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

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

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

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

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

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

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

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

(h) The agency's decision concerning ineligibility and amounts owed may be appealed pursuant to s. PW-PA 20.18, [ch. HSS 225]. During the appeal process the agency may take no further recovery actions pending a decision. Benefits shall be continued pending the decision on the appeal. When the hearing decision is subsequently adverse to the client the benefits paid pending a decision on the appeal shall be collectable as incorrect payments.

(i) The agency shall immediately deposit monies collected under this subsection to a designated bank account. The collection shall be reported to the department in the manner and on forms designated by the department within 30 days following the end of the month in which the collection is made, and shall be transmitted to the state in accordance with departmental instructions.

(4) AUTHORIZATION OF PAYMENTS. (a) The board created under s. 46.23 or 51.42, Stats., in the county in which the recipient resides shall

authorize payment by the department for outpatient mental health services funded by the MA program, as well as inpatient psychiatric services for persons in the age group 22 to 64. The board shall be liable for a portion of the cost of services as designated in s. 49.46 (2) (b) 6 f and 7, Stats.

(b) As part of its function of managing the provision of mental health services, the board shall contract with a sufficient number of psychotherapy providers qualified to meet the standards of s. HSS 105.22, to serve recipients in each county who require psychotherapy.

(c) The board shall review all claims and prior authorization requests for mental health services, and shall note the completion of the review on the provider's request in accordance with the guidelines in s. HSS 107.13.

(d) In the case of inpatient psychiatric services for persons age 22 through 64 in a psychiatric hospital, the county shall be responsible for the state's share of MA costs for the calendar month in which the recipient is admitted.

(5) ESTABLISHING A PROGRAM OF MEDICAL SUPPORT LIABILITY. Pursuant to s. 59.07 (97), Stats., counties shall contract with the department to implement and administer the child support collection program under Title IV-D of the Social Security Act of 1935, as amended. One of the responsibilities of a county's child support agency defined in s. HSS 215.02 (1) is to establish a program of medical support liability along with the child and spousal support and paternity establishment program.

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

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

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

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

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

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

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

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

History: Cr. Register, December, 1979, No. 288, eff. 2-1-80; renum. from HSS 108.02 and am. Register, February, 1986, No. 362, eff. 3-1-86; cr. (6), Register, December, 1988, No. 396, eff. 1-1-89.