Chapter HSS 1

UNIFORM FEE SCHEDULE

HSS 1.01 Introduction
HSS 1.02 Liability
HSS 1.03 Billing rates and payment provisions
HSS 1.04 Fee establishment
HSS 1.05 Collections
HSS 1.06 Records and reports

Note: Chapter HSS 1 as it existed on August 31, 1978 was replaced and a new chapter HSS 1 was created effective September 1, 1978.

HSS 1.01 Introduction. (1) STATEMENT OF INTENT. These rules, implementing ss. 46.03 (18) and 46.10, Stats., standardize on a statewide basis the determination of liability and ability to pay, and otherwise regulate billing and collection activities for care and services provided or purchased by the department, a county department of public welfare or social services, or a board created under s. 51.42, 51.437, or 46.23, Stats.

Note: Boards operated under the provisions of s. 46.033, Stats., or boards designated under s. 55.02, Stats., are included as well since authority is derived from the agencies specified above.

(2) DEFINITIONS. (a) "Administratively unfeasible" means that the total payments realized would approximate or be less than the cost of collections for a specified type of service.

(b) "Department" means the state department of health and social services.

(c) "Division" means one of the major subunits of the department.

(d) "Facility" means any agency, office, institution, clinic, etc., that delivers client services.

(e) "Family" means an adult, the adult's spouse, if any, and any other person (s) who meet (s) internal revenue service standards as their dependent (s). However, any person described by one of the following conditions shall not be included as a family member in determining the ability to pay of any given responsible party under these rules:

1. A family member who is receiving services in a full-care facility, or

2. A legal dependent living outside the household of the responsible party for whom there is a court-ordered support/maintenance obligation.

Note: An adult client residing in the home of his or her parent (s) shall be considered a separate family in determining ability to pay under these rules.

(f) "Fee" means a single, cost-related, per unit charge or rate assigned to a purchased or provided service furnished by a provider of service calculated and/or approved according to the provisions of this rule for the purpose of establishing the liability of responsible parties and billing third-party payers.

Note: In the context of these rules "fee" does not mean the payment that is expected of the client or his or her family.

(g) "Full financial information" means such information about a family's income, expenses, liquid assets, and insurance coverage as is necessarily and reasonably requested for the purpose of determining ability-to-pay and for billing all applicable insurance.

(h) "Income" means money, wages or salary, net income from nonfarm self-employment, net income from farm self-employment, social security, dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers compensation, alimony (maintenance payments), child support, and veteran pensions.

(i) "Parent" means a child's adoptive or biological mother or father who has legal responsibility for the child.

(j) "Payment Approval Authority" means an administrator of a division, the director of a county department of public welfare or social services, or the program director of a board established under ss. 51.42, 51.437, or 46.23, Stats., or a designee.

(k) "Secretary" means the secretary of the department of health and social services.

(l) "Student" means an individual who is attending a school, college, university, or a course of vocational or technical training.

(3) WHERE RULES APPLY. These rules apply to all client-specific care and services purchased or provided by the department, county departments of public welfare or social services, and boards created under s. 51.42, 51.437, or 46.23, Stats., except as provided in section HSS 1.01 (4) of these rules.

(4) EXCEPTIONS. The following services are not subject to direct billing to responsible parties under these rules:

(a) Federal exemptions: any service for which the imposition of a charge is prohibited by federal law, regulation, or valid federal grant requirement, including educational services to handicapped pre-school age children with exceptional education needs under Title I of P.L. 89-313.

(b) Statutory or judicial exemptions: services exempted in ss. 46.03 (18) (a) and 46.10 (2m), Stats., services for handicapped children with exceptional education needs which local school districts must ensure be available under ss. 115.83 and 115.85, Stats., and any other care or service for which the imposition of a charge is prohibited by state law or court order.

(c) Exemptions established by the department, pursuant to s. 46.03 (18) (a), Stats.:

1. Services offered and defined under the State Plan for Title XX of the Social Security Act which are specifically exempted from fee charging in the Plan.

