into which DHFS must deposit the fees, for performance by DHFS of MA audits and investigations.

INSERT A2

(p-1081)

a person may take over the operation (as defined in the bill) of a MA provider, the person must obtain ~~MA~~ MA certification with respect to the provider's operation, regardless of whether the person is currently certified. Also, before a person may take over the operation of a MA provider that is liable for repayment of improper or erroneous MA payments or overpayments, full repayment must be made. DHFS must, upon request, notify the person or provider as to whether notwithstanding the prohibition, the person takes over the provider's operation and the provider is liable. If the outstanding repayment is not made, DHFS may withhold certification from the person and may proceed against any liable party. If, within 30 days after DHFS provides notice, the repayment is not paid in full, DHFS may bring an action to compel payment, to decertify a provider, or to do both.

(INSERT 3-3)

(p. 1031)

SECTION . CR; 20.435 (4) (iL) (B)

20.435 (4) (iL) Medical assistance provider fees. (I)

All moneys received from fees charged under s. 49.45 (2)(a) 10m., for performance by the department of audits and investigations of improper or erroneous medical assistance provider payments and medical assistance provider overpayments.

*** NOTE: BUD

SECTION . CR; 49.45(2)(a) 10m.

49.45(2)(a) 10m. After providing reasonable notice and opportunity for a hearing, charge a fee to a provider that ~~has been subject~~ repeatedly to recoveries under subd. 10. because of the provider's failure to follow identical or similar billing procedures or to follow other identical or similar program requirements. The fee may not exceed $1,000 or 200% of the amount of any such repeated recovery made, whichever is greater. The provider shall pay the fee to the department within 10 days after receipt of notice of the fee or the final decision after administrative hearing, whichever is later. The department may recover any part of a fee not timely paid by offsetting the fee against any medical assistance payment owed to the provider and may refer any such unpaid fees not collected in this

manner to the attorney general, & Failure timely to pay a fee charged under this subdivision is grounds for decertification under subd. 12. A provider's payment of a fee does not relieve the provider of any other legal liability incurred in connection with the recovery for which the fee is charged, but is not evidence of violation of a statute or rule. The department shall credit all fees received under this subdivision to the appropriation account under s. 20.435 (4) (iL).

who may proceed with collection under this subdivision.

End of INS 4-7

LINSERT 6-16

p-10,1

SECTION . CR; 49.45 (2)(b) 8.

49.45 (2)(b) 8. Require ~~that~~ a person who takes over the operation of a provider, as defined in sub. (21) (ag), to first obtain certification under par. (a) 11., regardless of whether the person is currently certified. The department may withhold the certification required under this subdivision until any outstanding repayment under sub. (21) is made.

for the operation of the provider

LINSERT 8-7

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

p-12
1

, or during any period of ~~failure~~ provider failure or refusal to accord access ~~to information~~ as required under par. (g)

(INSERT 13-10 ✓)

(p. 185)

Section #. 49.45 (21) (title) of the statutes is amended to read:

49.45 **(21)** (title) ~~TRANSFER OF BUSINESS; LIABILITY FOR~~ REPAYMENTS; TAKING OVER PROVIDER'S OPERATION; REQUIRED.

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; 1999 a. 9, 63, 103, 180, 185.

INSERT 13-10 V

p. 2035

Section #. 49.45 (21) (a) of the statutes is renumbered 49.45 (21) (ar) and amended to read:

Before a person may take over the operation of a provider that is

49.45 **(21)** (ar) ~~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 responsible for contacting the department and ascertaining if the transferor~~ is liable ~~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; 1999 a. 9, 63, 103, 180, 185.

, full repayment shall be made. Upon request, the department shall notify the provider or the person that intends to take over the operation of the provider as to whether the provider

SECTION . CR;49.45(21)(ag)

49.45(21)(ag) In this subsection, "take over the operation" means obtain, with respect to an aspect of a provider's business for which the provider has filed claims for medical assistance reimbursement, any of the following:

1. Ownership of the provider's business or all or substantially all of the assets of the business.

2. Majority control over decisions.

3. The right to any profits or income.

4. The right to contact and offer services to patients, clients, or residents served by the provider.

5. An agreement that the provider will not compete with the person at all or with respect to a patient, client, resident,

service, geographical area, or other part of the provider's business.

6. The right to perform services that are substantially similar to services performed by the provider at the same location as those performed by the provider.

7. The right to use any distinctive name or symbol by which the provider is known in connection with services to be provided by the person.

