1. Mental hygiene inpatient facilities

2. Foster homes

3. Group homes

4. Child caring institutions

5. Community based residential facilities

6. Juvenile correctional facilities

(d) For other services, supplies or materials, where the cost is the fee, an itemized statement describing the service and cost will suffice.

(4) ADDITIONAL PROVISIONS FOR RECORDING PER DAY UNITS OF SERVICE. (a) Except as otherwise stated, a charge shall be made for each day a patient or resident is physically at the institution or facility at midnight of the day. No charge shall be made for the day the patient or resident leaves.

(b) A charge shall be made if the patient or resident both enters and leaves during the same day.

(c) No charge shall be made for any day during which a patient or resident has been granted a leave or furlough or is on unauthorized absence for one or more overnights.

(d) A charge shall be made for each day during which a patient or resident of a state institution is confined at university of Wisconsin hospital and clinics as a charge of the department institution when admitted under s. 46.115, Stats. Patients or residents placed on authorized leave or furlough and sent to a general hospital overnight or longer at their own expense shall not be charged for institution care while so hospitalized.

(5) REPORTING EXCEPTION FOR SOCIAL SERVICES. For fee-chargeable services of the type that have no potential for third-party payment recovery, a simplified reporting system may be established to eliminate the reporting of units of service to the facility's or agency's billing unit for clients and other responsible parties who show a documented zero ability to pay according to HSS 1.03. However, agency records shall contain information specified in HSS 1.06.

(6) LESSER SPECIAL RATES. These procedures govern the computation of a "lesser special rate" for residential facilities subject to s. 46.10 (14), Stats., where "no liability may accrue for the difference between the lesser special rate and $4 per day."

(a) Inpatient facilities. While HSS 1.02 (2) (b) requires the application of a lesser special rate when care exceeds one year, it is also permissible to apply a lesser special rate during the first year of such care when it is virtually certain that care will exceed one year and not to do so would work a documentable hardship on the family. The earlier application of the lesser special rate shall be determined by the payment approval authority.

(b) Residential non-medical facilities. Where the family's monthly payment rate determined according to HSS 1.03 is less than $122, a lesser special rate shall be applied at the outset of services in lieu of the

parental payment limit of $4.00 per day. Agencies may set lesser special rates in one of the following ways:

1. A monthly rate shall be the lesser of $122 or the family's monthly payment rate as determined according to HSS 1.03; however, the application of a monthly rate must not result in a parental payment of more than $4.00 per day of care for any month.

2. A daily rate may be used by charging a family the lesser of $4.00 per day or an amount consisting of their monthly payment rate multiplied by 12 with that product divided by 365.

(7) PARENTAL LIABILITY FOR NON-RESIDENTIAL SERVICES. (a) Parents are liable for the full cost of non-residential services; however, under certain conditions, HSS 1.03 (18) (a) limits parental billings for outpatient psychotherapy purchased or provided by county agencies to $120 per month. Billings for other non-residential services are limited to $4.00 per day. Claims for third parties are filed at the full cost of service. (See paragraph (b) on how health insurance recovery affects the billing amount to parents.) In billing parents, if the total charges in a calendar month exceed the monthly payment rate as calculated in HSS 1.03, the charges to the parents for that month shall be reduced to the monthly payment rate.

(b) Where the parental payment limit is $120 per month, the parents' payment obligation for a given month is credited by any insurance payments received for services during that month. Where the parental payment limit is $4.00 per day, the parents' payment obligation for a given day is credited by any insurance payments received for services on that day.

(8) 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 monthly payment rate as calculated in section HSS 1.03 (12) or (13) and adjusted, as appropriate, under section HSS 1.03 (14).

(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.

(9) 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 in whole or in part 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; am. (1), (2) (b), ren. (3) and (4) to be (8) and (9) and am. (8) (a) and (9), cr. (3) to (7), Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.03 Billing rates and ability to pay. (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 RESIDING IN FACILITIES (MEDICAL OR NON-MEDICAL) WITH UNEARNED INCOME. A client receiving room and board with care or services 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 RESIDING IN FACILITIES (MEDICAL OR NON-MEDICAL) WITH EARNED INCOME. Except for clients who are full time students or part-time students who are not full time employes, clients receiving room and board with care or services 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 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 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 RESIDING IN FACILITIES (MEDICAL OR NON-MEDICAL) WITH LIQUID ASSETS IN EXCESS OF ELIGIBILITY FOR SSI OR MEDICAID. Clients residing in 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) NOTIFICATION. The payment approval authority shall assure that clients and responsible parties are informed as early as administratively and clinically feasible of their rights and responsibilities under the uniform fee system. The department shall provide sample brochures for the various service categories to assist payment approval authorities with this requirement.

(8) 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 and authorizations for billing all applicable insurance shall not be eligible under section HSS 1.02 (8) to discharge liability other than by means of full payment.

(9) INTAKE PROCESS. In conjunction with appropriate notification, the intake process for each client who receives fee-chargeable or third-party billable services shall include sufficient time and capability to complete all necessary information for billing including an application for ability to pay considerations.

(10) FINANCIAL INFORMATION FORM (APPLICATION FOR ABILITY TO PAY PROVISIONS). (a) Except as otherwise provided in these rules, the Financial Information Form (DHSS 130) is mandatory when a responsible party chooses to be considered for ability to pay provisions.