2. Probation and parole services, court ordered supervision and other supervision services.

Note: In situations where this provision conflicts with the Title XX Plan and Regulations, the latter take precedence.

3. Purchases of education services by the divisions of corrections and vocational rehabilitation.

4. Sheltered employment, work activity, and adult non-medical day services programs for the handicapped.

5. Non-medical initial diagnosis and evaluation services.

6. Family planning services.

7. Advocacy.

(d) Further exemptions: any provider of a service may request that the service be exempted from these rules under procedures established by the secretary. The provider shall be granted an exemption from these rules, unless prohibited by law, if the secretary or designee finds that the benefit of the service in question will be significantly impaired if the imposition of a charge continues or that the imposition of a charge is administratively unfeasible.

(5) CROSS REFERENCE TO OTHER RULES. Rules governing fees for services provided under s. 46.25, Stats., shall be promulgated under (PW) of the Wis. Adm. Code pertaining to the bureau of child support.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

HSS 1.02 Liability. (1) RESPONSIBLE PARTIES. Whenever a client receives a service which is subject to these rules, the persons identified in ss. 46.03 (18) (b) and 46.10 (2), Stats., shall be responsible for paying for the service in the manner set forth in these rules. These persons shall hereinafter be referred to as "responsible parties." Their legal obligation for the service received shall hereinafter be referred to as "liability."

(2) EXTENT OF LIABILITY. Liability for a service shall equal the fee, as determined pursuant to these rules, times the number of units of service provided, except as follows:

(a) For parties and services specified in s. 46.10 (14), Stats., liability of responsible parties listed therein and of insurance firms shall be as specified therein.

(b) Notwithstanding paragraph (a), when inpatient care for minors at facilities listed in s. 46.10 (14), Stats., exceeds one year, the liability of responsible parties with limited liability under s. 46.10 (14), Stats., shall be the lower of the rate established in s. 46.10 (14), Stats., or their maximum monthly payment rate as calculated under section HSS 1.03 (9) and adjusted as appropriate under section HSS 1.03 (10).

(3) DISCHARGE OF LIABILITY OTHER THAN BY MEANS OF FULL PAYMENT. At the end of a treatment episode, the liability of responsible parties remaining after recovery of benefits from all applicable insurance shall be deemed discharged if responsible parties provide persons with billing responsibility with full financial information and obtain a waiver as follows:

(a) For all care and service except inpatient mental hygiene, by having paid the lesser of the liability remaining after crediting third-party payments each month or the maximum monthly payment rate as calculated in section HSS 1.03 (9) and adjusted, as appropriate, under section HSS 1.03 (10).

(b) For inpatient mental hygiene care and services, when liability remaining exceeds $1000 or discharge of liability at the maximum monthly payment rate would exceed 5 years, by entering into an agreement with the appropriate payment approval authority to pay a substantial portion of the liability outstanding as a lump sum.

(4) EXEMPTION FROM LIABILITY. If it is determined in the case of a particular family that the accomplishment of the purpose of a service would be significantly impaired by the imposition of liability, the accrual of liability during a period not to exceed 90 days may be voided by the appropriate payment approval authority. If the need to avoid imposition of liability continues, a further cancellation may be granted.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

HSS 1.03 Billing rates and payment provisions. (1) APPLICABLE INSURANCE. Where applicable insurance exists, the insurer shall be billed an amount equal to the fee, as determined pursuant to these rules, times the number of units of service provided.

(2) CLIENTS IN FULL-CARE FACILITIES (MEDICAL AND NON-MEDICAL) WITH UNEARNED INCOME. A client receiving full-care service and who is the beneficiary of monthly payments intended to meet maintenance needs and/or accrues unearned income (including but not limited to interest from assets such as savings and investments), shall be expected to pay the lesser of the monthly liability for that care or the total amount of unearned income that month less an amount sufficient to satisfy the client's unmet personal needs and any court-ordered payments or support of legal dependents. The monthly amount of interest income is determined by dividing the current annual interest income by 12. If payments of unearned income are made to a representative payee or guardian, that person shall be expected to pay from the resources of the client as specified for the client but subject to further possible reductions according to other prerequisite uses of the benefit payments a payee may be required or permitted to make as established by the payer. For clients in full-care, non-medical facilities receiving SSI benefits, no attempt shall be made to collect from any responsible party any remaining liability for those months that SSI payments are applied to the cost if such collections would reduce the SSI payment.

