CR 83-115

CERTIFICATE

STATE OF WISCONSIN)
) SS
DEPARTMENT OF HEALTH AND SOCIAL SERVICES)

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Linda Reivitz, Secretary of the Department of Health and Social Services and custodian of the official records of said Department, do hereby certify that the annexed rules relating to application and eligibility for Medical Assistance and the rights and duties of recipients of Medical Assistance were duly approved and adopted by this Department on November 12, 1985.

I further certify that this copy has been compared by me with the original on file in this Department and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the ~~city~~ of Madison, this 12th day of November, 1985.

SEAL:

Linda Reivitz, Secretary
Department of Health and Social Services

RECEIVED
NOV 12 1985
4:05 PM
Revisor of Statutes
Bureau

3-1-86

ORDER OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
AMENDING, REPEALING AND RECREATING, AND CREATING RULES

To amend HSS 104 (title) and 104.01 to 104.04; to repeal and recreate HSS 102 and HSS 103; and to create HSS 104.035 and HSS 104.05, relating to application and eligibility for Medical Assistance and the rights and duties of recipients of Medical Assistance.

Analysis Prepared by the Department of Health and Social Services

The rules for the Wisconsin Medical Assistance Program (MA), Chapters HSS 101 through 108, Wisconsin Administrative Code, are revised to interpret and implement changes made in ss. 49.43 to 49.497, Stats., and related statutes by Chapters 20, 93 and 317 Laws of 1981 and to accommodate recent change in Federal statutes or regulations including the Omnibus Reconciliation Act of 1981 (P.L. 97-35). Other revisions clarify revised and existing administrative policies and procedures and incorporate proposals for policy change in order to enhance program controls.

Chapters HSS 102 and 103 have been repealed and recreated to incorporate statutory and departmental policy changes regarding application and eligibility for MA, and to be consistent with Chs. HSS 201 and 205, new rules for Aid to Families with Dependent Children (AFDC). Significant changes include the revision of divestment policy to conform with federal statutory language and s. 49.45(17), Stats., and the revision of recipient eligibility date language.

Chapter HSS 104 is amended to make changes in recipient rights and duties. Major areas of change are addition of language on cost sharing, such as copayments, and language regarding freedom to choose providers and to enroll in Health Maintenance Organizations (HMOs).

Pursuant to authority vested in the Department of Health and Social Services by s. 49.45(10), Stats., the Department of Health and Social Services hereby renumbers, amends, repeals and recreates, and creates rules interpreting ss. 49.43 to 49.497, Stats., as follows:

SECTION 1. HSS 102 is repealed and recreated to read:

Chapter HSS 102

APPLICATION FOR MEDICAL ASSISTANCE

HSS 102.01 APPLICATION. Application for medical assistance (MA) shall be made pursuant to s. 49.47(3), Stats., for medically indigent persons, and s. 49.46, Stats., for categorically needy persons, and this chapter. Applications shall be made and reviewed in accordance with the following provisions:

(1) RIGHT TO APPLY. Any person may apply for MA. Application shall be made on a form prescribed by the department and available from an agency.

(2) APPLICATIONS FROM OUTSIDE WISCONSIN. (a) Except as provided under par. (b), application for Wisconsin MA shall not be accepted for a person residing outside Wisconsin.

(b) If a Wisconsin resident becomes ill or injured when absent from the state or is taken outside the state for medical treatment, application for Wisconsin MA for that person shall be made on a Wisconsin application form and witnessed by the public welfare agency in the other state in accordance with 42 CFR 435.403.

(3) WHERE APPLICATION IS MADE. Application shall be made to the agency in the county in which the primary person resides. An individual residing in a nursing home is considered a resident of the county where the nursing home is located. However, an application for a person in a state facility -- northern, central, or southern center for the developmentally disabled; Winnebago or Mendota mental health institute; or the University of Wisconsin hospitals -- shall be received and processed by the agency in the county in which the person resided at the time he or she was admitted to the facility.

(4) ACCESS TO INFORMATION. Persons inquiring about or applying for MA shall be given the following information by the agency in written form, and orally as appropriate: coverage, conditions of eligibility, scope of the program and related services available, and applicant and recipient rights and responsibilities. Bulletins or pamphlets specifically developed for this purpose shall be available at the agency. In those instances where there is a substantial non-English-speaking or limited-English-speaking population, the agency shall take whatever steps are necessary to communicate with this population in its primary language.

(5) SPECIAL APPLICATION SITUATIONS. Under the following circumstances, the following special application procedures shall apply:

(a) When a person 18 years of age or older is living in the household of the primary person but is not the primary person, the primary person's spouse, or a dependent 18-year old as defined in s. 49.19(1)(a), Stats., the agency shall determine the eligibility of that person and that person's spouse or child, if any, separately from the rest of the persons listed on the application.

(b) When an unmarried man and woman reside together and have a minor child-in-common, the agency shall determine the eligibility of the man and woman together if the man is the father of the child, which shall be determined as follows:

1. If both the woman and the man are available, the man shall be considered the father of the child if his name is on the birth record, if a court proceeding has established paternity, or if a completed statement of paternity form has been signed by him and the mother and has been mailed or delivered to the agency.

2. If only the man is in the home and the woman is not available to participate in the steps necessary to fulfill the requirements of subd. 1, the man shall be determined to be the father of the child if:

a. His name is on the birth records;

b. He provides the agency with an affidavit in which he states that he is the child's father and proves that he and the child's mother lived together at the time of conception;

c. He files with the department a declaration of paternal interest under s.48.025, Stats., and proves that he and the child's mother lived together at the time of conception;

d. He provides the agency with a written statement in which he acknowledges his paternity and proves that he and the child's mother lived together at the time of conception; or

e. He submits to the agency a sworn statement describing in sufficient detail the circumstances upon which he bases his claim to be the child's father and the agency has no reason to doubt his credibility.

Note: The statement of paternity form (DOH 5024 VS-4) can be obtained from the Bureau of Economic Assistance, P.O. Box 7851, Madison, WI 53707.

(c) When a child or adult resides in a MA-certified skilled nursing facility, intermediate care facility, or inpatient psychiatric facility, or is hospitalized and is unable to live outside of the hospital, the agency may determine individually the eligibility of the child or adult.

(d) When a foster child resides in a licensed foster home or a child resides in a group home, the agency shall consider the child as the primary person for purposes of application.

(e) When a child is a parent or is pregnant, but not married and not under the care of a relative as specified in s. 49.19(1)(a), Stats., the agency shall determine individually the eligibility of the child.

(f) In cases where 3 generations reside together, the agency shall consider the first generation to be caring for both the second-generation and third-generation children.

(g) 1. When a completed application is received before the death of an applicant who dies before eligibility is determined, the agency shall process and take action on the application in the same manner as with any other application.

2. An application on behalf of a deceased person may be made by an interested person who attests to the correctness of the eligibility information on behalf of the deceased.

(6) PROVIDING CORRECT AND TRUTHFUL INFORMATION. The applicant, recipient, or person described in sub. (7) acting on behalf of the applicant or recipient is responsible for providing to the agency, the department or its delegated agent, full, correct and truthful information necessary for eligibility determination or redetermination and for disclosing assets which the agency determines may affect the applicant's or recipient's eligibility, including but not limited to health insurance policies or other health care plans and claims or courses of action against other parties on the part of the applicant or recipient. Changes in income, assets or other circumstances which may affect eligibility shall be reported to the agency within 10 days of the change.

(7) SIGNING THE APPLICATION. Each application form shall be signed by the applicant or the applicant's caretaker relative, under s.HSS201.03(5), legal guardian or authorized representative. The application shall be signed in the presence of an agency representative except when an institution superintendent makes application for public assistance on behalf of a resident pursuant to s.49.13(1), Stats. The signatures of 2 witnesses are required when the application is signed with a mark.

HSS 102.02 REFUSAL TO PROVIDE INFORMATION. If a person refuses to provide information necessary for the determination of eligibility, all persons whose eligibility depends upon the withheld information shall be denied eligibility.

HSS 102.03 VERIFICATION OF INFORMATION. (1) An application for MA shall be denied when the applicant or recipient is able to produce required verifications but refuses or fails to do so. If the applicant or recipient is not able to produce verifications, or requires assistance to do so, the agency may not deny assistance but shall proceed immediately to verify the data elements.

(2) The agency shall verify those data elements deemed appropriate under the circumstances of the case history for an applicant who has been convicted of public assistance-related fraud, is repaying aid pursuant to an agreement with the district attorney's office, or is known to have provided erroneous information on a previous application which resulted in an incorrect issuance of assistance.

(3) The following items shall be verified when applicable:

(a) Income;

(b) Pregnancy, including a pregnancy which is the basis of nonfinancial eligibility under s. HSS 103.03(1)(b)1;

(c) Incapacitation which is the basis of nonfinancial eligibility, unless incapacitation is presumed to exist according to s. HSS 103.03(1)(e);

(d) Social security number;

(e) Age;

(f) Citizenship or alien status;

(g) Disability, blindness, or both;

(h) Assets; and

(i) Residence.

HSS 102.04 ELIGIBILITY DETERMINATION. (1) DECISION DATE. As soon as possible but not later than 30 days from the date the agency receives a signed application completed to the best of the applicant's ability, the agency shall conduct a personal interview with the applicant and shall determine the applicant's eligibility for MA. If a delay in processing the application occurs because of a delay in securing necessary information, the agency shall notify the applicant in writing that there is a delay in processing the application, specify the reason for the delay, and inform the applicant of his or her right to appeal the delay under ss. 49.45(5) and 49.50(8), Stats. If medical examination reports are needed to determine disability or blindness, the agency shall make the disability decision no later than 60 days from the date the agency receives the signed application.

(2) NOTICE OF DECISION. The agency shall send timely and adequate notice to applicants and recipients to indicate that MA has been authorized or that it has been reduced, denied or terminated. In this subsection, "timely" means in accordance with s. 49.19(13), Stats., and "adequate notice" means a written notice that contains a statement of the action taken, the reasons for and specific regulations supporting the action, and an explanation of the individual's right under ss.49.45 (5) and 49.50 (8), Stats., to request a hearing and the circumstances under which aid will be continued if a hearing is requested.