(INS 13-10)

(p. 5 of 5)

Section #. 49.45 (21) (b) of the statutes is amended to read:

2b, notwithstanding the prohibition under par. (ar), a person takes over the operation of a provider

49.45 **(21)** (b) ~~If a transfer 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 proceed under sub. (2) (a) 12.

(ar)

2

If the amount is not repaid in full

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; 1999 a. 9, 63, 103, 180, 185.

any liable party

, in addition to withholding certification as authorized under sub. (2) (b) 8.,

, or may do both.

shall be repaid

End D
INS
13-10

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0193/1dn
DAK...:.....

To Melissa Mullikin and Anne Miller:

1. Language proposed for s. 49.45 (2) (a) 10. b. would require DHFS to stay the collection of MA reimbursement that was improperly or erroneously paid and of MA overpayments for a period sufficient to afford the provider a reasonable opportunity to present information and argument about the recovery; however, language proposed to amend s. 49.45 (2) (a) 10. a., stats., deletes the requirement for reasonable notice and opportunity for a hearing with respect to the recovery. How would the provider know that this period is available if he or she has no notice that the collection is going to be made? For this draft, I have kept in the language about notice in s. 49.45 (2) (a) 10. a., stats. Please review.

2. Under s. 49.45 (2) (a) 10m., DHFS proposes that it be required to charge a fee, after reasonable notice and opportunity for a hearing, to a provider "that has been subject repeatedly to recoveries under subd. 10. because of the provider's failure to follow identical or similar billing procedures or to follow other identical or similar program requirements". The fee may be no more than $1,000 or 200% of the amount of any such repeated recovery made, whichever is greater. The DHFS proposed language indicates that the purpose of the fee is to help defray the costs of audits and investigations by DHFS of provider overpayments. I have created a PR appropriation, s. 20.435 (4) (iL), for receipt of the fees. I have the following questions:

a. Was this fee imposition actually intended as a duty of the department, rather than a power?

b. The "fee" looks very much like a forfeiture. I can find no other instance in the statutes in which the imposition of a fee that is not related to licensure is subject to a hearing; also, what, in the hearing, is at issue: the fee amount, or the basis for its imposition? The fee is not in a set amount, nor does it have restrictions, such as "reasonable expenses of the department". There is, in fact, no express linkage between the amount of the fee and any costs of DHFS of investigation, audit, etc. Its purpose, therefore, appears to be punitive only. Whether, if the statute were challenged, a court would decide that it is a forfeiture masquerading as a fee is at least a possibility.

c. In any case, can the language that specifies the basis for charging the fee be tightened? As it is, the language is so nonspecific that it would compel the department to charge a "fee" for the smallest of repeat rule infractions. Is that the department's intent?

d. Do you want the fee first to apply to recoveries against a provider that are made on the act's effective date, or at some other time (see SECTION 9323 (2) of the bill)?

e. Is the fee amount 200% of the amount of one recovery or of the sum of two or more recoveries?

f. Is a provider who fails to pay a fee subject to decertification even in an instance in which the fee amount has been offset against any MA payment owed the provider and has been, therefore, paid?

3. The DHFS instructions regarding transfer of a provider's business to another state are, in part, to "[R]equire a provider to obtain new certification if that provider takes over an operation of another provider.... Require the full amount of monies identified in a recovery of an operation to be paid to DHFS before that operation may be transferred between providers. If full payment is not made, then both the transferee and the transferor are liable for the payment of recovery to DHFS, and DHFS may deny certification to the transferee." The following appear to be problems with this concept:

a. The proposed language for s. 49.45 (21) (a), stats (renumbered in this bill as s. 49.45 (21) (ar)) and for s. 49.45 (21) (b), stats., is written in passive voice, each requiring that outstanding repayments "be made" or "be repaid". I assumed that this language is intended to permit DHFS to proceed against either the transferor or the transferee for repayment. However, the proposed language does not achieve this effect; as proposed, s. 49.45 (21) (ar) states, "Before a person may take over the operation of a *provider that is liable* for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497, full repayment shall be made. Upon request, the department shall notify the provider or the person that intends to take over the operation of the provider *as to whether the provider is liable.*" And, under the changes proposed to s. 49.45 (21) (b), stats., the department may proceed against "any liable party"; this could only be the provider, since the language that authorizes DHFS to proceed against the transferor *or transferee* is stricken. Therefore, the language now restricts liability to the transferor, which is not the result DHFS indicates it intended. Since the language proposed and the instructions differ with each other, please let me know what you want.

b. As proposed, s. 49.45 (21) (b) states, "Within 30 days after receiving notice from the department, the amount shall be repaid in full." To whom does the department provide notice?

c. As proposed, under s. 49.45 (2) (b) 8., a person that takes over the operation of a provider must first obtain new MA provider certification. According to Anne, this means new certification only with respect to the operation of that specific provider. Under s. 49.45 (21) (b), if the repayment is not made in full, DHFS may withhold this certification. Thus, the language requires that the person obtain the new certification before the transaction takes place and, somewhat indirectly, also requires that the repayment be made before the transaction takes place. Does DHFS want authority to decertify the person (as to the operation of the provider) if the deal falls through after the person has been newly certified?