(3) CLIENTS IN FULL-CARE FACILITIES (MEDICAL AND NON-MEDICAL) WITH EARNED INCOME. Except for clients who are full time students or part-time students who are not full time employes, clients residing in full-care facilities who have earned income shall be expected to pay any remaining liability for that care each month from earnings as follows: After subtraction of the first $65 of net earnings (after taxes) and any unmet court-ordered obligations or support of legal dependents, up to one-half the remaining amount of earnings.

(4) PAYMENT ADJUSTMENT FROM CLIENT'S EARNED INCOME. The appropriate payment approval authority may authorize the following modification to subsection (3) of this section for clients whose care-treatment plans provide for economic independence within less than one year: Subtract up to $240 of net earnings after taxes and proceed under the provisions of subsection (3) of this section provided that any amounts subtracted beyond $65 per month under this subsection are used for the following purposes:

(a) Savings to furnish and initiate an independent living arrangement for the client upon release from the full-care facility. Under this provision, earnings shall not be conserved beyond the point that the client would no longer meet the asset eligibility limits for SSI or Medicaid.

(b) Purchase of clothing and other reasonable personal expenses the client will need to enter an independent living arrangement.

(c) Repayment of previously incurred debts.

(5) PAYMENT ADJUSTMENT FROM CLIENT'S UNEARNED AND EARNED INCOME. When a client resides in a full-care facility less than 15 days in any calendar month, payments expected under subsections (2) and (3) of this section may be prorated between the days the client spends in and out of the facility. A daily payment rate may be calculated by multiplying the monthly amount determined under subsections (2) and (3) of this section by 12 and dividing by 365. The daily payment rate times the days the client spends in the facility determines the amount of the payment expected from the client's income. The provisions for determining the client's "available income" in billing Medicaid shall take precedence over this procedure wherever applicable.

(6) CLIENTS IN FULL-CARE FACILITIES (MEDICAL AND NON-MEDICAL) WITH LIQUID ASSETS IN EXCESS OF ELIGIBILITY FOR SSI OR MEDICAID. Clients in full-care facilities shall be expected to pay any remaining liability for that care until their assets are reduced to eligibility limits for SSI or Medicaid except as follows:

(a) As protected by law or an order of the court.

(b) As may be protected in full or in part by a written agreement approved by the appropriate payment approval authority upon presentation in writing by the client or client's guardian, trustee or advocate, any specific and viable future plans or uses for which the excess assets are intended. Such documentation shall include the extent to which the client's funds need to be protected for purposes of preventing further dependency of the client upon the public and/or of enhancing development of the client into a normal and self-supporting member of society.

(7) REFUSAL TO PROVIDE FULL FINANCIAL INFORMATION. A responsible party who is informed of his or her rights and knowingly refuses to provide full financial information shall not be eligible under section HSS 1.02 (3) to discharge liability other than by means of full payment.

(8) BILLING ON THE BASIS OF ABILITY TO PAY. (a) A responsible party who provides full financial information shall be billed on the basis of the family's ability to pay.

(b) For each family, ability to pay shall be determined in the following manner:

1. The annual gross income of family members shall be determined and totaled except that the earned income of any child who is a full time student or a part-time student but not a full time employe shall be excluded. Income from self-employment or rent shall be the total net income after expenses. The income of any family member in a full-care setting is treated separately under this rule.

2. The monthly average income shall be computed by dividing the annual gross income by 12.

3. Monthly payments from court ordered obligations shall be subtracted from monthly average income.

4. From the remaining amount there shall be subtracted:

a. An amount determined by the department based on the bureau of labor statistics' most recent annual lower-level-budget monthly figure adjusted for a family of like size, and

b. The estimated amount of income taxes and social security or federal retirement obligations above the level determined in subparagraph a. for a family of like income and size.