(3) REVIEW OF ELIGIBILITY. A recipient's eligibility shall be redetermined:

(a) When information previously obtained by the agency concerning anticipated changes in the individual's situation indicates the need for redetermination;

(b) Promptly after a report is obtained which indicates a change in the individual's circumstances that may affect eligibility;

(c) Within 6 months after the date initial eligibility is determined for AFDC-related persons;

(d) Within 365 days after the date eligibility was last determined for SSI-related persons except that when a person is determined to be permanently disabled no further determination shall be made of that disability unless the agency becomes aware of information that would affect the determination of permanent disability; and

(e) At any time the agency has a reasonable basis for believing that a recipient is no longer eligible for MA.

HSS 102.05 FRAUD. When the agency director or a designee has reason to believe that fraud has been committed by an applicant or recipient, or by the representative of an applicant or a recipient, the case shall be referred to the district attorney.

SECTION 2. HSS 103 is repealed and recreated to read:

Chapter HSS 103

ELIGIBILITY FOR MEDICAL ASSISTANCE

HSS 103.01 INTRODUCTION. (1) PERSONS ELIGIBLE. Eligibility for medical assistance (MA) shall be determined pursuant to ss. 49.46(1) and 49.47(4), Stats., and this chapter, except that MA shall be provided without eligibility determination to persons receiving AFDC or SSI.

(2) SINGULAR ENROLLMENT. No person may be certified eligible in more than one MA case.

HSS 103.02 DIVESTMENT. (1) PURPOSE. This section implements s. 49.45(17), Stats., which makes an applicant for or recipient of MA ineligible when the applicant or recipient disposes of a resource at less than fair market value within 2 years before or at any time after his or her most recent application for MA or any review of eligibility for MA. Section 49.45(17)(d), Stats., is specifically concerned with an applicant for or recipient of MA who resides as an inpatient in a skilled nursing facility (SNF), intermediate care facility (ICF) or inpatient psychiatric facility and who has disposed of homestead property at any time during or after the 2-year period prior to the date of the most recent application or any review of eligibility.

(2) DIVESTMENT OF NON-HOMESTEAD PROPERTY. (a) Amount of divestment. For any person who disposed of a resource, except a homestead or other exempt resource, at less than fair market value within 2 years before or at any time after his or her most recent application for MA, or any review of eligibility, the agency shall determine the amount of the divestment in the following manner:

1. If the compensation received is less than net market value, the difference between the compensation received and the net market value is the divested amount and shall be considered an asset.

2. If the divested amount plus other nonexempt assets are equal to or less than the appropriate assets limit, the divestment shall not be considered a bar to eligibility.

3. If the divested amount plus the other nonexempt assets are greater than the appropriate assets limit, the excess over this limit shall be the amount of divestment to be expended for maintenance needs and medical care.

(b) Divestment as a barrier to eligibility. 1. Divestment by any person within 2 years before or at any time after his or her most recent application for MA or any review of eligibility shall, unless shown to the contrary, be presumed to have been made in contemplation of receiving MA. Divestment bars eligibility for MA except as provided in subds. 2 and 3 and par. (c).

2. To rebut the presumption that divestment was made in contemplation of seeking aid, the applicant shall furnish convincing evidence to establish that the transaction was exclusively for some other purpose. For example, the applicant may rebut the presumption that the divestment was done in contemplation of receiving aid by showing by convincing evidence that at the time of divesting the applicant had provided for future maintenance needs and medical care.

3. Divestment shall only be considered a barrier to eligibility when the net market value of all the resources disposed of exceeds the medically needy asset levels in s.49.47(4)(b)3, Stats.

4. Division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments is not divestment.

(c) Removing divestment as a barrier to eligibility. 1. Divestment is no longer a barrier to MA eligibility for persons who are determined to have divested non-homestead property:

a. If the divested amount is $12,000 or less, when the sum of the divestment has been expended for maintenance needs and medical care of the applicant or recipient or when 2 years have elapsed since the date of divestment, whichever occurs first; or,

b. If the divested amount exceeds $12,000, when the entire sum of the divestment has been expended for maintenance needs and medical care of the applicant or recipient.

2. The amount expended for maintenance needs and medical care of the applicant or recipient shall be calculated monthly, as follows:

a. For a non-institutionalized person, the expended amount is the medical care expenses for the person plus the appropriate medically needy income limit for either AFDC or SSI, depending upon which program the person would be eligible for under MA, were it not for the divestment; and

b. For a person institutionalized in a SNF, ICF or inpatient psychiatric facility, the expended amount is the total cost of the institutional care.

(3) DIVESTMENT OF HOMESTEAD PROPERTY. (a) Applicability. Divestment by any person of his or her homestead property is a barrier to eligibility only if he or she is a resident of an SNF, ICF or inpatient psychiatric facility.

(b) Amount of divestment. A person who is a resident of an SNF, ICF or inpatient psychiatric facility who disposed of his or her homestead for less than fair market value on or after July 2, 1983, but within 2 years before or at any time after his or her most recent application for MA or any review of his or her eligibility for MA, shall have the amount of divestment determined in the same manner as in sub. (2)(a).

(c) Divestment as a barrier to eligibility. 1. Divestment of a homestead by any person residing as an inpatient in an SNF, ICF or inpatient psychiatric facility within 2 years prior to the date of his or her most recent application for MA or any review of his or her eligibility for MA, shall, unless shown to the contrary, be presumed to have been made in contemplation of receiving MA. Divestment bars eligibility for MA except as provided in subds. 2 and 3 and par. (d).

2. To rebut the presumption that divestment was made in contemplation of receiving aid, the applicant shall furnish convincing evidence to establish that the transaction was exclusively for some other purpose. For example, the applicant may rebut the presumption that the divestment was done in contemplation of receiving aid by showing by convincing evidence that, at the time of divesting, the applicant had provided for his or her future maintenance needs and medical care.

3. Divestment shall only be considered a barrier to eligibility when the net market value of all the resources disposed of exceeds the medically needy asset levels in s.49.47(4)(b)3, Stats.

4. Divestment does not occur in cases of division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments.

(d) Removing divestment as a barrier to eligibility. 1. Divestment of a homestead is no longer a barrier to eligibility for institutionalized persons:

a. If the amount of divestment to be expended for maintenance needs and medical care is less than the average MA expenditures for 24 months of care in an SNF, when the entire amount of the divestment is expended for this care, or 2 years has elapsed since the date of the divestment, whichever occurs first; or

b. If the amount of divestment to be expended for maintenance needs and medical care is greater than the average MA expenditure for 24 months of care in an SNF, when the entire amount of the divestment has been expended.

2. Expended amounts shall be determined, as long as the person is institutionalized, by using the average monthly MA expenditure, statewide, for care provided in an SNF.

3. An individual who is an inpatient in a SNF, ICF or inpatient psychiatric facility who has been determined to have divested a homestead, may be found eligible if:

a. It is shown to the satisfaction of the department that the individual can reasonably be expected to be discharged from the medical institution and return to that homestead;

b. The title to the homestead was transferred to the individual's spouse or child who is under age 21 or is blind or totally and permanently disabled according to a determination made by the department's bureau of social security disability insurance;

c. It is shown to the satisfaction of the department that the individual intended to dispose of the homestead either at fair market value or for other valuable consideration; or

d. It is determined by the department that the denial of eligibility would work undue hardship on the individual.

HSS 103.03 NON-FINANCIAL CONDITIONS FOR ELIGIBILITY. In order to be eligible for MA, a person shall meet both non-financial conditions for eligibility in this section and financial conditions for eligibility under s. HSS 103.04. The non-financial conditions for eligibility are:

(1) AFDC-RELATEDNESS OR SSI-RELATEDNESS. (a) Requirement. To be non-financially eligible for MA, applicants shall be AFDC-related or SSI-related.

(b) AFDC-related persons. In this subsection, "AFDC-related" means a person who meets one of the following conditions:

1. The person is pregnant and meets the conditions specified in ss. 49.46(1)(a)1m and 49.47(4)(a)2, Stats.;

2. The person is a dependent child as defined in s. 49.19(1)(a), Stats.;

3. The person is a caretaker relative as defined in s. 49.19(4)(d) and (dm) (intro.), Stats; or

4. The person is a foster child under 19 years of age living in a foster home licensed under s. 48.62, Stats., or is a child in a subsidized adoption placement under s.48.975, Stats.

(c) SSI-related persons. In this subsection, "SSI-related person" means a person who meets one of the following conditions:

1. The person is age 65 or over; or

2. The person is blind or disabled.

(d) Verification of blindness or disability. Except as provided under par. (e), the blindness or disability claimed under par. (c)2 shall be verified in one of the following ways:

1. By presentation of a current old age and survivors disability insurance (OASDI) disability award notice;

2. By presentation of a current medicare card indicating blindness or disability; or

3. By receipt of a disability determination made by the department's bureau of social security disability insurance, along with current medical reports.

(e) Presumption of disability in an emergency. 1. Under emergency circumstances, a person may be presumed disabled for purposes of demonstrating SSI-relatedness and be eligible for MA without the verification required under par. (d).

2. When an emergency need for MA exists, the department shall make a preliminary disability determination within 7 days of the date a completed disability determination form is received.

3. An emergency need for MA shall exist when the applicant is:

a. A patient in a hospital;

b. Seriously impaired and the attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months;

c. In need of long-term care and the nursing home will not admit the applicant until MA benefits are in effect; or

d. Unable to return home from a nursing home unless in-home service or equipment is available and this cannot be obtained without MA benefits.

Note: Copies of the presumptive disability determination form may be obtained from the Bureau of Economic Assistance, Department of Health and Social Services, P.O. Box 7851, Madison, Wisconsin 53707.

(2) CITIZENSHIP. U.S. citizenship shall be a requirement for eligibility for MA, except that an alien lawfully admitted for permanent residence may be eligible, including an alien lawfully present in the United States as a result of s. 203(a)7 (8 USC 1153), 207(c) (8 USC 1157), 208 (8 USC 1158) or 212(d)(5) (8 USC 1182) of the immigration and nationality act or an alien otherwise permanently residing in the United States under color of law within the meaning of 42 CFR 435.402.