4. In order to accommodate the changes requested for s. 49.45 (3) (h), stats., it was also necessary to amend s. 49.45 (3) (g), stats. In amending s. 49.45 (3) (g), stats., I updated

the term "recipient medical records" to "patient health care records of medical assistance recipients" (see s. 146.81 (4), stats.). However, under s. 146.82, stats. (the statute governing confidentiality of patient health care records), 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. Please review. (This change was also made in 99–1098, the draft in the previous budget concerning this subject, and DHFS seemed to have no objection to it.)

1999 A LRB

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0193/P1dn
DAK.kg:pg

November 17, 2000

To Melissa Mullikin and Anne Miller:

1. Language proposed for s. 49.45 (2) (a) 10. b. would require DHFS to stay the collection of MA reimbursement that was improperly or erroneously paid and of MA overpayments for a period sufficient to afford the provider a reasonable opportunity to present information and argument about the recovery; however, language proposed to amend s. 49.45 (2) (a) 10. a., stats., deletes the requirement for reasonable notice and opportunity for a hearing with respect to the recovery. How would the provider know that this period is available if he or she has no notice that the collection is going to be made? For this draft, I have kept in the language about notice in s. 49.45 (2) (a) 10. a., stats. Please review.

2. Under s. 49.45 (2) (a) 10m., DHFS proposes that it be required to charge a fee, after reasonable notice and opportunity for a hearing, to a provider "that repeatedly has been subject to recoveries under subd. 10. because of the provider's failure to follow identical or similar billing procedures or to follow other identical or similar program requirements." The fee may be no more than $1,000 or 200% of the amount of any such repeated recovery made, whichever is greater. The DHFS proposed language indicates that the purpose of the fee is to help defray the costs of audits and investigations by DHFS of provider overpayments. I have created a PR appropriation, s. 20.435 (4) (iL), for receipt of the fees. I have the following questions:

a. Was this fee imposition actually intended as a duty of the department, rather than a power?

b. The "fee" looks very much like a forfeiture. I can find no other instance in the statutes in which the imposition of a fee that is not related to licensure is subject to a hearing; also, what, in the hearing, is at issue: the fee amount, or the basis for its imposition? The fee is not in a set amount, nor does it have restrictions, such as "reasonable expenses of the department." There is, in fact, no express linkage between the amount of the fee and any costs of DHFS of investigation, audit, etc. Its purpose, therefore, appears to be punitive only. Whether, if the statute were challenged, a court would decide that it is a forfeiture masquerading as a fee is at least a possibility.

c. In any case, can the language that specifies the basis for charging the fee be tightened? As it is, the language is so nonspecific that it would compel the department to charge a "fee" for the smallest of repeat rule infractions. Is that the department's intent?

d. Do you want the fee first to apply to recoveries against a provider that are made on the act's effective date, or at some other time (see SECTION 9323 (2) of the bill)?

e. Is the fee amount 200% of the amount of one recovery or of the sum of two or more recoveries?

f. Is a provider who fails to pay a fee subject to decertification even in an instance in which the fee amount has been offset against any MA payment owed the provider and has been, therefore, paid?

3. The DHFS instructions regarding transfer of a provider's business to another state are, in part, to "[R]equire a provider to obtain new certification if that provider takes over an operation of another provider.... Require the full amount of monies identified in a recovery of an operation to be paid to DHFS before that operation may be transferred between providers. If full payment is not made, then both the transferee and the transferor are liable for the payment of recovery to DHFS, and DHFS may deny certification to the transferee." The following appear to be problems with this concept:

a. The proposed language for s. 49.45 (21) (a), stats (renumbered in this bill as s. 49.45 (21) (ar)) and for s. 49.45 (21) (b), stats., is written in passive voice, each requiring that outstanding repayments "be made" or "be repaid." I assumed that this language is intended to permit DHFS to proceed against either the transferor or the transferee for repayment. However, the proposed language does not achieve this effect; as proposed, s. 49.45 (21) (ar) states, "Before a person may take over the operation of a *provider that is liable* for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497, full repayment shall be made. Upon request, the department shall notify the provider or the person that intends to take over the operation of the provider *as to whether the provider is liable*." And, under the changes proposed to s. 49.45 (21) (b), stats., the department may proceed against "any liable party"; this could only be the provider, since the language that authorizes DHFS to proceed against the transferor *or transferee* is stricken. Therefore, the language now restricts liability to the transferor, which is not the result DHFS indicates it intended. Since the language proposed and the instructions differ with each other, please let me know what you want.