5. The resulting amount equals the family's "monthly available income". A positive amount signifies ability to pay.

(9) MAXIMUM MONTHLY PAYMENT RATE. A family which provides full financial information shall be billed monthly an amount equal to monthly available income multiplied by 50% which billing amount shall be called the "maximum monthly payment rate".

Note: The department shall annually develop and distribute a schedule for converting from average-dollars-available-monthly to the billing amount, as an aid for facilities covered by these rules.

(10) ADJUSTMENTS. The maximum monthly payment rate calculated under section HSS 1.03 (9) is adjustable in the following situations:

(a) In cases where family members who contribute to the family income are not responsible parties for the liability being charged to the family, the maximum monthly payment rate shall not exceed the sum of the unearned and one-half the earned income of responsible party(s), less a percentage of earnings equal to that used by the Wisconsin AFDC program for work related expenses.

(b) When payment at the maximum monthly payment rate, as calculated in section HSS 1.03 (9), would create a documentable hardship on the family, (such as the forced sale of the family residence or cessation of an education program), a lower maximum monthly payment rate may be authorized by the appropriate payment approval authority.

(11) RELATIONSHIP TO EXTENT OF SERVICES. When full financial information is provided, the maximum monthly payment rate is the total ceiling amount that the family may be billed a month regardless of the number of family members receiving services, the number of agencies providing services, or the magnitude or extent of services received.

(12) EXCEPTIONS. (a) For any service received by one or more minor children, the parents shall not be billed a total amount per child per day greater than the amount specified in s. 46.10 (14), Stats. When a minor child and an adult from one family receive services, the maximum set in s. 46.10 (14), Stats., shall not apply to billings for services to the adult.

(b) The appropriate payment approval authority may establish a minimum payment for therapeutic reasons for a specified type of service. The therapeutic charge may be a per month amount or a per visit or per unit of service charge and may result in a higher amount than the maximum monthly payment rate. A charge for "no-show" is considered a therapeutic charge. In no case may enforcement of the increased payment due resulting from a therapeutic charge be pursued through the

courts. The client's record shall reflect the nature of any such minimum therapeutic charge.

(13) REDETERMINATION OF MAXIMUM MONTHLY PAYMENT RATE. The maximum monthly payment rate established upon entry into the system shall be reviewed at least once per year. A redetermination shall be made at any time during the treatment or payment period that a significant change occurs in available income. The redetermined maximum monthly payment rate may be applied retroactively or prospectively.

(14) PAYMENT PERIOD. Monthly billing to responsible parties with ability to pay shall continue until:

(a) Liability has been met or

(b) A waiver of remaining liability is obtained or

(c) Client records for inpatient mental health services are placed in inactive status as specified under section HSS 1.06 (3) (b) of these rules.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

HSS 1.04 Fee establishment. (1) APPLICABILITY. With respect to client services for which responsible parties incur liability and may be billed, each facility operated by the department, a county department of public welfare or social services, or a board established under s. 51.42, 51.437, or 46.23, Stats.; or an agency providing services pursuant to a contract in excess of $10,000 per year with the department, a county department of public welfare or social services, or a board established under s. 51.42, 51.437, or 46.23, Stats., shall establish a fee or set of fees as follows:

(a) *Facility fee or service fee.* The division, county department of public welfare or social services, board established under s. 51.42, 51.437, or 46.23, Stats., or private firm in charge of the facility shall establish a uniform facility fee, except that if the facility provides 2 or more services of a disparate nature with associated wide differences in per-service cost, separate per-service fees shall be established.

(b) *Fee calculation.* Fees shall be determined in advance for each calendar year, except that divisions may determine fees in advance for each fiscal year. For purchased services, the contract rate and billable units to the purchaser should be identical to the fee and billable units to the responsible party (s), wherever possible. Fees shall be determined by dividing either the number of patient days projected by the year in question, or, if the facility or service provides less than 24 hour care, the number of hours of billable client service projected for the year in question, into allowable anticipated facility or service-related expenditures for the year in question. For purchased services not easily converted to time units and where the contract or agreement specifies purchase units other than time, fees shall be set using the contract unit.