(3) WISCONSIN RESIDENCE. (a) Definitions. In this subsection:

1. "Incapable of indicating intent" means:

a. The individual's IQ is 49 or less, or the individual has a mental age of 7 or less, based on tests acceptable to the department;

b. The individual is found legally incompetent under guardianship statutes; or

c. Medical documentation or other documentation acceptable to the department supports a finding that the individual is incapable of indicating intent.

2. "Intent to reside" means that a person intends that Wisconsin is the person's place of residence and that the person intends to maintain the residence indefinitely.

3. "Physical presence" means living in Wisconsin.

(b) Physical presence and intention. An eligible person shall be a Wisconsin resident, as determined under 42 CFR 435.403. Residence shall be based on physical presence, except as provided in an interstate agreement, and on the person's stated intent to maintain Wisconsin residence indefinitely, except as otherwise provided in pars. (c) to (g).

(c) Migrant farm workers. A migrant farm worker who is living in Wisconsin and who entered with a job commitment or to seek employment shall be considered a resident so long as there is no medical assistance being received from another state. In this paragraph, "migrant farm worker" means any person whose primary employment in Wisconsin is in the agricultural field or cannery work, is authorized to work in the United States, who is not immediate family by blood or marriage of the employer, and routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment. Members of the migrant farm worker's family who live with the worker in Wisconsin shall also be considered Wisconsin residents.

(d) Non-institutionalized persons. The residence of a person under age 21 shall be determined in accordance with the rules governing residence under the AFDC program except that non-institutionalized persons under age 21 whose MA eligibility is based on blindness or disability are residents if they are physically present in Wisconsin.

(e) Institutionalized persons. 1. For any institutionalized person who is under age 21, or who is age 21 or older and became incapable of indicating intent before age 21, the state of residence is that of:

a. The parents or the legal guardian, if one has been appointed and parental rights have terminated at the time of placement in an institution; or

b. The parent applying for MA on behalf of the applicant if the parent resides in another state and there is no appointed legal guardian.

2. Institutionalized persons over age 21 are Wisconsin residents when they are physically present with the intent to reside in Wisconsin except that persons who become incapable of indicating intent at or after age 21 are residents of the state in which they are physically present.

(f) Out-of-state institutional placements. When a state arranges for a person to be placed in an institution located in another state, the state making the placement is the state of residence irrespective of the person's indicated intent or ability to indicate intent.

(g) Establishment of residence. Once established, residence is retained until superseded by a new place of residence.

(4) FURNISHING OF A SOCIAL SECURITY NUMBER. All individuals for whom MA benefits are requested, including all children except preadoptive infants residing in foster homes awaiting adoption, shall have a social security number and shall furnish the number to the agency. If an applicant does not

have a social security number, application for the number shall be made by or on behalf of the applicant to the federal social security administration. If there is a refusal to furnish a number or apply for a number, the person for whom there is a refusal is not eligible for MA. The department may not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's social security number.

(5) ASSIGNMENT OF MEDICAL SUPPORT. The parent or caretaker relative of a dependent child enumerated in s. 49.19(1)(a), Stats., shall be deemed to have assigned all rights to medical support to the state as provided in s. 49.45(19)(a), Stats. If there is a refusal to make the assignment, the person who refuses is not eligible for MA.

(6) NOT A PERSON DETAINED BY LEGAL PROCESS. A person detained by legal process is not eligible for MA benefits. For purposes of this subsection, "detained by legal process" means incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, and delinquent acts. A person who returns to the court after observation, is found not guilty of a law violation by reason of mental deficiency and is subsequently committed to a mental institution shall not be considered detained by legal process.

(7) NOT A PERSON RESIDING IN A CERTIFIED PSYCHIATRIC FACILITY. A person 22 to 64 years of age who resides in a certified psychiatric facility is not eligible for MA benefits.

(8) NOT AN INELIGIBLE CARETAKER RELATIVE. A caretaker relative enumerated in s. 49.19(1)(a), Stats., with whom a dependent child as defined in s. 49.19(1)(a), Stats., is living when the income and resources of the MA group or fiscal test group exceed the limitations of ss. 49.19, and 49.177, Stats., or title XVI of the social security act of 1935, as amended, is not eligible unless the caretaker relative is SSI-related in accordance with sub. (1)(c), or is a woman who is medically verified to be pregnant.

(9) NOT A STRIKER. A person on strike is not eligible. When the striker is a caretaker relative, all members of the MA group shall be ineligible. In this subsection, "striker" means anyone who on the last day of the month is involved in a strike or a concerted effort with other employes to stop work including a stoppage of work due to the expiration of a collective bargaining agreement, or any concerted slowdown or other concerted interruption of operations by employes.

HSS 103.04 ASSET AND INCOME LIMITS. The nonexempt assets and budgetable income of the MA group or, when applicable, the fiscal test group, shall be compared to the following asset and income limits established in this section to determine the eligibility of the MA group:

(1) CATEGORICALLY NEEDY. (a) The MA group or fiscal test group shall first be tested against the categorically needy standard. Persons who meet the non-financial eligibility conditions and who meet the income and asset standards specified in this subsection shall be determined eligible as categorically needy in accordance with s. 49.46(1)(e), Stats., and shall receive MA benefits in accordance with s. 49.46(2), Stats., and chs. HSS 101 to 108.

(b) The AFDC-related categorically needy income standard for MA applicants shall be the appropriate AFDC assistance standard as specified in s. 49.19(11)(a)1, Stats., except that persons who are ineligible to receive AFDC solely because of the application of s. 49.19(11)(a)6, Stats., which specifies that payments that are not whole dollar amounts shall be rounded down to the nearest whole dollar, shall receive MA as categorically needy. The AFDC- related categorically needy asset standard shall be the same as that set out in s. 49.19(4), Stats.

(c) The SSI-related categorically needy income standard shall be the maximum SSI payment including state supplement that a single person or a couple, as appropriate, could receive in Wisconsin under s. 49.177, Stats., or federal title XVI of the social security act of 1935, as amended. The SSI-related categorically needy asset standard shall be the same as specified in s. 1613 of title XVI of the social security act of 1935, as amended.

(2) MEDICALLY NEEDY. If the MA group or fiscal test group is not eligible as categorically needy, the medically needy standard shall be applied. Persons who meet non-financial conditions for eligibility and meet the income and assets criteria set forth in s. 49.47(4)(b) and (c), Stats., and this chapter, except for AFDC-related adult caretakers who are not blind, disabled or age 65 or older, shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47(6), Stats., and chs. HSS 101 through 108.

(3) EXCESS INCOME CASES. (a) In this subsection, "spend-down period" means the period during which excess income may be expended or obligations to expend excess income may be incurred for the purpose of obtaining MA eligibility, as described under s. HSS 103.08(2)(a).

(b) When an SSI-related or AFDC-related fiscal test group is found ineligible as medically needy and excess income is the only reason, the group may expend or incur obligations to expend the excess income above the appropriate medically needy income limit pursuant to s. 49.47(4)(c)2 and 3, Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47(6), Stats., and chs. HSS 101 to 108 for the balance of the spend-down period.

(c) Health insurance premiums actually incurred or paid, plus any medical service recognized by state law received by a member of the MA or fiscal test group shall be counted toward fulfilling the excess income expenditure or incurrence requirement when the service is prescribed or provided by a medical practitioner who is licensed by Wisconsin or another state and if either or both of the following conditions are met:

1. The service is received during the spend-down period; or

2. The expense was incurred prior to the spend-down period and a fiscal test group member is still legally responsible for the debt and is consistently making payments, in which case the payments made during the spend-down period shall be counted.

(d) No medical costs that are incurred and are to be paid or have been paid by a person other than the applicant or members of the fiscal test group may be counted toward fulfilling the excess income expenditure or incurrence

requirement. No expense for which a third party is liable, including but not limited to medicare, private health insurance, or a court-ordered medical support obligation, may be used to meet the expenditure of excess income requirement.

(4) SPECIAL FINANCIAL STANDARDS FOR INSTITUTIONALIZED PERSONS. The categorically needy and medically needy asset standards shall be the same for institutionalized persons as for non-institutionalized persons. The eligibility standards against which an institutionalized person's income is tested shall be the following:

(a) Categorically needy standard. The categorically needy standard for an institutionalized person shall be an amount equal to 3 times the federal share of the SSI payment for one person living in that person's own home.

(b) Medically needy standard. An institutionalized person shall be determined medically needy in accordance with requirements under 42 CFR 435.1007.

(5) IRREGULAR CASES. (a) Mixture of AFDC and SSI-relatedness. When there is a mixture in an MA group of AFDC-relatedness and SSI-relatedness, AFDC-related financial eligibility procedures shall be used except when no minor child is in the home, in which case SSI-related procedures shall be used.

(b) Fiscal test groups in which some are receiving AFDC and some are applying for MA only. 1. If some members of the fiscal test group are receiving AFDC and some are not, the eligibility of the non-AFDC recipients

shall be determined by comparing the assets of the entire fiscal test group to the appropriate asset standard and by comparing the income of the non-AFDC members or, if appropriate, the fiscal test group, to the appropriate share of the total family income standard.

2. For purposes of this paragraph, the family consists of parents and all children, including AFDC recipients, in the household for whom either spouse is legally responsible, except that the family does not include SSI recipients and children who do not have a legally responsible parent in the home.

(c) SSI-related child when family is ineligible. A blind or disabled child in a family found financially ineligible for AFDC-related MA may have his or her eligibility determined individually according to SSI-related financial procedures for child-only cases specified in s. HSS 103.05.

(d) Non-legally responsible relative (NLRR) case. 1. If SSI-related adults are caring for a minor child for whom they are not legally responsible, the adults shall have their financial eligibility determined according to AFDC-related procedures, except that their eligibility may be determined according to SSI-related financial procedures if they are found ineligible for AFDC-related MA because of earned income or if they elect to be processed as SSI-related.