b. As proposed, s. 49.45 (21) (b) states "Within 30 days after receiving notice from the department, the amount shall be repaid in full." To whom does the department provide notice?

c. As proposed, under s. 49.45 (2) (b) 8., a person that takes over the operation of a provider must first obtain new MA provider certification. According to Anne, this means new certification only with respect to the operation of that specific provider. Under s. 49.45 (21) (b), if the repayment is not made in full, DHFS may withhold this certification. Thus, the language requires that the person obtain the new certification before the transaction takes place and, somewhat indirectly, also requires that the repayment be made before the transaction takes place. Does DHFS want authority to decertify the person (as to the operation of the provider) if the deal falls through after the person has been newly certified?

4. In order to accommodate the changes requested for s. 49.45 (3) (h), stats., it was also necessary to amend s. 49.45 (3) (g), stats. In amending s. 49.45 (3) (g), stats., I updated

the term "recipient medical records" to "patient health care records of medical assistance recipients" (see s. 146.81 (4), stats.). However, under s. 146.82, stats. (the statute governing confidentiality of patient health care records), 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. Please review. (This change was also made in 1999 LRB–1098, the draft in the previous budget concerning this subject, and DHFS seemed to have no objection to it.)

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Kennedy, Debora

From: Miller, Anne
Sent: Wednesday, January 10, 2001 3:11 PM
To: Mullikin, Melissa
Cc: Bove, Fredi-Ellen; Gebhart, Neil; Thornton, Lori; White, Alan; Kraus, Jennifer; Kennedy, Debora
Subject: Response to drafter's note for LRB-0193/P1dn

MA-fraud-amdmts-02-drafternt_1...

Hi Melissa!

Here is DHFS's response to Debora's questions on draft LRB-0193/P1dn the MA Fraud and Abuse stat language request. If you or Debora have any questions or concerns, please feel free to contact us.

Anne Miller
DHFS/OSF
6-5422

LRB-0193/P1dn

RESPONSES TO 11/17/00 DRAFTER'S NOTE

1. Language proposed for s. 49.45 (2) (a) 10. b. would require DHFS to stay the collection of MA reimbursement that was improperly or erroneously paid and of MA overpayments for a period sufficient to afford the provider a reasonable opportunity to present information and argument about the recovery; however, language proposed to amend s. 49.45 (2) (a) 10. a., stats., deletes the requirement for reasonable notice and opportunity for a hearing with respect to the recovery. How would the provider know that this period is available if he or she has no notice that the collection is going to be made? For this draft, I have kept in the language about notice in s. 49.45 (2) (a) 10. a., stats. Please review.

Revise applicable language as follows:

SECTION 1. 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 the provider to present information and argument to department staff ~~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~~ or requiring the provider to make direct payment to the department or its fiscal intermediary.

Omit 10.b. and renumber 10.c. to 10.b.

2. Under s. 49.45 (2) (a) 10m., DHFS proposes that it be required to charge a fee, after reasonable notice and opportunity for a hearing, to a provider "that repeatedly has been subject to recoveries under subd. 10. because of the provider's failure to follow identical or similar billing procedures or to follow other identical or similar program requirements." The fee may be no more than $1,000 or 200% of the amount of any such repeated recovery made, whichever is greater. The DHFS proposed language indicates that the purpose of the fee is to help defray the costs of audits and investigations by DHFS of provider overpayments. I have created a PR appropriation, s. 20.435 (4) (iL), for receipt of the fees. I have the following questions:

a. Was this fee imposition actually intended as a duty of the department, rather than a power?

Imposing the fee should probably be a department power rather than a department duty. It therefore should be included under 49.45(2)(b) rather than (2)(a).

b. The "fee" looks very much like a forfeiture. I can find no other instance in the statutes in which the imposition of a fee that is not related to licensure is subject to a hearing; also, what, in the hearing, is at issue: the fee amount, or the basis for its imposition? The fee is not in a set amount, nor does it have restrictions, such as "reasonable expenses of the department." There is,

in fact, no express linkage between the amount of the fee and any costs of DHFS of investigation, audit, etc. Its purpose, therefore, appears to be punitive only. Whether, if the statute were challenged, a court would decide that it is a forfeiture masquerading as a fee is at least a possibility.