Note: Form DHSS 130 may be ordered from:

Department of Health & Social Services
Forms Center - Room B364
1 West Wilson Street
Madison, Wisconsin 53702.

(b) County agencies may use their own forms in place of DHSS 130 subject to the prior approval of the department. Any substitute form (s) must be capable of fulfilling the same provisions as the current DHSS 130.

(11) BILLING ON THE BASIS OF ABILITY TO PAY. (a) A responsible party who provides full financial information and authorizations for billing all applicable insurance 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 residential 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.

(12) 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.

(13) MINIMUM PAYMENT. The appropriate payment approval authority may establish a minimum payment rate up to $25.00 per month across the board for all families receiving a fee chargeable service whose maximum monthly payment as calculated according to sub. (12) is less than the minimum rate. Where such minimum rates are used, all families shall be expected to pay the applicable minimum rate except where liability is waived according to HSS 1.02 (9) or where a minimum payment exceeds the available income of the responsible party(ies). Minimum charges under this section may also be set on a per unit basis (e.g. per hour, per day, etc.) provided such minimum charges do not accumulate to exceed $25.00 per month.

(14) ADJUSTMENTS. The maximum monthly payment rate calculated under section HSS 1.03 (12) or (13) 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 (12) or (13), 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 under the following provisions:

1. Hardship adjustments are normally restricted to situations where services extend more than one year, and sufficient relief is not afforded to the family through an extended or deferred payment plan.

2. Each hardship adjustment shall be documented by additional family financial information. Such documentation shall become part of the client's collection file as provided in HSS 1.06.

3. Responsible parties shall be informed in writing of approval or denial with approval taking the form of a written agreement.

4. Hardship adjustments shall be reviewed annually and, if necessary, renegotiated.

(15) EXTENDED PAYMENT PLANS. Agencies must have the capability to work out an extended payment plan with any responsible party who indicates that payment at their monthly payment rate would place a burden on their family. Such payment plans have the effect of the responsible party paying a lesser monthly amount over a longer period of time but with the total expected amount to equal the full application of the monthly payment rate under HSS 1.02 (8). Authority to approve extended payment plans may be placed at whatever staff level the payment approval authority determines is appropriate.

(16) SHORTCUTS TO DOCUMENT NO ABILITY TO PAY FOR SERVICES NOT COVERED BY THIRD-PARTY PAYERS. (a) Family income information in form DHSS 130 is not required where no family member receives earned income and the family is supported in full or in part by income maintenance benefits.

(b) The financial information form (DHSS 130) is not required for fee-chargeable services when zero ability to pay can be documented. The following families making application for services are automatically considered to have no ability to pay when the following financial information is documented on other forms required by the department.

1. Recipients of SSI.

2. When the family has no earned income and are recipients of AFDC, Medical Assistance, Food Stamps or General Relief.

3. Group-eligibles under the state Title XX plan who request services.

4. Families whose income is lower than the point at which payment begins according to the maximum monthly payment rate schedule for families of similar size.

(17) RELATIONSHIP TO EXTENT OF SERVICES. When full financial information is provided, the monthly payment rate established according to sub. (12) or (13) and adjusted according to sub. (14) (a) 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.

(18) EXCEPTIONS. (a) For outpatient psychotherapy purchased or provided by county agencies, parents who provide full financial information shall not be billed a total amount per child per month greater than $120. For all other services, parents who provide full financial information shall not be billed more than $4.00 per day for each child who receives service. When a minor child and an adult from one family receive services, the parental payment limit shall not apply to billings for services to the adult.

(b) The appropriate payment approval authority may bill a responsible party a minimum payment for therapeutic reasons for a fee chargeable 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. Therapeutic charges may not exceed the maximum monthly payment by more than $25.00 per month. Therapeutic charges and minimum charge(s) established under sub. (13) may not total more than $25.00 per family nor may a therapeutic charge exceed the responsible party's available income.

(19) 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.

(20) 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) (d) of these rules.

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; am. (2) to (6), renum. (7) to (14) to be (8), (11), (12), (14), (17) to (20) respectively and am. (8), (11), (14), (17), (18) (b) and (20), r. and recr. (18) (a), cr. (7), (9), (10), (13), (15) and (16), Register, November, 1979, No. 287, eff. 1-1-80.

HSS 1.04 Fee establishment, calculation and approval. (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 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 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) *Calculating fee(s).* A division, county department of social services, board established under s. 51.42, 51.437, or 46.23, or private firm (under contract to one of the above) responsible for the calculation of the facility or service fees shall complete form CD-142 [143] or the calculation of such unit rates. Budgeted costs shall be segregated among cost-centers based on groupings of programs which have significantly different costs. Since a single fee is acceptable for a facility, a single direct treatment cost-center may be used if the facility does not provide services of a disparate nature with associated wide discrepancies in cost. Multi-service facilities providing services outside the scope of the Uniform Fee System shall not include costs for those services in their calculations of fees. The following steps shall be completed in calculating the fee(s) for a facility:

Note: An example of services with costs of a disparate nature would be services provided by disciplines such as psychiatrists versus social workers.

1. Salaries of staff and costs of clinically-related consultants shall be divided among administration, exempt services and direct treatment/service cost-centers on the basis of time spent in each area. Salary of clerical staff, accounting staff, and other support service staff shall be listed as administration costs. Salaries or wages of dietary, maintenance, housekeeping, groundskeeping, laboratory, medical records, pharmacy,