2. The income and assets of a child residing with an NLRR shall be measured against the AFDC-related standard for one person, except that when the NLRR child is blind or disabled eligibility shall be determined according to SSI-related financial procedures.

3. If the child is found financially ineligible, the eligibility of the NLRR caretaker relative shall be determined by measuring that relative's income and assets against AFDC-related eligibility standards.

(e) Child residing in a licensed foster or group home. For a child who lives in a foster or group home licensed under ch. HSS 56 or 57, only the child's own income and assets shall be used when determining the child's financial eligibility. The child's income and assets shall be measured against the AFDC-related income and asset standards for one person.

HSS 103.05 DETERMINING ASSETS AND INCOME IN CHILD-ONLY CASES. (1) MEANING OF CHILD-ONLY CASE. A child-only case exists when:

(a) A family has been determined financially ineligible for AFDC-related MA only and there is a child in the family who is SSI-related but not receiving SSI payments;

(b) A step-parent family requests MA exclusively for a stepchild;

(c) A step-parent family refuses or is determined ineligible for AFDC;

(d) A step-parent family is determined financially ineligible for MA only; or

(e) A step-parent family is determined ineligible for MA because a caretaker relative is a striker.

(2) ESTABLISHING CHILD-ONLY MA GROUPS. In child-only cases, the child or children of each legal parent shall form their own MA group and shall be tested for financial eligibility with the children's own income and assets, if any, plus the income and assets deemed to the children of this group according to subs. (3) and (4).

(3) DEEMING OF PARENTAL ASSETS. (a) All of the legal parent's nonexempt assets shall be deemed to the child in 3-generation and stepparent cases.

(b) In cases of an SSI-related child where 2 parents are in the home, parental assets in excess of the SSI asset limit for 2 persons shall be deemed to the blind or disabled child. Where there is one parent, parental assets in excess of the SSI asset limit for one person shall be deemed to the blind or disabled child in accordance with 42 CFR 435.845.

(4) DEEMING OF PARENTAL INCOME. (a) To the third-generation child. All of the net income of the second-generation minor parent shall be deemed to the third-generation child.

(b) To the stepchild. The income deemed to the stepchild shall be the remainder of the total of the net income of the legal parent minus the categorically needy income standard based on the number of ineligible family members.

(c) To the SSI-related child. The amount of parental monthly income deemed to the SSI-related child shall be determined according to the procedure set out in this paragraph. The department shall adjust the monthly amounts in

accordance with changes in the SSI program. Beginning with unearned income, parental monthly gross income shall be deemed to each ineligible child to bring the child's income up to an amount equal to one-half the maximum federal share of the SSI benefit paid to a single individual living in his or her own household. The remaining parental income shall be deemed to the SSI-related child as follows:

1. When the only type of parental income remaining is unearned, $20 shall be subtracted. Then, where there are 2 parents, an amount equal to the maximum federal share of the SSI benefit paid to a couple living in their own household shall be subtracted, and where there is one parent, an amount equal to the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted. The remaining income shall be considered available to the SSI-related child as unearned income.

2. When the only type of parental income remaining is earned, $85 shall be subtracted. Then, where there are 2 parents, an amount equal to 3 times the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted, and where there is one parent, an amount equal to 2 times the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted. The remaining income shall be considered available to the SSI-related child as unearned income.

3. When parental income remaining is a mix of unearned and earned, $20 shall be subtracted using unearned income first. From any remaining earned income, $65 shall be subtracted and then one-half of the remainder. When there are 2

parents, an additional amount equal to the maximum federal share of the SSI benefit paid to a couple living in their own household shall be subtracted, and when there is one parent, an additional amount equal to the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted. The remaining income shall be considered available to the SSI-related child as unearned income.

(5) INCOME LIMITS FOR CHILD-ONLY MA GROUPS. (a) In third-generation and stepchild cases, each MA group shall be tested against an income standard consisting of a proportionate share of the AFDC-related standard for the appropriate family size. For purposes of this paragraph, "family" means parents and all children in the household for whom either spouse is legally responsible, including the third generation, but not SSI recipients or NLRR children. If the stepchild or third-generation child is ineligible for MA because of excess income, the applicant may elect either a family spend-down period or a child-only spend-down period to gain MA eligibility.

(b) The eligibility of an SSI-related child shall be determined by testing against the SSI-related income standard for one person.

HSS 103.06 ASSETS. (1) SPECIAL SITUTATIONS OF INSTITUTIONALIZED PERSONS. (a) In determining the eligibility of an institutionalized person, only the assets actually available to that person shall be considered.

(b) The homestead property of an institutionalized person is not counted as an asset if:

1. The institutionalized person's home is currently occupied by the institutionalized person's spouse, child who is under age 18, or child who is 18 years or older and who is developmentally disabled;

2. The institutionalized person intends to return to the home and the anticipated absence from the home, as verified by a physician, is less than 12 months; or

3. The anticipated absence of the institutionalized person from the home is for more than 12 months but there is a realistic expectation, as verified by a physician, that the person will return to the home. That expectation shall include a determination of the availability of home health care services which would enable the recipient to live at home.

(c) If none of the conditions under par. (b) is met, the property is no longer the principal residence and becomes non-homestead property.

(d) When income that has been protected for the personal needs of institutionalized recipients accumulates to the point that the asset limit is exceeded, the recipient may voluntarily apply the excess assets accumulation as a refund to the department. If the recipient does not elect one of the refund options under par. (e), MA eligibility shall terminate at the time the asset limit is exceeded. Eligibility may not be reinstated until the assets are below the limit at which time a new application shall be required.

(e) The recipient may apply the excess assets as a refund to the department in one of the following ways:

1. The agency may project the amount of excess assets expected over a year to arrive at an amount for the client to refund the department. When refunds equal MA benefits already received, no more refunds may be made until more MA benefits have been received. In no instance may refunds exceed benefits; or

2. If, at the time of review, excess assets do not exceed an amount 3 times the federal share of the SSI payment for one person living at his or her home, eligibility may be continued on condition that the recipient agrees in writing to refund the excess assets to the MA program.

(2) MOTOR VEHICLES. (a) In this section:

1. "Motor vehicle" means a passenger car or other motor vehicle used to provide transportation of persons or goods and which is owned by a person in the MA or fiscal test group.

2. "Equity value" means the fair market value minus any encumbrances which are legal debts.

3. "Fair market value" means the wholesale value shown in a standard guide on motor vehicle values or the value as estimated by a reliable expert.

(b) For persons whose eligibility is being determined according to AFDC categorically needy or AFDC medically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned, up to $1,500 of equity value shall be exempted; and

2. If more than one vehicle is owned, up to $1,500 of equity value from the vehicle with the greatest equity value shall be exempted. The equity value of any other vehicle is counted as an asset.

(c) For SSI-related persons whose eligibility is determined based on medically needy financial standards, the following conditions shall apply:

1. If only one vehicle is owned, it shall be exempted;

2. If 2 or more vehicles are owned and fewer than 2 vehicles are needed for employment or medical care, the vehicle with the highest equity value shall be exempted. The equity value of the other vehicles shall be counted as an asset; and

3. If 2 or more vehicles are needed for employment or medical care, the 2 vehicles with the highest equity value shall be exempted. The equity value of any other vehicle shall be counted as an asset.

(3) JOINT ACCOUNTS AND JOINTLY HELD PROPERTY. (a) Joint accounts. A joint account shall be deemed available to each person whose name is on the account or listed as an owner. The value of a joint savings or checking account shall be determined as follows in determining eligibility for MA:

1. For persons who receive MA who are not age 65 or over, or not blind or disabled, the division of a joint account shall be determined according to applicable federal law; and

2. For persons who receive MA who are age 65 or over or who are blind or disabled, joint accounts shall be divided as follows:

a. If both owners of the joint account receive MA, equal shares of the joint acount shall be included for the purpose of determining MA eligibility; and

b. If only one owner of the joint account receives MA, the full amount of the joint account shall be included for the purpose of determining MA eligibility.

(b) Jointly held property. If the applicant or recipient is a joint owner of property with a person who refuses to sell the property and who is not a legally responsible relative of the applicant or recipient, the property shall not be considered available to the applicant or recipient and may not be counted as an asset. If the property is available to the applicant or recipient, it shall be divided equally between the joint owners.

(4) HOMESTEAD PROPERTY. (a) A home owned and lived in by an applicant or recipient is an exempt asset.

(b) Net proceeds from the sale of homestead property shall be treated as assets except when the proceeds are placed in escrow in contemplation of purchase of another home. Proceeds in escrow are exempt assets for a maximum of one year.

(5) NON-HOMESTEAD REAL PROPERTY. (a) If the equity value of the non-homestead property together with all other assets does not exceed the asset limit, the person may retain the property and be eligible for MA.

(b) If the value of non-homestead property together with the value of the other assets exceeds the asset limit, the non-homestead property need not be counted as an asset if it produces a reasonable amount of income. In this paragraph, "reasonable amount of income" means a fair return considering the value and marketability of the property.

(c) If the total value of non-homestead property and non-exempt assets exceeds the asset limit, the person who owns the non-homestead property shall list the property for sale with a licensed realtor at a price which the realtor certifies as appropriate. If the property is listed for sale, it may not be counted as an asset. When the property is sold, the net proceeds shall be counted as an asset.

(6) LIFE ESTATE. The applicant or recipient or that person's spouse may hold a life estate in a homestead without affecting eligibility for MA. If the person leaves the property and it is sold, any proceeds received shall be considered assets.

(7) TRUSTS. (a) Trust funds shall be considered available assets, except that:

1. Trust funds payable to a beneficiary only upon order of a court shall not be considered available assets if the trustee or other person interested in the trust first applied to the court for an order allowing use of part or all of the trust fund to meet the needs of the beneficiary and the court denied such application;

2. Trust funds held in a trust which meets the requirements of s. 701.06, Stats., shall not be considered available assets unless the settlor is legally obligated to support the beneficiary;

3. For SSI-related MA applicants and recipients, the pertinent SSI standards on the treatment of trusts as resources shall apply; and

4. For AFDC-related applicants and recipients, the pertinent AFDC standards on the treatment of trusts as resources shall apply.