The Department is aware that the fee could be confused with a forfeiture, and is prepared to make the case that it is not. In this regard, the Department's original draft included the following sentence, which we request be restored: "The purpose of fees under this subdivision is to help defray the costs of audits and investigations by the department relative to overpayments to providers."

✓ c. In any case, can the language that specifies the basis for charging the fee be tightened? As it is, the language is so nonspecific that it would compel the department to charge a "fee" for the smallest of repeat rule infractions. Is that the department's intent?

This concern has been alleviated by moving the fee provision from the list of department duties to the list of department powers.

✓ d. Do you want the fee first to apply to recoveries against a provider that are made on the act's effective date, or at some other time (see SECTION 9323 (2) of the bill)?

The fee should first apply in situations where a repeated recovery is made on the act's effective date, regardless of whether the initial recovery was made prior to the act's effective date.

e. Is the fee amount 200% of the amount of one recovery or of the sum of two or more recoveries? From Neil Gebhardt 1/16/01: Ignore this ?; it should be

The basis for calculating the fee should be the sum of the amount of all repeat recoveries, i.e., excluding only the initial recovery.

✓ f. Is a provider who fails to pay a fee subject to decertification even in an instance in which the fee amount has been offset against any MA payment owed the provider and has been, therefore, paid?

No. A provider should be subject to decertification only if the fee has not been paid in any manner.

3. The DHFS instructions regarding transfer of a provider's business to another state are, in part, to "[R]equire a provider to obtain new certification if that provider takes over an operation of another provider.... Require the full amount of monies identified in a recovery of an operation to be paid to DHFS before that operation may be transferred between providers. If full payment is not made, then both the transferee and the transferor are liable for the payment of recovery to DHFS, and DHFS may deny certification to the transferee." The following appear to be problems with this concept:

The instructions do not relate to transfer of a provider's business "to another state," but rather any transfer from one entity to another. We assume "to another state" was included inadvertently.

✓ a. The proposed language for s. 49.45 (21) (a), stats (renumbered in this bill as s. 49.45 (21) (ar)) and for s. 49.45 (21) (b), stats., is written in passive voice, each requiring that outstanding repayments "be made" or "be repaid." I assumed that this language is intended to permit DHFS to proceed against either the transferor or the transferee for repayment. However, the proposed language does not achieve this effect; as proposed, s. 49.45 (21) (ar) states, "Before a person may take over the operation of a *provider that is liable* for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497, full repayment shall be made. Upon request, the department shall notify the provider or the person that intends to take over the operation of the provider *as to whether the provider is liable*." And, under the changes proposed to s. 49.45 (21)(b), stats., the department may proceed against "any liable party"; this could only be the provider, since the language that authorizes DHFS to proceed against the transferor *or transferee* is stricken. Therefore, the language now restricts liability to the transferor, which is not the result DHFS indicates it intended. Since the language proposed and the instructions differ with each other, please let me know what you want.

The Department's intent is that the transferor and transferee be jointly and severally liable for any amount owed to the Department by the provider.

✓ b. As proposed, s. 49.45 (21) (b) states "Within 30 days after receiving notice from the department, the amount shall be repaid in full." To whom does the department provide notice?

The notice should be sent to the entity currently certified as the provider.

✓ c. As proposed, under s. 49.45 (2) (b) 8., a person that takes over the operation of a provider must first obtain new MA provider certification. According to Anne, this means new certification only with respect to the operation of that specific provider. Under s. 49.45 (21) (b), if the repayment is not made in full, DHFS may withhold this certification. Thus, the language requires that the person obtain the new certification before the transaction takes place and, somewhat indirectly, also requires that the repayment be made before the transaction takes place. Does DHFS want authority to decertify the person (as to the operation of the provider) if the deal falls through after the person has been newly certified?

No. The Department would have certified the prospective transferee only if the transferor's liability to the Department had been paid. If the deal falls through after the prospective transferee is certified, the transferor would need to re-apply for certification.

✓ 4. In order to accommodate the changes requested for s. 49.45 (3) (h), stats., it was also necessary to amend s. 49.45 (3) (g), stats. In amending s. 49.45 (3) (g), stats., I updated the term "recipient medical records" to "patient health care records of medical assistance recipients" (see s. 146.81 (4), stats.). However, under s. 146.82, stats. (the statute governing confidentiality of patient health care records), 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. Please review. (This change was also made in 1999 LRB–1098, the draft in the previous budget concerning this subject, and DHFS seemed to have no objection to it.)

This change is acceptable.