(c) *Expenditures.* Expenditures mean ordinary and necessary budgeted non-capital expenses and depreciation on capital equipment. Cost standards that govern purchase of care and services under s. 46.036, Stats., shall apply to expenditures for calculating the fee. Outlays associated with non-client-specific community service and with client services exempted under section HSS 1.01 (4) plus a pro-rata share of depreciation and associated administration or indirect costs are excluded. Where

the facility establishes separate per-service fees, expenditures mean ordinary and necessary per-service expenses plus a pro-rata share of depreciation and indirect or administration costs.

(d) *Fee approval.* The facility fee or service fees for services provided by a division, a county department of public welfare or social services, or board established under s. 51.42, 51.437, or 46.23, Stats., shall not take effect until approved by the secretary or a designee, either in the context of approving a general facility or program plan or by approving the fee(s) separately, except where another form of approval is provided by law. The administrative unit authorized to enter into contracts or agreements for purchased services shall approve the fee(s) for such services before execution of the contract or agreement and the approved fee(s) shall be included in the contract.

(e) *Effective date of fee.* Fees in effect at any time shall remain in effect until new fees are determined and approved pursuant to these rules. No fees shall be modified without the prior consent of the fee-approving authority.

(2) EXCEPTIONS. (a) *Purchases totaling less than $10,000.* Facilities providing services pursuant to contracts or agreements of $10,000 or less with a division, a county department of public welfare or social services, or a board established under s. 51.42, 51.437, or 46.23, Stats., shall establish fees which shall be equal to the "usual and customary charge." Each facility shall establish a uniform facility fee, except that if the facility provides 2 or more services of a disparate nature with associated wide differences in per-service cost, the facility shall establish separate per-service fees. The initial fee established under these rules shall be approved by the administrative unit authorized to enter into the contract or agreement before taking effect. Fees shall not be modified without the prior approval of the purchasing authority.

(b) *General hospitals and special hospitals.* The rates approved for reimbursement under the rate review process established by s. 146.60, Stats., shall be the fee for services rendered on and after January 1, 1979. Rates for hospitals not subject to rate review shall be determined and approved by the applicable provisions set forth in these rules. Public patient rates for University of Wisconsin Hospital and Clinics approved under s. 142.07 (1) (b) and (c), Stats., shall be the fee for those services.

(c) *Private practitioners.* For services provided by a private practitioner the fee shall be the usual and customary charge for such services when such charges are in accord with all laws or regulations governing such charges.

(d) *Statewide rates.* Where the department has established a statewide rate for a service, that rate shall be the fee.

(e) *County departments of public welfare or social services.* In special circumstances with approval of the department, county departments of public welfare or social services may use a fee of $12 per hour for services delivered by professional staff and $8 per hour for services provided by paraprofessionals instead of establishing fees under HSS 1.04 (1).

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

HSS 1.05 Collections. (1) BOARDS ESTABLISHED UNDER SECTION 51.42, 51.437, OR 46.23, WIS. STATS. With respect to each service not provided in

state facilities, the responsibility for billing and collections pursuant to these rules shall be delegated to a board established under ss. 51.42, 51.437, or 46.23, Stats., under authority established by s. 46.10 (16), Stats., subject to the conditions specified by the department. The board may further delegate responsibility for billing and collection to a service provider by written agreement specifying the conditions of such delegation.

(2) COUNTY DEPARTMENTS OF PUBLIC WELFARE OR SOCIAL SERVICES. Where services covered by these rules are delivered through a county department of public welfare or social services, the county department of public welfare or social services shall have billing and collection responsibility for those services unless it delegates such responsibility to another agency or agencies by written agreement specifying the conditions of such delegation.

(3) REVOCATION OF DELEGATED AUTHORITY. All delegations under section HSS 1.05 (1) and (2) of these rules are subject to revocation should the department find violations of these rules or of generally recognized good accounting practices.