(8) PERSONAL PROPERTY. Household and personal effects of reasonable value, considering the number of members in the fiscal test group, shall be exempt.

(9) LOANS. Money received on loan shall be exempt unless it is available for current living expenses, in which case the money shall be treated as an asset even if a repayment schedule exists.

(10) LIFE INSURANCE POLICIES. The cash value of a life insurance policy shall be considered an asset, except that for SSI-related persons it is an asset only when the total face value of all policies owned by the person exceeds $1,500. In this subsection, "cash value" means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it, and "face value" means the dollar amount of the policy which is payable on death.

(11) LUMP SUM PAYMENTS. All lump sum payments, unless specifically exempted by federal statute or regulation, shall be treated as assets instead of income. In this subsection, "lump sum payment" means a nonrecurring payment such as retroactive social security benefits, income tax refunds, and retroactive unemployment benefits.

(12) WORK-RELATED ITEMS. Work-related items essential to the employment or self-employment of a household member, except motor vehicles, are exempt from being counted as assets. For business or farm operations, internal revenue service (IRS) returns shall be used to determine whether or not the operation is profitable or moving toward becoming profitable. If the operation is not profitable or becoming profitable, all assets related to the operation shall be counted in the determination of eligibility.

(13) SPECIAL EXEMPT ASSETS FOR BLIND OR DISABLED PERSONS. The following assets shall be exempted in determining the eligibility of blind or disabled persons:

(a) Assets essential to the continuing operation of the person's trade or business;

(b) Income-producing property; and

(c) Funds conserved for a departmentally approved plan for self-support of a blind or disabled person. The conserved funds shall be segregated from other funds. Interest earned on conserved funds is exempt so long as the conserved funds do not exceed the provision of the approved plan.

HSS 103.07 INCOME. (1) SPECIAL SITUATIONS OF INSTITUTIONALIZED PERSONS. (a) Support received by institutionalized persons. 1. Any financial support or contribution received by an institutionalized person shall be considered available when determining the eligibility of that person for MA.

2. The income and assets of the parents of children under age 18 who reside in institutions shall be evaluated by the department to determine whether, pursuant to s. 46.10(14), Stats., collections may be made from one or both parents. If the child is residing in an institution not specified in s. 46.10(14), Stats., but the institution is approved to receive MA payments, the parental liability shall be the same as that provided in s. 46.10(14), Stats., and collected in the same manner.

3. The agency shall decide if the spouse of an institutionalized applicant or recipient should be referred for support action under s. 52.01, Stats. When deciding whether to refer for support action, the agency shall consider the spouse's basic essential needs and present and future expenses. In no case may support from the spouse of an institutionalized applicant or recipient be pursued when the spouse's assets, not counting homestead property and a motor vehicle, are less than $1,500 and when the spouse's income is less than monthly need as specified in par. (b)1. and 2.

(b) Allocation of institutionalized person's income to dependents outside the institution. No allocation may be made from an institutionalized applicant's or recipient's income to a spouse who is eligible for SSI but who refuses to obtain SSI. No allocation may be made to a spouse or to minor children under the spouse's care if the spouse or any of the children are receiving AFDC or SSI. Otherwise, allocations shall be made as follows:

1. If the spouse is caring for a minor child for whom either the institutionalized person or the spouse is legally responsible, the AFDC assistance standard plus expenses that would be allowed under s. HSS 103.04(3) shall be used to determine the need of the spouse and children. If their total net income is less than their need, income of the institutionalized person shall be allocated in an amount sufficient to bring the spouse's and children's income up to their monthly need. In this subdivision, "total net income" means income equal to unearned income plus net earned income, and "net

earned income" means income equal to gross earned income minus work-related expenses according to requirements of AFDC. Income disregards of the AFDC program under 45 CFR 233.20(a) shall be used as appropriate in computing income.

2. If the spouse is not caring for a minor child, the SSI payment level for one person living in that person's own household shall be used to determine the spouse's monthly need. The spouse's earned income shall be netted by subtracting the work-related expenses according to sub. (3) and $20 from earned or unearned income or both. If the spouse's net income is less than the spouse's monthly need, income of the institutionalized person may be allocated in an amount sufficient to bring the spouse's income up to monthly need. Income disregards of the SSI program under 20 CFR 416.1112 and 416.1124 shall be used as appropriate in computing income.

3. The following amounts shall be excluded when computing the income of the spouse and children under subd. 1 or the spouse alone under subd. 2:

a. All earnings of a child less than 14 years old, or less than 18 years old when the child is a full-time student;

b. All earnings of a child less than 18 years old who attends school part-time and is employed fewer than 30 hours a week;

c. Any portion of any grant, scholarship, or fellowship used to pay the costs of tuition, fees, books, and transportation to and from classes;

d. Amounts received for foster care or subsidized adoption;

e. The bonus value of food stamps and the value of foods donated by the federal department of agriculture;

f. Home produce grown for personal consumption; and

g. Income actually set aside for the post-high school education of a child who is a junior or senior in high school.

(c) When both spouses are institutionalized and there is an application for MA. When both spouses are institutionalized, the following shall apply:

1. If one spouse applies for MA, the total income of both spouses may be combined to ascertain if their combined income is less than total need, provided that the spouse not applying has income exceeding that spouse's needs and is willing to make that income available;

2. If the combined income of both spouses is less than total need, separate determinations shall be made to see if either spouse has excess income. Any excess may be allocated to the other spouse. Either one or both of the spouses may be eligible depending on income allocation; and

3. If the combined income of both spouses exceeds total need, separate determinations shall be made. Only the actual amount of income made available from one spouse to the other may be used in determining the eligibility of the other spouse. If the spouse refuses to make a reasonable amount available, the agency shall review the case under par. (a)3. to determine if legal action for support should be taken pursuant to s. 52.01, Stats.

(d) Computing income available towards cost of care. Institutionalized recipients of MA shall apply their available income toward the cost of their care. In this paragraph, "available income" means any remaining income after the following reductions are made:

1. Unearned income, including support actually received, up to the personal needs allowance allowed;

2. If employed, the first $65 and one-half of the remainder of gross earnings;

3. The cost of health insurance;

4. Necessary medical or remedial care recognized under state law but not covered by MA;

5. The actual amount paid by the institutionalized person for support of a person for whom the institutionalized person is legally responsible but not to exceed the appropriate AFDC assistance standard unless the institutionalized person is paying court-ordered support in an amount greater than the AFDC assistance standard in s. 49.19(11)(a)1, Stats.; and

6. The monthly cost of maintaining a home when the conditions of s. HSS 103.06(1)(b)3. are met, but not to exceed the SSI payment level for one person living in that person's own household.

(2) SPECIAL TYPES OF INCOME. (a) Farm and self-employment income. Farm and self-employment income used in MA calculations shall be determined by adding back into the net earnings the following: depreciation, personal business and entertainment expenses, personal transportation, purchases of capital equipment, and payments on the principal of loans. The total shall be divided by 12 to get monthly earnings. If no tax return has been filed, the individual shall complete a 1040 form of the internal revenue service (IRS) to determine net earnings or loss, or to anticipate, in case of relatively new businesses, net earnings as required by the IRS. If the latest income tax return does not accurately reflect the household's actual circumstances because the household has experienced a substantial increase or decrease in business, the agency shall calculate the self-employment income based on anticipated earnings. Agencies shall determine whether it is necessary to use anticipated earnings on a case-by-case basis and shall document the reasons for the determination in the case record.

(b) Contractual employment income. Income received on other than an hourly or piecework basis from employment performed under a contract which is renewable on an annual basis shall be averaged over a 12-month period. Persons receiving this income shall be considered to receive compensation for the entire 12-month period even though actual compensation may only be received for part of the year.

Note: For example, if school teachers are paid 9 months a year, the wages they receive shall be averaged over a 12-month period.

(c) In-kind benefits. Predictable in-kind benefits received regularly and in return for a service or product delivered shall be treated as earned income in MA calculations. The value of the in-kind income is determined by using the prevailing wage rate in the local community for the type of work performed, but not less than the minimum wage for that type of work.

(d) Income from providing room and board. Net profit from room and board shall be treated as earned income in MA calculations. Net profit is determined by deducting the following expenses of providing room and board from the gross room and board income received:

1. Roomer only - $15.00;

2. Boarder only - current food stamp allotment for one; and

3. Roomer and boarder - current food stamp allotment for one plus $15.00.

(e) Income from rentals. When the owner reports rental income to the IRS as self-employment income, the procedures set forth in par. (a) shall be followed in MA calculations. If the owner does not report rental income to the IRS as self-employment income, net rental income shall be determined as follows:

1. When the owner is not an occupant, net rental income is the rental income minus the mortgage payment and verifiable operational costs.

2. When the owner receives rental income from a duplex or multiple rental unit building and the owner resides in one of the units, net rental income shall be computed according to the following method:

a. Add the interest portion of the mortgage and other verifiable operational costs common to the entire operation;

b. Multiply the number of rental units by the total in subpar. a.;

c. Divide the result in subpar. b. by the total number of units;

d. Add the result in subpar. c. to any operational costs paid by the owner that are unique to any rental unit; and

e. Subtract the result in subpar. d. from the total rent payments. The result is net rental income.

(f) Income of SSI child's parents. Income of a disabled child's parents shall not be considered when determining the child's eligibility for MA if the child meets the conditions stated in 42 USC 1396A(e)(3).

(g) Income disregards. Income disregards of the AFDC program under 45 CFR 233.20(a) and of the SSI program under 20 CFR 416.1112 and 416.1124 shall be used as appropriate.

(3) DEDUCTIONS FROM EARNED INCOME. (a) Work-related deductions. If an individual is employed 30 hours or more a week, $75 shall be deducted from the earned income in the determination of MA eligibility. If an individual is employed fewer than 30 hours a week, the lesser of 18 percent of the individual's gross income or $74 shall be deducted from earned income.

(b) Dependent care. When employment cannot be maintained without dependent care for a child or incapacitated adult in the MA or fiscal test group, the following deduction shall be applied:

1. If employed 30 hours or more a week, the dependent care costs actually paid, but no more than $160 for each dependent each month, shall be deducted from the individual's earned income; and

2. If employed less than 30 hours a week, the dependent care costs actually paid, but no more than $120 for each dependent each month, shall be deducted from the individual's earned income.

(c) Special deductions for employed blind persons. Transportation expenses incurred in getting to and from work, expenses related to job performance and expenses related to improving job ability such as training meant to improve employability and increase earning power shall be deducted from the earned income of blind persons.

Note: Examples of expenses related to job performance are a reader, translation of material into braille, or the cost and upkeep of a seeing eye dog for a blind person, or the cost of a prosthesis.

(4) DEDUCTION FROM ANY INCOME FOR SUPPORT TO AN INSTITUTIONALIZED PERSON. If a person in the MA group has legal responsibility for a person residing in an institution where the cost of care cannot be covered by MA, any income actually made available by the MA group toward the institutional cost of care shall be deducted from the MA group's income.

HSS 103.08 BEGINNING OF ELIGIBILITY. (1) DATE. Except as provided in subs. (2) to (4), eligibility shall begin on the date on which all eligibility requirements were met, but no earlier than the first day of the month 3 months prior to the month of application. Retroactive eligibility of up to 3 months may occur even though the applicant is found ineligible in the month of application.

(2) SPEND-DOWN PERIOD. (a) 1. The spend-down period shall begin on the first day of the month in which all eligibility factors except income were met, but no earlier than the first day of the month 3 months prior to the month of application. However, at the recipient's option, it may begin on the first day of any of the 3 months prior to the date of application if all eligibility factors, except income, were met in that month. A recipient's decision to choose an optional beginning date shall be recorded in the agency's case record. For persons who previously received MA and then reapply, the spend-down period cannot cover the time during which they were receiving MA.

2. The MA group shall be eligible as of the date within the spend-down period on which the expenditure of excess income or the obligation to expend excess income is achieved.

3. The applicant shall be responsible for some bills or parts of bills for services received on the first day of eligibility if there is remaining unspent and unobligated excess income on that day.

(b) If the amount of the monthly excess income changes before the expenditure or obligation of excess income is achieved, the expenditure or obligation of excess income for the remainder of the 6-month period shall be recalculated. When the size of the MA group changes, the monthly income limit shall be adjusted appropriately to the size of the new group, and the amount of excess income to be expended or obligated shall be adjusted accordingly. If any change is reported that may affect eligibility, the eligibility of the entire MA group may be redetermined and, if there is determined to be excess income, a new spend-down period shall be established.

(c) 1. Once the expenditure or obligation of excess income has been achieved, the MA group shall be eligible for the balance of the 6-month spend-down period, unless it is determined that assets have increased enough to make the MA group ineligible, or that a change in circumstances has caused someone in the MA group to become ineligible for nonfinancial reasons.

2. If the entire group is determined ineligible, the MA benefits shall be discontinued with proper notice. If only one person in the MA group is determined ineligible for nonfinancial reasons, only that person's MA benefits shall, with proper notice, be discontinued. The other person or persons in the MA group continue their eligibility until the end of the 6-month period.

3. If the size of the MA group increases due to the addition of a child, that child is eligible for benefits during the rest of the spend-down period. An adult caretaker who enters the group, except a woman who is medically verified as pregnant or a person who is SSI-related, is not eligible for benefits during the remainder of the spend-down period.

(3) PRESUMPTIVE DISABILITY CASES. If, in a presumptive disability case, the applicant meets all other conditions for eligibility, MA benefits shall begin on the date the presumptive disability finding is made and shall continue at least until the official disability determination is completed. Presumptive disability eligibility shall not be granted retroactively. MA benefits based on presumptive disability shall not be continued pending an appeal of a negative official disability determination.

(4) MATERNITY CASES. For maternity cases, eligibility shall begin on the date pregnancy is verified or the date of application, whichever is later, pursuant to ss. 49.46(1)(a)1m and 49.47(4)(a)2, Stats.

HSS 103.09 TERMINATION OF MEDICAL ASSISTANCE. (1) FINAL MONTH COVERAGE. When eligibility ends, except in the case of death of the recipient, the MA benefits shall continue until the end of the calendar month.

(2) FOUR-MONTH CONTINUATION OF ELIGIBILITY. (a) When an MA group has become ineligible for AFDC because of increased earnings or hours of employment, has received an AFDC payment in at least 3 months of the 6 months preceding the month in which ineligibility for AFDC occurred and at least one person included in that MA group is employed, eligibility for MA shall continue for 4 months from the date that AFDC eligibility was terminated.

(b) When an MA group has become ineligible for AFDC due to excess income, is receiving child support payments, and has received an AFDC payment in at least 3 of the 6 months immediately preceding the month in which ineligibility begins, eligibility for MA shall continue for 4 months from the date that AFDC eligibility was terminated. The 6 months preceding the month in which ineligibility begins includes the month in which the MA group became ineligible for AFDC if the MA group was eligible for and received AFDC for that month.

(3) TWELVE-MONTH CONTINUATION OF ELIGIBILITY. (a) When an MA group has become ineligible for AFDC because of the loss of the earned income disregards under s. 49.19(5)(a)4 and 4m, Stats., eligibility for MA shall continue for 12 months from the date that AFDC eligibility was terminated.

(b) The MA group's eligibility shall be redetermined after nine months of continued coverage by application of the earned income disregard that originally closed the AFDC case. Eligibility shall be redetermined monthly until the end of the 12 months.

(4) TIMELY NOTICE. The agency shall give the recipient timely advance notice and explanation of the agency's intention to terminate MA. This notice shall be in writing and shall be mailed to the recipient at least 10 calendar days before the effective date of the proposed action. The notice shall clearly state what action the agency intends to take and the specific regulation supporting that action, and shall explain the right to appeal the proposed action and the circumstances under which MA is continued if a fair hearing is requested.

HSS 103.10 REDETERMINATION OF ELIGIBILITY. The agency shall give the recipient timely advance notice of the date on which the recipient's eligibility will be redetermined. This notice shall be in writing and mailed to the recipient at least 15 calendar days but no more than 30 calendar days before the redetermination date. The requirement for timely advance notice of eligibility redetermination does not apply to spend-down cases in which the period of certification is less than 60 days.

SECTION 3. HSS 104 (title) is repealed and recreated to read:

Chapter HSS 104

MEDICAL ASSISTANCE: RECIPIENT RIGHTS AND DUTIES

SECTION 4. HSS 104.01 to 104.03 are amended to read:

HSS 104.01 RECIPIENT RIGHTS. (1) CIVIL RIGHTS. No applicant for or recipient of medical assistance~~,~~ (MA) ~~shall~~ may be excluded from participation in ~~medical assistance~~ MA or denied ~~medical assistance~~ benefits~~,~~ or otherwise be subjected to discrimination under ~~the medical assistance Program~~ MA for reasons which violate title VI of the civil rights act~~.~~ of 1964, as amended, 42 USC 200d et seq., and the implementing regulations, 45 CFR Part 80.

(2) RIGHTS OF HANDICAPPED PERSONS. No otherwise qualified handicapped individual ~~shall~~ may, solely by reason of handicap, be excluded from the participation in MA, be denied benefits of MA or be subjected to dis-

crimination under ~~under, any program or activity receiving federal financial assistance~~ MA.

Note: See s. 504 of the rehabilitation act of 1973, as amended, 29 USC 794, and the implementing regulations, 45 CFR Part 84.

(3) CONFIDENTIALITY OF MEDICAL INFORMATION. Information about recipients shall be confidential in accordance with ~~pursuant to s. 905.04(4)(f),~~ ss. 146.81 to 146.83, Stats. ~~,~~ No privilege ~~shall exist~~ exists under ~~the medical assistance program~~ MA regarding communications or disclosures of information requested by appropriate federal or state agencies~~,~~ or their authorized agents concerning the extent or kind of services provided recipients under the program. The disclosure by a provider of ~~such~~ these communications or medical records, made in good faith under the requirements of this program, shall not create any civil liability or provide any basis for criminal actions ~~of~~ for unprofessional conduct.

(4) FREE CHOICE OF PROVIDER. (a) Selection of a provider. The department or agency shall maintain a current list of certified providers and shall assist eligible persons in securing appropriate care.

(b) Limitations. A recipient may request service from any certified provider, subject to ss. HSS 104.02(1), ~~and~~ 104.03~~,~~, and 104.05, except as provided in par. (d).

(c) Right to fair hearing. A recipient who believes the recipient's freedom of choice of provider has been denied or impaired unfairly may request a fair hearing within 45 days of the department's action, pursuant to s. PW-PA 20.18~~,~~ ~~Wis. Adm. Code~~ [ch. HSS 225].

(d) Nursing home admission. Free choice of a skilled nursing ~~home~~ or intermediate care facility shall be limited so as to provide only care which is necessary to meet the medical and nursing needs of the recipient. A preadmission screening assessment shall take place to determine appropriate service needs.

(e) Non-covered services. A recipient's participation in ~~medical assistance~~ MA does not preclude the recipient's right to seek and pay for services not covered by the program.

(5) APPEALS (a) Fair hearing. 1. Applicants and recipients have the right to a fair hearing in accordance with ~~established procedures and consistent with applicable state law and federal regulations~~ procedures set out in s. PW-PA 20.18 [ch. HSS 225] and this subsection when aggrieved by action or inaction of the ~~county~~ agency or the department. This subsection does not apply to actions taken by a PRO.

~~1.~~ 2. Every applicant or recipient shall be informed in writing at the time of application for MA and at the time of any action affecting the recipient's claim of the right to a fair hearing, of the manner by which a fair hearing may be obtained and of the right to be represented or to represent self at such a fair hearing.

~~2.~~ 3. The applicant or recipient shall be provided reasonable time, not to exceed ~~90~~ 45 days, in which to appeal an agency action. The department shall take prompt, definitive, and final administrative action within 90 days of the date of the request for a hearing.