(4) STATE BUREAU OF COLLECTIONS. Except where responsibility for collections is delegated under sections HSS 1.05 (1) and (2), the bureau of collections of the department shall be responsible for the billing and collection function. The bureau of collections shall also provide collection services for individual delinquent, or otherwise referred, client accounts.

(5) APPROACH TO BILLING AND COLLECTIONS. (a) All billing and collection efforts shall strive toward what is fair and equitable treatment for both clients who receive service and taxpayers who bear unmet costs.

(b) Billing and collection activity shall consider the rights, dignity, and physical and mental condition of the client and other responsible parties. Responsible parties with no ability to pay and without applicable insurance shall not be pursued for payment. Billings shall be made no more frequently than monthly.

(c) All billing and collection activity shall be pursued in a forthright and timely manner according to these rules:

1. Where applicable insurance exists, the insurance company shall be billed directly wherever possible by the unit with collection responsibility for the facility providing the service. Where a responsible party is covered by Medicare and private insurance, Medicare shall be billed for the full coverage it provides and the private insurance company shall be billed for any remaining amount. Medicaid, where applicable, is the payer of last resort.

2. Responsible private parties shall be billed for liability not covered by insurance, at their maximum monthly payment rate as calculated under section HSS 1.03 (9) and adjusted where appropriate under section HSS 1.03 (10) of these rules.

(6) APPLICATION OF PAYMENTS. (a) Payments shall be applied to the oldest period of service for which a liability remains, except as provided in the following paragraphs of this subsection.

(b) When a responsible party has liability for inpatient mental health care and for some other type of service, payments shall not be applied to

inpatient mental health liability until other liabilities have been satisfied according to these rules.

(c) When private insurers or government agencies make payments against claims or statements that specify dates of service, such payments shall be applied to liability for the period indicated.

(d) For clients in full-care facilities, payments from client's own income shall be applied to the liability incurred during the month the income is received except that retroactive benefits may be applied to liability incurred back to the date of entitlement. The priority of payments for clients in full-care facilities is as follows:

1. Payments from any responsible parent for a child under custody in accordance with ch. 48, Stats.

2. Payment from any unearned income of the client.

3. Payment from any earned income of the client.

4. Payment from any other responsible party.

5. Payment from any excess assets of the client.

(7) DELINQUENT ACCOUNT PROCEDURES. (a) An account is considered delinquent when a determination has been made that ability to pay currently exists, that no payment has been made over a period of 90 days, and that 3 or more contacts have been made to secure a payment.

(b) Responsible parties involved shall be notified in writing when the agency plans to refer the account for collection.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.

HSS 1.06 Records and reports. (1) CONFIDENTIALITY. Information regarding a client and all interested parties, collected by a facility or agency subject to these rules, shall remain confidential.

(2) EXCEPTION. Confidentiality provisions shall not prohibit disclosure of information in the following situations:

(a) To employes or directors of the facility, agency, or department where it is needed by them to carry out their responsibilities, or

(b) As otherwise provided by law.

(3) CLIENT RECORDS. (a) *Contents.* With respect to each client served by a facility or agency subject to these rules, a client file or files shall be maintained as prescribed by the department and shall include complete, clear, and exact records relating to the services received by the client and the financial situation of the family involved.

(b) *Active client record.* Records remain active as long as liability exists with the following exception: For inpatient mental health services, client records may be placed in inactive status when third-party sources have been exhausted and it has been determined the responsible parties have a permanent inability or unlikely future ability to pay.

(c) *Inactive client records.* Inactive client records shall be available for audit purposes and kept a minimum of 5 years with the following exception: Where liability for inpatient mental health services remains, client records shall be kept a minimum of 10 years after the last transaction is posted to the record.

(4) AGENCY RECORDS. Each agency or facility covered by these rules shall keep complete, clear, and exact records of allocation of staff time, service units delivered, and all revenues and gross expenditures.

(5) REQUIRED REPORTS. Each facility or agency covered by these rules shall submit to the department such reports on client liability, billings, and collections as the department may require.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78.