~~3. The procedure for the fair hearing shall be found in PW-PA-20.18, Wis. Adm. Code.~~

4. No fair hearing is required when the sole issue being petitioned involves an automatic grant adjustment or change which affects an entire class of recipients and is the result of a change in state or federal law.

(b) Purpose of hearing. The purpose of the fair hearing is to allow a recipient to appeal department actions which result in the denial, discontinuation, termination, suspension, or reduction of the recipient's ~~medical assistance~~ MA benefits. The fair hearing process is not intended for recipients who wish to lodge complaints against providers concerning quality of services received, nor is it intended for recipients who wish to institute legal proceedings against providers. Recipients' complaints about quality of care should be lodged with the appropriate channels established for ~~such purposes~~ this purpose, ~~such as~~ to include but not limited to provider peer review organizations, consumer advocacy organizations, regulatory agencies ~~or~~ and the courts.

(c) Concurrent review. 1. After the department has received a recipient's request for a fair hearing and has set the date for the hearing, the department shall review and investigate the facts surrounding the recipient's request for fair hearing in an attempt to resolve the problem informally.

~~1.~~ 2. If, before the hearing date, an informal resolution is proposed and is acceptable to the recipient, the recipient may withdraw the request for fair hearing.

~~2.~~ 3. If~~,~~ before the fair hearing date~~,~~ the concurrent review results in ~~an~~ a proposed informal resolution not acceptable to the recipient, the fair hearing shall proceed as scheduled.

~~3.~~ 4. If the concurrent review has not resolved the recipient's complaint satisfactorily by the fair hearing date but an informal resolution acceptable to the recipient appears imminent to all parties, the hearing may be dropped without prejudice and resumed at a later date. However, if the informal resolution proposed by the department is not acceptable to the recipient, the recipient may proceed with a fair hearing~~,~~ and a new hearing date shall be set promptly.

~~4.~~ 5. If before the fair hearing date~~,~~ the concurrent review has not been initiated, the fair hearing shall proceed as scheduled.

(d) Absence of petitioner. Pursuant to s. 49.50(8)(b)1d, Stats., if the recipient does not appear at a scheduled hearing and does not contact the department's office of administrative hearings with good cause for postponement, the hearing examiner may dismiss the petition.

(6) COVERAGE WHILE OUT-OF-STATE. Medical assistance shall be furnished under any of the following circumstances to recipients who are Wisconsin residents but ~~who are~~ absent from the state~~,~~ provided that they are within the United States, Canada or Mexico:

(a) When an emergency arises from accident or illness; ~~or~~

(b) When the health of the recipient would be endangered if the care and services were postponed until the recipient returned to Wisconsin; ~~or~~

(c) When the recipient's health would be endangered if the recipient undertook travel to return to Wisconsin; or

(d) When prior authorization has been granted for provision of a non-emergency service, except that prior authorization is not required for non-emergency services provided to Wisconsin recipients by border status providers certified by the Wisconsin MA program.

(7) FREE CHOICE OF FAMILY PLANNING METHOD. Recipients eligible for family planning services and supplies shall have freedom of choice of family planning method so that a recipient may choose in accordance with the dictates of conscience and shall neither be coerced nor pressured into choosing any particular method of family planning.

(8) CONTINUATION OF BENEFITS TO COMMUNITY CARE ORGANIZATION CLIENTS. Recipients who were eligible for or receiving services from any of the local community care organization (CCO) projects ~~sites~~ in ~~(~~La Crosse county, Barron county, or Milwaukee county~~)~~, ~~as of~~ in April 1976, shall be allowed to continue to receive any of the CCO services~~,~~ and ~~such~~ these services shall be reimbursed under ~~the program.~~ MA.

(9) RIGHT TO INFORMATION CONCERNING PROGRAM POLICY. (a) Program manuals. Recipients may examine program manuals and policy issuances which affect the public, including rules and regulations governing eligibility, need and amount

of assistance, recipients' rights and responsibilities and services ~~offered~~ covered under ~~medical assistance~~ MA, at the department's state~~,-county~~ or regional offices, or an agency's offices, ~~on-regular-work-days~~ during regular office hours.

(b) Notice of intended action. 1. Except when changes in the law require automatic grant adjustments for classes of recipients, in every instance in which the department intends to discontinue, terminate, suspend or reduce a recipient's ~~medical assistance~~ eligibility for MA or coverage of services to a general class of recipients, the department shall send a written notice to the recipient's last known address ~~no later than 10 days~~ at least by the minimum time period required under 42 USC 601-613 and before the date upon which the action would become effective, informing the recipient of the following:

a. The nature of the intended action;

b. The reasons for the intended action;

c. The specific regulations supporting ~~such~~ the action;

d. An explanation of the recipient's right to request a fair hearing; and,

e. The circumstances under which assistance ~~is~~ will be continued if a hearing is requested.

2. The department shall mail ~~such~~ the individual written notice to be received no later than the date of intended action under any of the following circumstances:

a. The department receives a clear written statement signed by a recipient that states the recipient no longer wishes assistance, or that gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands that ~~this must be~~ the consequence of supplying the information; will be termination or reduction of assistance;

b. The department has factual information confirming the death of a recipient;

c. The recipient has been admitted or committed to an institution and further payments to the recipient do not qualify for federal financial participation under the state plan for MA;

d. The recipient has been placed in skilled nursing care, intermediate care or long-term hospitalization;

e. The recipient's whereabouts are unknown and departmental mail directed to the recipient has been returned by the post office indicating no known forwarding address;

f. A recipient has been accepted for assistance in a new jurisdiction and that fact has been established by the jurisdiction previously providing assistance;

g. An AFDC child is removed from the home as a result of judicial determination or voluntarily placed in foster care by a legal guardian;

h. A change in level of medical care is prescribed by the recipient's physician;

i. The recipient's eligibility for MA is to be terminated or suspended under the provisions of s. HSS 104.02(5); or

j. The recipient has received service during a period of ineligibility and the department is preparing to take recovery action, pursuant to s. HSS 108.03(3).

(10) PROMPT ACCESS TO ASSISTANCE. Applicants have the right to prompt decisions on their applications. Eligibility decisions shall be made within 30 days of the date the application was signed. For individuals applying as disabled, where medical examination reports, determination of disability, and other additional medical and administrative information is necessary for the decision, eligibility decisions shall be made not more than 60 days after the date the application was signed. Health care shall be furnished promptly to eligible recipients without any delay attributable to the department's administrative process and shall be continued ~~regularly~~ as needed until the ~~individuals are~~ individual is found ineligible.

(11) RIGHT TO REQUEST RETURN OF PAYMENTS MADE BY A RECIPIENT FOR COVERED SERVICES DURING PERIOD OF RETROACTIVE ELIGIBILITY. If a person has paid all or part of the cost of health care services received and then ~~the person~~ becomes a recipient of MA benefits ~~and the recipient's~~ with retroactive eligibility ~~is made retroactive to allow the MA program to pay~~ for those covered services for which the recipient has previously made payment, then ~~such~~ the recipient has the right to notify the certified provider of the retroactive eligibility period. At ~~such~~ that time the certified provider shall submit claims to ~~medical assistance~~ MA for covered services provided to the recipient during the retroactive period. Upon the provider's receipt of the MA payment, the provider shall ~~be required to~~ reimburse the recipient for the lesser of the amount received from MA or the amount paid by recipient or other person, minus any relevant copayment. In no case may the department reimburse the recipient directly.

~~(12) FREEDOM FROM LIABILITY FOR COVERED SERVICES. (a) Recipients cannot be held liable by certified providers for covered services and items furnished by providers under the medical assistance program so long as the recipients are eligible for medical assistance benefits and meet all other program requirements.~~

(12) FREEDOM FROM LIABILITY FOR COVERED SERVICES. (a) Exceptions to cost-sharing. 1. Recipients of MA are liable for payment of any copayment or deductible amount established by the department pursuant to s.49.45(18), Stats., for the cost of a service, except as provided in this subsection.

The recipient shall pay the copayment or deductible to the provider of service. Copayments or deductibles are not required:

a. From recipients who are nursing home residents;

b. From recipients who are members of a health maintenance organization or other prepaid plan for those services provided by the HMO or PHP;

c. From any recipient who is under age 18;

d. For services furnished to pregnant women if the services relate to the pregnancy, or to any medical condition which may complicate the pregnancy when it can be determined from the claim submitted that the recipient was pregnant;

e. For emergency hospital and ambulance services and emergency services related to the relief of dental pain;

f. For family planning services and related supplies;

g. For transportation services by a specialized medical vehicle;

h. For tranportation services provided through or paid for by a county social services department;

i. For home health services or for home nursing services if a home health agency is not available;

j. For physician office visits over 6 visits per recipient, per physician, in a calendar year;

k. For laboratory and x-ray services prescribed by a physician;

l. For outpatient psychotherapy services received over 15 hours or $500, whichever comes first, during one calendar year; or

m. For occupational, physical or speech therapy services received over 30 hours or $1,500 for any one therapy, whichever comes first, during one calendar year.

2. If the recipient uses one pharmacy or pharmacist as his or her sole provider of prescription drugs, the monthly amount of copayment a recipient is required to pay may not exceed $5.

(b) Freedom from having to pay for services covered by MA. Recipients may not be held liable by certified providers for covered services and items furnished under the MA program, except for copayments or deductibles under par. (a), if the patient identifies himself or herself as an MA recipient and shows the provider the MA identification card.

Note: Recipients seeking nonemergency services from noncertified providers are liable for all charges, unless the services were authorized by the department prior to service delivery.

(c) Prior authorization of services. When a service must be authorized by the department in order to be covered, the recipient may not be held liable by the certified provider unless the prior authorization was denied by the department and the recipient was informed of the recipient's personal liability before provision of the service. In that case the recipient may request a fair hearing. Negligence on the part of the certified provider in the prior authorization process shall not result in recipient liability.

Note: For example, if a provider does not inform a recipient that a procedure or service requires prior authorization, and performs the service before submitting a prior authorization request or receiving an approval and then submits a claim for services rendered which is rejected, the recipient may not be held liable.

~~(b)~~ (d) Freedom from having to pay the difference between charges and MA payment. ~~Recipients cannot be~~ Providers may not charge ~~by providers~~ recipients for the amount of the difference between charge for service and ~~the program's payment amount,~~ MA reimbursement, except in the case of recipients wishing to be in a private room in a nursing home or hospital, in which case the provisions of ~~section~~ s. HSS 107.09(3)(k) shall be met.

HSS 104.02 RECIPIENT DUTIES. (1) DUPLICATION OF SERVICES. A recipient ~~shall~~ may not seek the same or similar services from more than one provider, except as provided in s. HSS 104.04. ~~of this rule.~~

(2) PRIOR IDENTIFICATION OF ELIGIBILITY. Except in ~~bona fide~~ emergencies that preclude prior identification, the recipient shall, before receiving services, inform the provider that the recipient is receiving benefits under ~~the medical assistance program~~ MA, and shall present to the provider a current valid MA identification card.

(3) REVIEW OF BENEFITS NOTICE. Recipients shall review the monthly explanation of benefits (EOB) notice sent to them by the department and shall report to the department any payments made for services not actually provided. The explanation of benefits notice ~~shall~~ may not specify confidential services, such as family planning, and ~~shall~~ may not be sent if the only service furnished ~~was~~ is confidential.

(4) INFORMATIONAL COOPERATION WITH PROVIDERS. Recipients ~~are responsible for giving~~ shall give providers full, correct and truthful information requested by providers and necessary for the submission of correct and complete claims for ~~medical assistance~~ MA reimbursement. ~~Such~~ This information ~~includes~~ shall include but is not limited to:

(a) Information concerning the recipient's eligibility status, accurate name, address and MA identification number;

(b) Information concerning the recipient's use of the ~~medical assistance~~ MA card;

(c) Information concerning the recipient's use of ~~medical assistance~~ MA benefits; and

(d) Information concerning the recipient's coverage under other insurance programs.

(5) PENALTIES. ~~Recipients who abuse or misuse the MA card or benefits in any manner may be subject to limitation of benefits or decertification from the~~

~~program.~~ If a recipient abuses or misuses the MA card or benefits in any manner, the department or agency, as appropriate, may limit or terminate benefits. For purposes of this subsection, "abuses or misuses" includes, but is not limited to, any of the following actions:

(a) Altering or duplicating the MA card in any manner;

(b) Permitting the use of the MA card by any unauthorized individual for the purpose of obtaining health care through MA;

(c) Using an MA card that belongs to another recipient;

(d) Using the MA card to obtain any covered service for another individual;

(e) Duplicating or altering prescriptions;

(f) Knowingly misrepresenting material facts as to medical symptoms for the purpose of obtaining any covered service;

(g) Knowingly furnishing incorrect eligibility status or other information to a provider;

(h) Knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which MA has been billed;

(i) Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary;

(j) Knowingly obtaining duplicate services from more than one provider for the same health care condition, excluding confirmation of diagnosis or a second opinion on surgery; or

(k) Otherwise obtaining health care by false pretenses.

(6) NOTIFICATION OF PERSONAL OR FINANCIAL STATUS CHANGES. Recipients shall inform the ~~county~~ agency within 10 days of any change in address, ~~eligibility,~~ income, assets, need, or living arrangements~~,~~ which may affect eligibility. In addition, the department may require as a condition for continuation of MA coverage that certain recipients report each month under ch. HSS 205 whether there has been any change of circumstances that may affect eligibility.

(7) FINANCIAL RESPONSIBILITY OF SPOUSE OR RESPONSIBLE RELATIVE. Within the limitations provided by ch. 52, Stats., and this ~~rule,~~ chapter, the spouse of an applicant of any age or the parent of an applicant under 18 years of age shall be charged with the cost of medical services before ~~medical assistance~~ MA payments shall be made. However, eligibility ~~shall~~ may not be withheld, delayed or denied because a responsible relative fails or refuses to accept financial responsibility. When the ~~county~~ agency determines that a responsible relative is able to contribute without undue hardship to self or immediate family but refuses to contribute, the agency shall exhaust all available administrative procedures to obtain that relative's contribution. If the

responsible relative fails to contribute support after the ~~county~~ agency notifies the relative of the obligation to do so, the ~~county~~ agency shall notify the district attorney in ~~an effort~~ order to commence legal action against that relative.

HSS 104.03 PRIMARY PROVIDER. (1) REQUIRED DESIGNATION. (a) Required when program is abused. If the department discovers ~~program abuse,~~ that a recipient is abusing the program, including abuse under s. HSS 104.02~~(1)~~(5), the department may require the recipient to designate, in any or all categories of health care provider, a primary health care provider of the recipient's choice, except when free choice is limited under s. HSS 104.035.

(b) Selection of provider. The department shall allow a recipient to choose a primary provider from the department's current list of certified providers, except when free choice is limited under s. HSS 104.035. The recipient's choice shall become effective only with the concurrence of the designated primary provider. The ~~name~~ type of service and identification number of the primary provider shall be endorsed on the recipient's ~~medical assistance identification~~ MA card.

(c) Failure to cooperate. If the recipient fails to designate a primary provider after receiving a formal request from the department, the department shall designate a primary provider for the recipient in the proximity of the receipient's residence.

(2) REFERRAL TO OTHER PROVIDERS. A primary provider may, within the scope of the provider's practice, make referrals to other providers of medical services

for which reimbursement will be made if the referral can be documented as medically necessary and the services are covered by ~~the medical assistance program~~ MA. This documentation shall be made by the primary provider in the recipient's medical record.

(3) ALTERNATE PRIMARY PROVIDER. The department may allow the designation of an alternate primary provider. When approval is given by the department to select an alternate primary provider, the recipient may designate an alternate primary provider in the same manner a primary provider is designated.

(4) EXCEPTIONS. The limitations imposed in this section do not apply in the case of an emergency. Emergency health care provided by any provider to a recipient restricted under this section shall be eligible for reimbursement if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

SECTION 5. HSS 104.035 is created to read:

HSS 104.035 PRUDENT BUYER LIMITATIONS. Free choice of a provider may be limited by the department if the department contracts for alternate service arrangements which are economical for the MA program and are within state and federal law, and if the recipient is assured of reasonable access to health care of adequate quality.

SECTION 6. HSS 104.04 is amended to read:

HSS 104.04 SECOND OPINION PROGRAM. (1) PURPOSE. ~~Pursuant to~~ Under ~~chapter 29, laws of 1977,~~ s. 49.45(3)(i), Stats., the department shall require ~~may establish~~ a second medical opinion ~~program~~ for selected elective surgical procedures, ~~to promote the quality of care for recipients. The purpose of the~~

~~program is~~ in order to provide a recipient additional medical information about the medical appropriateness of the proposed procedure~~,~~ before the recipient makes a decision to undergo ~~a surgical~~ the procedure. ~~and to allow reimbursement of the costs related to providing the second opinion. Second opinions apply only to non emergency procedures.~~ Procedures for which a second medical opinion is required are the following:

(a) Cataract extraction, with or without lens inplant;

(b) Cholecystectomy;

(c) Non-obstretrical D and C;

(d) Hemorrhoidectomy;

(e) Hernia repair, inguinal;

(f) Hysterectomy;

(g) Joint replacement, hip or knee;

(h) Tonsillectomy;

(i) Adenoidectomy; and

(j) Varicose vein surgery.

(2) APPLICABILITY. The requirement for a second opinion applies only to nonemergency procedures.

(3) SANCTIONS. (a) If a provider performs an elective surgical procedure covered under the program and no second opinion has been obtained, the primary surgeon's fees are not reimbursable by MA.

(b) If the provider who provides the second opinion also performs the surgery, the primary surgeon's fees are not reimbursable by MA.

SECTION 7. HSS 104.05 is created to read:

HSS 104.05 PREFERRED ENROLLMENT. (1) CONTRACTS FOR SERVICES FROM GROUP PLANS. The department may enter into contracts for MA services with health maintenance organizations (HMOs) or prepaid health plans (PHPs). Each contract shall include specific information about services to be provided by the group, the number and types of practitioners who will provide the services, the geographic service area covered by the group plan, the period of time in which recipients are enrolled, the procedures for recipient enrollment, additional services which may be available, and the cost of services for each enrollee.

(2) ENROLLMENT RESPONSIBILITY. MA recipients within the geographic area stipulated in a group plan service contract shall have the choice of enrolling for service membership under the following conditions:

(a) Minimum enrollment period. The department may enter into arrangements with HMOs or PHPs which establish minimum enrollment periods for MA recipients.

(b) Disenrollment period. In geographic areas where there is only one certified group plan provider, each recipient may be automatically enrolled in the group plan. A recipient may disenroll from the group plan, and the

effective date of disenrollment shall be no later than one month from the month in which the recipient disenrolls.

(3) CONTROL OF SERVICES. Enrollees in an HMO or PHP shall obtain services paid for by MA from that organization's providers, except for referrals or emergencies. Recipients who obtain services in violation of this section shall pay for these services.

(4) IDENTIFICATION OF COVERED SERVICES. Services available to MA recipients shall be identified in the provider's contract with the department and shall be made known to all MA enrollees.

The repeals and rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.026(1), Stats.

Department of Health and Social Services

Dated: November 12, 1985

By _____
Linda Reivitz, Secretary

SEAL:

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
1 West Wilson Street, Madison, Wisconsin 53702

Anthony S. Earl
Governor

Linda Reivitz
Secretary

Mailing Address:
Post Office Box 7850
Madison, WI 53707

November 12, 1985

Mr. Orlan Prestegard
Revisor of Statutes
30 on the Square - 9th Floor
Madison, Wisconsin 53702

Dear Mr. Prestegard:

As provided in s. 227.023, Stats., there is hereby submitted a certified copy of HSS 102, 103 and 104, administrative rules relating to application and eligibility for Medical Assistance and the rights and duties of recipients of Medical Assistance.

These rules are also being submitted to the Secretary of State as required by s. 227.023, Stats.

Sincerely,

Linda Reivitz
SECRETARY

Enclosure